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Senate Human Services Committee
Subject Matter Hearing
August 14, 2018

Children in the Department of Children and Family Services Care who were Hospitalized and Held Beyond Medical Necessity

The Cook County Public Guardian is the court-appointed attorney and guardian *ad litem* for children and youth with cases pending in Cook County due to allegations that they are abused, neglected, or dependent. The Public Guardian currently represents approximately 6,000 children ranging in age from newborn to 21 in this capacity. The vast majority of our clients are in the guardianship or temporary custody of the Illinois Department of Children and Family Services. The Public Guardian appreciates the time the members of the Senate Human Services Committee are devoting to addressing the critical issue of youth in care who are warehoused in psychiatric hospitals and who, as a result, are not receiving the treatment, nurturing and care they desperately need to overcome significant trauma and to thrive.

There is an urgent and unmet need for therapeutic placements for children in care with severe emotional and behavioral challenges.

For years the Public Guardian has expressed that the most pressing issue for children in state care is the lack of safe, stable and nurturing placements that are available to meet their needs on a timely basis. The June 5, 2018, article in The Atlantic, "The 'Stuck Kids' of Illinois," describes the tragic circumstances of several youth in care languishing in psychiatric hospitals.[1]

Two years ago we described the problem as having reached a crisis stage.

Since then it has grown worse.

Senate Resolution 140, adopted on April 25, 2015, directed the Illinois Auditor General to conduct a Performance Audit of DCFS regarding the number of youth in care who were being left in psychiatric hospitals beyond medical necessity (BMN), in detention and Juvenile Justice facilities simply because a placement could not be located, and in temporary shelters longer than

[1] *Available at* https://www.theatlantic.com/family/archive/2018/06/kids-psychiatric-hospital-illinois/561572/.

30 days. With respect to the youth in psychiatric hospitals, the audit documents a more than two-fold increase in the number of youth in DCFS care remaining beyond medical necessity in psychiatric hospitals from 2014 (75 youth) to 2015 (168 youth), in addition to a significant increase in the number of days, on average, that they waited for clinically appropriate placements.

Over the past two years, the Foster Care Alumni of America – Illinois Chapter (FCAA-IL) and the Public Guardian have collaborated to look at the number of youth in care beyond medical necessity. Based on information provided by DCFS to the FCAA-IL pursuant to the Freedom of Information Act, the number of youth beyond medical necessity has again increased dramatically, and the number of days children waited on average has at best, remained the same, and more likely, has increased. A summary of the findings is attached as Attachment A.

How many children were left by DCFS in psychiatric hospitals beyond medical necessity?

2014	75[2]
2015	168[3]
FY2018[4]	300[5]

How many days, on average, did the child remain in the psychiatric hospital beyond medical necessity?

2014	28 days[6]
2015	40 days[7]
FY2018	At least 39 days[8]

[2] State of Illinois, Office of the Auditor General, Performance Audit of Department of Children and Family Services' Placement of Children, September 2016, http://www.auditor.illinois.gov/Audit-Reports/Performance-Audits.asp.

[3] Id.

[4] Data was also provided by the Department of Children and Family Services via FOIA to the FCAA-IL for youth in psychiatric hospitals beyond medical necessity for FY2017. However, the data for FY2017 was provided on a monthly, instead of weekly basis, making it less likely to capture as many youth who were BMN, and making it impossible to determine, even approximately, how long a particular youth remained hospitalized while BMN. For that reason, only the FY2018 data is presented here. However, based on the data that was provided for FY2017, there were at least 177 children BMN in FY2017.

[5] Data provided by the Department of Children and Family Services via FOIA to the FCAA-IL. Because individual identifying information was not provided, it is possible that in a few instances, one youth in care was BMN twice during FY2018, and counted here as two discrete youth. There are also three instances where children may duplicate one another, but certain other information conflicts and it is impossible to discern whether it is a data error, or two distinct youth.

[6] State of Illinois, Office of the Auditor General, Performance Audit of Department of Children and Family Services' Placement of Children, September 2016, http://www.auditor.illinois.gov/Audit-Reports/Performance-Audits.asp.

[7] Id.

[8] Because data was provided weekly, and actual placement dates were not provided, the length of time a particular youth was BMN is underestimated by up to 7 days per child. It is unknown when in the 7-day period the child was placed. The data is calculated based on each youth being placed on the earliest possible date. For youth entering care while BMN, only the days they were BMN while in DCFS care are counted.

How did we get here?

The results are sobering, but unfortunately not shocking to those who work closely with children in care. A crisis exists that requires an urgent response.

Since the Audit, DCFS embarked on a deliberate effort to reduce in-state residential beds for youth in care, despite the fact that according to DCFS' own clinical assessment, the vast majority of youth waiting for placement while BMN require placement in a residential treatment facility. For example, DCFS determined that over 65% of the children who were BMN in FY2018 needed placement in a residential treatment facility.

Remarkably, in FY2016, DCFS requested a nearly 30% *reduction* in funding for residential and group home care.[9] In FY2017, DCFS commended itself for making "great strides to reduce the number of youth in shelter and high-end residential placements," and announced a continued goal of "reducing the department's over-reliance on shelter and high-end residential placements."[10] Again in FY2018, DCFS announced that it continued "our drive to move children and youth from institutional settings to community based care," although the Department had not taken the initiative to explore the impact of the moves on the 84 children affected by the closure of two of the larger programs that year -- Maryville and JCFS.[11] In FY2018, DCFS again requested a nearly 30% *reduction* in residential and group home funding.

DCFS now reports that "over the last five years in Illinois, the private agencies have closed more than 500 beds for youth with serious and on-going mental health needs." The vast majority of those 500 beds were either deliberately cut by DCFS or were so drastically underfunded that agencies had no choice but to close or be shut down. DCFS has been unwilling to engage in honest conversations about (1) the needs of the children in its care and (2) the actual cost of caring for our most vulnerable children with the most challenging emotional and behavioral needs.

Some private agencies contracted by DCFS to provide care have been unable to continue to heavily supplement the DCFS rate with private fundraising and have closed their doors. Others have been severely challenged to find and retain qualified staff. High staff turnover contributes to chaos in programs, and leads to the loss of available beds for youth due to intake holds, quality improvement plans, corrective action plans and sometimes, program closure. Despite the loss of 500 beds in 5 years, and the growing lists of children in care waiting for the same beds, DCFS failed to request additional funding to support its existing beds and increase the overall number of beds for FY2019.

The impact on youth in care

When DCFS is given custody or guardianship of a child, DCFS is required by law to place the child in the least restrictive setting appropriate for the child that is consistent with the child's health, safety and best interests. 20 ILCS 505/7(c); 89 ILAC 301.60(a); 89 ILAC 301.60(b)(1). Psychiatric hospitals serve a critical role in the mental health service spectrum, but their purpose is to provide short-term crisis intervention, not to provide long-term treatment. Youth in psychiatric hospitals only receive a few hours (if that) of very generalized

[9] DCFS FY2016 Budget Briefing. Portions of this percentage are attributable to the additional request in FY2016 to cut *all* services for youth in care ages 18-21.
[10] DCFS FY2017 Budget Briefing.
[11] DCFS FY2018 Budget Briefing.

educational instruction per day; their social interactions are limited to other youth like themselves, who are hospitalized; and their freedom is severely restricted. Children who stay longer than necessary watch others come and go, exacerbating their own feelings of hopelessness, anger and rejection. These youth suffer irreparable harm because their treatment is delayed, their education is put on hold, and their faith in human relationships is severely compromised, which in turn, makes achieving sustainable permanency extraordinarily challenging.

The children who require residential treatment are moved up and down on waiting lists -- vying for the coveted first place spot -- depending on their specific circumstances. Decisions regarding placement are frequently driven by what placements are available, not necessarily by what the youth needs. Children are referred out-of-state simply because in-state programs are at capacity and recommendations for children to be placed in secured care are made even when a child has been accepted to in-state placements that are not secure. Adolescents who need foster homes are frequently diverted to congregate care settings. And some youth remain in residential care facilities because appropriate specialized foster homes are not available for them. Because their placements are contrary to their needs, the children deteriorate emotionally and become discouraged, angry and hopeless.

Alyssa[12]

Alyssa turned 11 on April 8, 2018. She has been in a psychiatric hospital beyond medical necessity since May 19, 2018 -- 87 days as of August 13 -- waiting for DCFS to place her in a clinically appropriate residential treatment setting.

Alyssa has a long history with DCFS. Her first contact with DCFS was at the age of 16 months when DCFS opened an intact family services case after an indicated report of environmental neglect. DCFS closed the case over a year later when it could not locate the family. Thereafter, young Alyssa and her siblings were the subjects of several other child abuse and neglect investigations, some indicated and some unfounded, including two unfounded reports of sexual abuse to Alyssa (not yet 5 years old) by two different male perpetrators. Alyssa and her younger brother entered DCFS care when Alyssa was 4 years old after her mother's boyfriend was indicated for causing cuts, welts and bruises to Alyssa. Alyssa would later disclose that that she was sexually abused by a female cousin before she entered care.

Alyssa's time in care has not been any less traumatic than her first four years of life. From the ages of four to nine DCFS moved Alyssa through several relative and non-relative foster homes, sometimes with her siblings and sometimes not.

Alyssa was removed from one foster home because of abuse -- she and her siblings missed several days of school because they had marks from being hit. In September 2016, then 9-year-old Alyssa was sexually assaulted by a taxi cab driver who was contracted to transport her to and from school. Alyssa also reported several incidents of molestation and sexual assault by a foster parent's 16-year-old grandson. On January 1, 2017, 9-year-old Alyssa ran away from her foster home because she wanted to find her brother. From January 2017 through January 2018,

[12] All names have been changed to protect confidentiality.

Alyssa and her siblings were placed together with a relative in California. This was Alyssa's fifth foster home in 5 years.

Unfortunately, a lifetime of trauma and abuse left Alyssa with Post-Traumatic Stress Disorder, Reactive Attachment Disorder, and Major Depressive Disorder. She continued to have significant emotional struggles and was psychiatrically hospitalized in California for the first time shortly after her 10th birthday. By November 13, 2017, Alyssa's team had determined that 10-year-old Alyssa needed to be placed in a residential treatment center. Her relative in California continues to care for her siblings, remains very involved in Alyssa's treatment, and would like to have Alyssa join them again in the future.

Alyssa was brought back to Illinois in January 2018, placed in her 6th foster home, and psychiatrically hospitalized within weeks, after trying to run away from the home.

Alyssa was hospitalized for a third time on April 9, 2018, and she remains in the hospital today, despite having been ready for discharge on May 19, 2018.

After determining that Alyssa needed residential treatment on November 13, 2017, DCFS referred Alyssa to several facilities in Illinois. Alyssa was declined from two facilities, a third had an "extensive waiting list" and a fourth accepted her, but there were ***"19 other youth ahead of this child"*** on the waiting list.

In April 2018, DCFS planned to place Alyssa at a residential treatment facility in Arkansas. The Public Guardian objected to the placement, asserting that if an out-of-state placement were to be considered, placements in California should be considered to make it easier to facilitate Alyssa's eventual return to her relative caregiver and siblings. Eventually, DCFS withdrew its plan to place Alyssa in Arkansas after the Public Guardian brought information to the Department's attention regarding the inadequate quality of care provided at the proposed facility.

In June 2018, DCFS obtained a 22-page Sexual Abuse Assessment of Alyssa. The assessment recommends Alyssa be placed in "residential care facility which provides specialized treatment for children with sexual behavior problems." The evaluator noted, "I am not frankly as concerned about whether the residential facility is locked or unlocked at present; what appears more central is wherever she is that the staff are able to provide the monitoring until and if she can develop these internal skills. All things considered, I would recommend that if there is a facility which has potentials to assist [Alyssa] internally that this would be far more important than whether the facility is locked or not."

Five days later, in a one-page "addendum" the same evaluator states that Alyssa requires placement in a secure residential treatment facility.

As of August 13, 2018, it has been 274 days since DCFS determined Alyssa needed placement in a residential treatment facility. Eleven-year-old Alyssa has been beyond medical necessity for 87 days.

Jayda

Fourteen-year-old Jayda and her brother were the subjects of several calls to the DCFS child abuse and neglect hotline alleging physical abuse in 2013, 2016 and 2017. Jayda was psychiatrically hospitalized on October 17, 2017, because of suicidal ideations, while DCFS was investigating an allegation of physical abuse. It was Jayda's approximately 13th such hospitalization. DCFS determined on November 3, 2017, that Jayda required placement in a residential treatment facility. On December 8, 2017, the court appointed DCFS as Jayda's temporary custodian. At that point, Jayda had already been beyond medical necessity for 19 days.

As Jayda's temporary custodian, DCFS is legally obligated to act in her best interests, and to place her in the least restrictive, most family-like setting appropriate to meet her needs. Instead, DCFS allowed Jayda to continue to languish in the psychiatric hospital after she no longer needed to be hospitalized.

On February 2, 2018 -- when Jayda was 75 days beyond medical necessity -- the court granted the Public Guardian's motion and ordered DCFS to place Jayda appropriately by the end of the business day on February 5, 2018. At a subsequent court date, DCFS would argue that the court did not have authority to enter such an order. At a February 8, 2018, status date, Jayda was still in the hospital.

On February 13, 2018 -- when Jayda was 86 days beyond medical necessity -- the court entered a new order requiring DCFS to place Jayda appropriately by February 16, 2018.

DCFS had "matched" Jayda to three in-state residential treatment providers on November 15, 2017 -- weeks before DCFS was appointed as Jayda's temporary custodian. All three treatment providers had long waiting lists. At one point, DCFS raised the possibility of placing Jayda out-of-state. The Public Guardian objected based on Jayda's desire to continue connections with her family.

DCFS finally placed Jayda in a residential treatment center on February 20, 2018 -- after she had spent 93 days in a psychiatric hospital beyond medical necessity.

Dexter

Earlier this year Dexter celebrated his 17th birthday in a psychiatric hospital, although he was ready to be discharged a week before his birthday.

Dexter was admitted to the hospital on January 9, 2018, and was ready for discharge by January 23, 2018. The DCFS child abuse and neglect hotline was called on January 25, 2018, after Dexter's mother refused to take him home because she feared for her safety. DCFS waited over a month after the hotline call, during which Dexter remained at the psychiatric hospital, to conduct a clinical staffing regarding Dexter. At the February 27, 2018, clinical staffing, DCFS determined Dexter needed to be placed in a therapeutic residential program. DCFS did not send Dexter's referral packet to its Centralized Matching Team to refer Dexter to residential facilities until April 11, 2018. DCFS documents indicate that by May 23, 2018 -- when Dexter was 121

days BMN -- he was accepted for placement at a residential facility, but there were ***18 youth on the waiting list for placement*** ahead of Dexter.

DCFS finally took temporary protective custody of Dexter on June 28, 2018, when Dexter was 161 days BMN. DCFS brought his case to the attention of the court on July 2, 2018, and the court appointed the Public Guardian as Dexter's attorney and guardian *ad litem* and appointed DCFS as Dexter's temporary custodian. During Dexter's first conversation with his attorney he wondered whether he would be able see 4th of July fireworks from the hospital window.

The hospital expressed that "movement towards [Dexter's] placement had been very slow and DCFS was refusing to obtain custody, per [the investigator], stating it was due to not being accepted into any placement." DCFS' own documents confirm that the investigator was told to take protective custody *once a placement was located.* Taking protective custody triggers a requirement that the case be heard by a Child Protection Judge within 72 hours. When the investigator did appear in court for the temporary custody hearing, she reported that investigators are not to take protective custody of youth who are BMN until there is a placement.

On July 10, 2018, Dexter's attorney and guardian *ad litem* made a motion for an order directing DCFS to place Dexter in a clinically appropriate placement within 5 days. The court entered and continued the motion to give DCFS time to file a report explaining the steps it was taking to place Dexter appropriately. On August 1, 2018, the court ordered DCFS to place Dexter in a clinically appropriate placement within 5 days, after hearing that Dexter was on a waiting list for a placement that *may* become available within 30 days, contingent upon another child moving.

As of August 10 2018, Dexter remains in the psychiatric hospital where he has thus far been beyond medical necessity for 200 days.

* * *

Alyssa, Jayda and Dexter are only three of the youth who experienced lengthy BMN stays during FY2018. An in-depth look at their situations helps to highlight the issues related to children who are BMN, correct some common misperceptions, and identify needed solutions.

a. BMN is only one symptom of a significant placement capacity problem

There is a significant lack of adequate placement capacity for youth in care with emotional and behavioral needs – the fact that more and more youth are being left beyond medical necessity is one egregious symptom of that problem, but not the only one. While the focus on BMN children is helpful to evaluate the scope of the problem and to generate conversation about the urgent solutions needed, it is essential to keep in mind that there are also children being held in emergency shelters, detention centers, and Juvenile Justice facilities, when they should instead be placed in appropriate therapeutic placements.

As of August 7, 2018, 7 of the 19 youth at one DCFS emergency shelter were waiting for placements in residential treatment facilities. On average, the 7 youth had been waiting 150 days

each in the shelter. As of July 10 2018, there were 13 youth at the Cook County Detention Center because DCFS had not located an appropriate placement for them. (Release upon Request [RUR] to DCFS).

Also, there are youth like Alyssa, placed in foster homes even after DCFS has determined the child needs to be in a residential facility. DCFS approved Alyssa for residential care on November 13, 2017, and then left her in her cousin's home in California, because there was not a bed available for her in a residential treatment facility. 274 days later, DCFS has still not found her an appropriate placement. During those 274 days, Alyssa was moved to a new foster home, ran away, was psychiatrically hospitalized twice, and spent 87 days (and counting) beyond medical necessity. What if she had been placed in a residential facility in November 2017 when DCFS first determined she needed to be? Perhaps today we would be planning for her discharge back to the home of her relative in California, instead of trying to address the trauma inflicted on her over the past 274 days.

b. Who are the youth who become BMN?

While attention has been focused on youth who are BMN because their parents left them at the hospital and refused to take them home ("new cases"), it is important to remember that most of the youth in care who experience episodes of BMN, like Alyssa, have been in care for a long period of time before they are hospitalized. Even some of the children who are considered new cases, are familiar to the Department, because they were previously in care.

Of the approximately 300 youth BMN in FY2018, 127 (42%) were new cases (most, but not all of them "lock-outs"), but 173 (58%) were children like Alyssa, who were in DCFS care before they were BMN. Of the 173 youth who were in care already, 60% had been in care for over a year; 20% had been in care for over 5 years. Of the 127 new cases, nearly 24% were children who were previously in care and had left care through adoption or private guardianship. Even in the situations where a youth is truly "new" to the Department, as in Dexter's case, the Department typically spends weeks, if not months, "investigating" the case, conducting a clinical staffing, and referring the youth to placement before bringing the case to the court's attention.

Moreover, the Department's legal responsibility to provide a child with a placement in the least restrictive most family like setting appropriate for the individual child is the same, no matter how long the child has been in the Department's care, or the reason the child entered care.

c. Youth should only be placed out-of-state when there is a specific reason to do so

Except in very rare circumstances, our children should be cared for in Illinois. There may be good reason, for example, to place Alyssa in an appropriate treatment facility in California, close to her relative and siblings, but not in Arkansas or Utah. As the result of a significant lack of in-state placement capacity, DCFS has turned at increasing rate to placing our most emotionally troubled youth in out-of-state facilities.

Year	Number of children in residential care out-of-state
2006	9
2007	7
2008	14
2009	23
2010	14
2011	19
2012	24
2013	21
2014	28
2015	47
2016	57
2017	76
2018	70 (as of 3/2018 -- DCFS has yet to respond to a 7/19/18 request for updated numbers)

While DCFS explains that the youth placed in out-of-state residential treatment facilities have extraordinary needs and are only referred out of state after multiple in-state placements have rejected them due to their needs, that is not our experience with the majority of our clients who are placed out of state. The vast majority of our clients considered for placement in out-of-state residential facilities were appropriately referred to several in-state facilities with long waiting lists before being considered for placement out of state, like Alyssa and Jayda. Pursuant to Public Act 100-136, effective August 18, 2017, DCFS must seek court approval to place a child in an out-of-state treatment facility. DCFS' motions filed in Cook County reflect that many of the youth cannot be placed in in-state facilities because of waiting lists, not because of such extraordinary needs that Illinois does not have a provider able to meet the need.

DCFS recently issued policies requiring the Department to visit out-of-state facilities before placing children in care at each facility and to consult with that state's licensing authority about the status of any complaints and investigations regarding each facility, but only after:

- A planned placement for one of our clients in an out-of-state facility was stopped after we learned that its state licensing authority had only recently removed an intake hold from the facility due to various complaints; and
- Several youth in care were removed from an out-of-state facility because DCFS had not realized how "institutional" the facility was.

While the new policies are necessary as long as children are being placed out of state, urgent attention needs to be placed on developing in-state resources. Out-of-state placements for youth with the most high-end needs raise many concerns, including obvious ones -- such as the difficulty and expense of monitoring the safety and well-being of youth and of conducting family visits and transitions to step-down placements -- and less obvious ones -- such as the lack of application of protections in Illinois law for youth in care in residential facilities, and increased risk to youth who run-away from out-of-state facilities.

d. Children left in limbo without judicial oversight

Dexter's situation highlights an alarming trend regarding BMN youth who are just entering care. DCFS is deliberately delaying bringing their cases to the attention of the court under the Juvenile Court Act, until the pressure, usually from the hospital, becomes too great. Many of these children are abandoned at the hospital by parents who have been instructed to do so in order to obtain the services their children desperately need. The youth are then left in the psychiatric hospital by the agency charged with protecting them for long periods of time before their case is brought to the attention of the court system. Moreover, when DCFS reports to the court how long these youth have been BMN, DCFS frequently starts the count on the day DCFS chose to screen the case into court (i.e., the day DCFS obtains legal custody), despite the fact that DCFS was involved in the case for weeks if not months earlier, and DCFS deliberately delayed bringing the case to the court's attention.

In Dexter's case, for example, Dexter was BMN on January 23, 2018, and DCFS was notified two days later. DCFS conducted a clinical staffing for Dexter in February and referred him to placements throughout the following months. DCFS finally brought Dexter to the court's attention on June 28, 2018, and was appointed as his temporary custodian on July 2, 2018. DCFS filed a report to the court required under the Juvenile Court Act for children who are BMN. The report never mentions the actual BMN date of January 23, 2018, but instead states, "Beyond Medical Necessity Notified Date: 7/2/2018."

Recommendations

1. Immediately create in-state residential placements

In-state residential beds need to be opened on an urgent basis. When children are sitting on waiting lists 18 children deep for placement, and court orders for placement cannot be followed, there can be no dispute that there is an urgent need to build placement capacity. The focus must be on building capacity to meet the long-term needs of children, and not on developing short-term solutions that will require these youth to move multiple times.

In response to The Atlantic article, DCFS asserts that on any given day in FY2018 there were 60-80 beds available to children in care but they are not the type of beds the waiting children needed. Placement will never be an exact science. Programs, and the beds in them, are for either girls or boys. Some programs are for specific populations – pregnant or parenting teens, youth with sexually reactive behaviors, youth with developmental delays or youth who do not have developmental delays. The system will always require some flexibility in order to address the complex needs of individual children.

However, 60-80 open beds on any given day seems excessive and incongruent with our knowledge of waiting clients -- whom we are frequently told are on long waiting lists for placement -- and our conversations with in-state residential providers regarding capacity. We requested data showing the number of available beds for youth in FY2018. In response DCFS produced a chart listing "available" beds at each facility for each month in FY2018. Many of the beds listed as "available" were actually not available.

For example, in July of 2017, DCFS lists 40 beds at one facility which were unoccupied because DCFS had just removed a long-standing intake hold that was placed as the result of a Corrective Action Plan. As of July 2017, although the corrective plan had been officially lifted, only one child was to be admitted per week. Part of the plan was to only permit one youth to be admitted to the program per week. In the same month, DCFS lists 28 unoccupied beds at a second facility. The facility was on intake hold, and as of June 2017, had announced that it would be closing by September 1, 2017. The 68 beds at these two facilities, while unoccupied, were not available for youth in care. Many of the other agencies listed were at various stages of corrective action, including intake holds, quality improvement plans, and corrective action plans. It is common, and common-sense, for intake to be slowed, or even stopped (even if an official intake hold is not placed), while programs attempt to correct staffing issues and other identified concerns so that they can competently meet the needs of youth in care.

Of the 81.7 "available" residential beds listed in June 2018:

62.1 Were in facilities that were on corrective action plans or quality improvement plans for concerns such as staffing issues, increase in child abuse and neglect hotline calls, concerns about restraints, and youth runaways.

15.6 Were on units where the same provider was over capacity on other units --

	Beds under capacity	Beds over capacity
Facility A	3.9	4.9
Facility B	1.0	1.0
Facility C	1.9	1.5
Facility D[13]	8.8	5.0

2. Develop therapeutic and specialized foster homes

There continues to be a need for the development of therapeutic and additional specialized foster homes to meet the needs of youth with emotional behavioral challenges. While DCFS' implementation of the therapeutic foster home program required by Public Act 99-350 has been a failure, the need for such homes has not changed.

3. Support Critical Resources at Realistic Funding Levels

All levels of placement for children in care must be funded at rates that realistically reflect the cost of providing quality care to children with complex needs. While DCFS asserts that the "BMN challenge for DCFS is not principally a matter of funding but availability of services," the provision of quality services, including maintaining qualified and nurturing staff at appropriate staffing levels, providing necessary clinical supports, and safe and enriching environments, cannot be disconnected from funding. When residential and foster care programs are not adequately compensated to meet the needs of children in care the children suffer. As the result of years of underfunding, many residential providers are limiting DCFS beds in their programs and are developing beds for youth funded by sources that pay higher

[13] This facility also had two units on quality improvement plans.

rates for comparable programming, including the Department of Juvenile Justice. It is troubling that despite the loss of over 500 beds in 5 years and long waiting lists for placements, DCFS would seemingly prefer to seek out-of-state placements for our children than have honest conversations about how to develop the needed resources in-state for our children.

4. Require DCFS to report regarding implementation of the Family First's provisions related to residential care.

The Family First Prevention Services Act creates an opportunity for DCFS to provide and seek federal funding for specified prevention services. However, receipt of these funds is tied to timely implementation of provisions regarding residential care. Beginning October 2019, new restrictions go into place requiring residential providers to be "Qualified Residential Treatment Programs," requiring a qualified person not employed by the state agency to approve referrals to residential care, and requiring judicial findings at certain points in the child's case. If these provisions are not put in place, DCFS will not only lose Title IV-E matching funds for residential placement, but will also forfeit funding for prevention services. DCFS should be required to report on a regular basis to the General Assembly regarding its progress toward ensuring that funding will not be jeopardized.

5. Require DCFS to report regarding BMN youth who are not yet in care

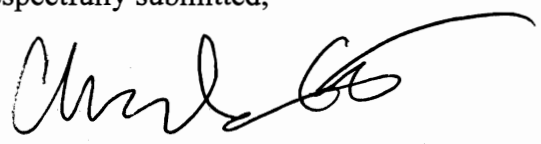
Children should not be left BMN without judicial oversight. It is unconscionable for DCFS to encourage parents to relinquish custody of their children to DCFS so that the children can receive necessary mental health services, and then for DCFS to leave the child in the hospital BMN because there are no such services available. DCFS should be required to report monthly to the General Assembly the following information regarding children reported to the DCFS child abuse and neglect hotline as psychiatric lock-outs:

- The date of the hotline call;
- The date DCFS conducted a clinical staffing;
- The recommendation from the clinical staffing;
- The date the child was brought to the attention of the court under the Juvenile Court Act;
- The date the child was appropriately placed.

* * *

Thank you for your time and commitment to addressing these extremely urgent issues. We look forward to continuing to work with the General Assembly and the Department to address this critical issue impacting children in care.

Respectfully submitted,



Charles P. Golbert
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FY2018 Episodes of Youth in Care Beyond Medical Necessity

Prepared by the Office of the Cook County Public Guardian

in collaboration with

Foster Care Alumni of America – Illinois Chapter

How many children were BMN?

2014	75[1]
2015	168[2]
FY2018	300[3]

How many days did they spend BMN, on average?

2014	28 days[4]
2015	40 days[5]
FY2018	39 days[6]

How long did they wait for placement?

270 of the 300 youth BMN in FY 2018 were placed as of 6/27/18. How **many days were they BMN before they were** placed?

49% waited 31 days or more.

80 children waited 31 - 60 days

36 children waited 61 – 90 days

15 children waited over 91 days.

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[1] State of Illinois, Office of the Auditor General, Performance Audit of Department of Children and Family Services' Placement of Children, September 2016, http://www.auditor.illinois.gov/Audit-Reports/Performance-Audits.asp.

[2] Id.

[3] Data provided by the Department of Children and Family Services via FOIA to the FCAA-IL. Because individual identifying information was not provided, it is possible that in a few instances, one youth in care was BMN twice during FY2018, and counted here as two discrete youth. There are also three instances where children may duplicate one another, but certain other information conflicts and it is impossible to discern whether it is a data error, or two distinct youth.

[4] State of Illinois, Office of the Auditor General, Performance Audit of Department of Children and Family Services' Placement of Children, September 2016, http://www.auditor.illinois.gov/Audit-Reports/Performance-Audits.asp.

[5] Id.

[6] Because data was provided weekly, and actual placement dates were not provided, the length of time a particular youth was BMN is under estimated by up to 7 days per child. It is unknown when in the 7-day period the child was placed. The data is calculated based on each youth being placed on the earliest possible date. For youth entering care while BMN, only the days they were BMN while in DCFS custody or guardianship are counted.

For youth BMN in FY2018, what type of placement did DCFS determine they needed?

65	%	Residential Treatment
25	%	Adolescent or Specialized Foster Care
6	%	Residential Treatment, Therapeutic Foster Care or Specialized Foster Care
1.3	%	Traditional Foster Care or Home of Relative
1.3	%	Recommended placement type not provided
0.6	%	Transitional Living Program
0.3	%	Group Home
0.3	%	Transitional Living Program or Residential Treatment

Comparing New Cases with Existing Cases – FY 2018

New Cases are cases where the child was not in DCFS custody until after the hospitalization, and almost always, after they were BMN. New cases include those referred to as "lock-outs" or "custody relinquishments." Some of the new cases are abuse and neglect cases, but it is not possible to discern from the data provided via the FOIA request how many of the new cases are "lock-outs" and how many are abuse/neglect cases.

New Cases: 127 youth (42%)

Of the new cases, 30 youth (23%) were previously in DCFS care.

Existing Cases are cases where the child was already in DCFS care when the child was hospitalized. The number of days in care prior to the child becoming BMN ranges from 7 days to 6614 days (approx. 18 years).

Existing Cases: 173 youth (58%)

Of the existing cases, how long were the youth in DCFS care prior to being BMN?[7]

Less than 6 months:	53 youth	31 %
6 months to 1 year:	14 youth	9 %
1 year to 4 years:	69 youth	40 %
Over 5 years:	34 youth	20 %

270 Youth who were BMN during FY18 were placed by 6/27/18.

How long did youth wait for placement after they were BMN?

	New Cases (113 placed)	Existing Cases (157 placed)
31-60 days	40 %	24 %
61-90 days	38 %	11 %
Over 90 days	5 %	6 %
Over 30 days total:	**60 %**	**40 %**

[7] The DCFS custody date was not provided in 3 cases.

How many days did youth spend BMN on average?[8]

New Cases: 43 days

Existing Cases: 36 days

Of the 30 youth still BMN on 6/27/18 how many days on average had they waited so far?

New Cases: 27 days

Existing Cases: 42 days

Age of youth at the time they were BMN

	New Cases[9]	Existing Cases
10 and under	6%	21%
11-14	37%	35%
15-17	54%	40%
18-21	0[10]	4%

Placement Recommendation:	New Cases	Existing Cases
Residential Treatment	75 %	58 %
Adolescent or Specialized Foster Care	20 %	25 %
Specialized or Therapeutic Foster Care or Residential Treatment	2.4 %	8.1 %
Traditional Foster Care or Home of Relative	1.6 %	1.2 %
Recommended Placement Type Not Provided		2.3 %
Group Home		0.6 %
Transitional Living Program	0.8 %	0.6 %
Transitional Living Program or Residential Treatment		0.6 %

[8] Because data was provided weekly, and placement dates were not provided, the length of time a particular youth was BMN is under estimated by up to 7 days per child. It is unknown when in the 7-day period the child was placed. The data is calculated based on each youth being placed on the earliest possible date.

[9] Three new cases did not have an age reported.

[10] Youth can no longer enter care once they have turned 18.