STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

REPORT DIGEST

PERFORMANCE AUDIT

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Audit performed in accordance with **Senate Resolution 140**

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EXECUTIVE SUMMARY

Department of Children and Family Services' Placement of Children

Senate Resolution Number 140 directed the Auditor General to conduct a performance audit of the Department of Children and Family Services' compliance with its obligations to place children in its care in placements consistent with their best interests. The resolution directed the Auditor General to examine the number of children who remain in certain placements (psychiatric hospitals, emergency shelters, and detention facilities) longer than necessary and the reasons involved. Specifically, the resolution asked for:

- The number of children;
- The reason they remain at the facility;
- The length of time at the facility;
- The type of recommended placement;
- The barriers to timely placement; and
- Whether the children were placed as recommended.

The Department of Children and Family Services (DCFS or the Department) did not track and could not provide the majority of the information asked for in the audit resolution. We are only able to report on the number of children and length of stay for children in psychiatric hospitals and emergency shelters. For the information we can report, we had issues with data and questions on its accuracy and completeness.

In a sample of cases examined, we identified barriers to timely placement including:

- Delays caused by a lack of timeliness of the matching process which includes matching the youth to a facility, scheduling interviews, attending interviews, and waiting for acceptance;
- Delays in DCFS scheduling and holding a planning meeting, which determines the type of recommended placement;
- Wait lists at facilities after the youth was accepted;
- Administrative delays including delays in sending out referral packets to facilities; and
- Youth not cooperating by going on the run or refusing to attend interviews.

The audit also found:

- The Department was not consistently using its own required internal forms. This also resulted in a lack of consistency in the content of the case files.
- The Department lacked internal procedures on the placement of children for two of the three areas specified in the audit resolution. In addition, for the one area that had procedures, the procedures were not followed.

AUDIT SUMMARY AND RESULTS

On April 23, 2015, Senate Resolution Number 140 was adopted directing the Auditor General to conduct a performance audit of the Department of Children and Family Services' compliance with its obligations to place children in its care in placements consistent with their best interests. The resolution directed the Auditor General to examine the number of children who remain in certain placements (psychiatric hospitals, emergency shelters, and detention facilities) longer than necessary and the reasons involved. Specifically, the resolution asked for:

DCFS did not track and could not provide the majority of the information asked for in the audit resolution.

- The number of children;
- The reason they remain at the facility;
- The length of time at the facility;
- The type of recommended placement;
- The barriers to timely placement; and
- Whether the children were placed as recommended. (page 4)

The Department of Children and Family Services (DCFS or the Department) did not track and could not provide the majority of the information asked for in the audit resolution. The only information we are able to report is shown below.

NUMBER OF CHILDREN AND AVERAGE LENGTH OF STAY

	Determination #1 – The number of children who remain **psychiatrically hospitalized** beyond medical necessity		**Determination #2** – The number of children who remain in **emergency shelters** beyond 30 days		**Determination #3** – The number of children who remain in a **detention facility** solely because placement cannot be located	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
Number of children	75	168	451	380	Not Available	
Average length of stay:	48 days	64 days	72 days	80 days	Not Available	
Days beyond medical necessity / days beyond 30 days	28 days[1]	40 days [1]	42 days [2]	50 days [2]	Not Available	

[1] This is the average number of days the youth stayed beyond medical necessity.

[2] This is the average number of days in the shelter beyond the 30 day standard outlined in the B.H. Consent Decree.

Source: OAG analysis and discussions with DCFS.

Of the information asked for in the audit resolution, we are only able to report on the number of children and length of stay for children in psychiatric hospitals and emergency shelters:

The number of children who remained psychiatrically hospitalized beyond medical necessity was 75 in 2014 and 168 in 2015.

- The number of children who remained psychiatrically hospitalized beyond medical necessity was 75 in 2014 and 168 in 2015. The average length of stay beyond medical necessity was 28 days in 2014 and 40 days in 2015.

The number of children who remained in emergency shelters beyond 30 days was 451 in 2014 and 380 in 2015.

- The number of children who remained in emergency shelters beyond 30 days was 451 in 2014 and 380 in 2015. The average length of stay for these children, from the date of admission was 72 days in 2014 and 80 days in 2015.
- The number of children who remained in a detention facility solely because the Department could not locate a placement was not available from the Department.

We had issues with DCFS data and questions on its accuracy and completeness.

However, even for the information we can report, we had issues with data and questions on its accuracy and completeness. The issues for each area are described briefly below:

- **Psychiatric Hospitals** – The Department does not specifically track in its computer systems the date a child is declared "beyond medical necessity." Because this date is not captured in its systems, **we could not obtain a download of children who stayed at a psychiatric hospital beyond medical necessity for calendar years 2014 and 2015**. Instead, the Department maintained a list of children, including the beyond medical necessity date, in a spreadsheet that was separate from its computer systems. However, **we had no way of verifying the completeness of this information**.

- **Emergency Shelters** – The Department provided data for all children who had been in an emergency shelter in 2014 and 2015; however, we encountered issues that made reporting the number beyond 30 days difficult. The data required manual editing by auditors to determine the number of children in emergency shelters beyond 30 days. This was due to disruptions in stays, such as the child going on the run from the shelter. There is no statutory requirement that DCFS place children within 30 days of entering a shelter. The 30 day standard is outlined in the B.H. Consent Decree. (88 C 5599 (N.D. Ill.))

DCFS was unable to provide data asked for in the audit resolution on children in detention facilities because it does not track scheduled release dates for youths in detention.

- **Detention Facilities – DCFS was unable to provide this data because it does not track scheduled release dates for youths in detention**. Without knowing a scheduled release date, we

could not determine if a youth was held beyond that time. (pages 19-22)

Since information asked for in the audit resolution was not available, we selected a random sample of cases from each area from the populations provided and asked DCFS to provide information for those cases only. We selected 100 cases from each calendar year (2014 and 2015) for a total of 200 cases (50 psychiatric hospital cases, 50 shelter cases, 100 detention facility cases). We selected more detention facility cases because the population included all DCFS youths that had been in a detention facility and not just youths held beyond their release date. However, only 7 of the 100 detention facility cases met the criteria specified in the resolution (children were held in a facility beyond their scheduled release date). This resulted in 107 cases (50 psychiatric hospital, 50 shelter, 7 detention facility) analyzed.

Children in the populations examined in this audit have issues in their past that can make placement difficult. These issues include a history of going on the run, multiple past placements, criminal histories, severe behavioral issues, and mental health issues.

Children in the populations examined in this audit have issues in their past that can make placement difficult. These issues include a history of going on the run, multiple past placements, criminal histories, severe behavioral issues, and mental health issues.

The reasons that children remained in a facility (psychiatric hospital, shelter, detention facility) and the barriers to timely placement were generally the same. The majority of cases we examined had multiple barriers. The most frequent barriers included:

- **Administrative – waiting while the matching process proceeded**: There were delays caused by a lack of timeliness of the matching process which includes matching the youth to a facility, scheduling interviews, attending interviews, and waiting for acceptance (37 of 107 cases);

- **Timeliness of the initial planning meeting**: There were delays in DCFS scheduling and holding the Clinical Intervention for Placement Preservation (CIPP) meeting which determines the type of recommended placement for the youth (26 of 107 cases);

- **Lack of placement – wait list**: A youth is accepted at a facility but there is a wait list (25 of 107 cases);

- **Lack of placement**: A general difficulty in finding placement which could be attributable to several factors including special needs of the youth (18 of 107 cases);

- **Lack of youth cooperation**: A youth going on the run or refusing to attend interviews (13 of 107 cases);

- **Lock-out:** Parent refusal to allow child to return home upon discharge; DCFS had to take temporary custody of the youth (12 of 107 cases); and

- **Administrative – delays**: There were delays in the process, such as in sending out referral packets to facilities (10 of 107 cases).

In our sample of cases for 2014 and 2015, children leaving a psychiatric hospital, emergency shelter, or detention facility were placed in their recommended placement type in 94 percent (47 of 50) of the psychiatric hospital cases; 62 percent (31 of 50) of the emergency shelter cases; and 86 percent (6 of 7) of the detention facility cases.

In our sample of cases for 2014 and 2015, children leaving a psychiatric hospital, emergency shelter, or detention facility were placed in their recommended placement type in 94 percent (47 of 50) of the psychiatric hospital cases; 62 percent (31 of 50) of the emergency shelter cases; and 86 percent (6 of 7) of the detention facility cases. (pages 23-45)

Other Issues

The Department had 38 computer systems and applications in its case management portfolio. While some systems interface with each other, many do not. The number of different systems and the separation of applications made it difficult to collect and analyze data for different aspects of a child's case. (pages 9-10)

The Department was not consistently using its own required internal forms. This also resulted in a lack of consistency in the content of the case files. Internal forms and case files were not maintained in one central location making it difficult for DCFS to obtain and access information on individual cases. (pages 10-12)

Delays in the matching process (matching a youth to an appropriate placement), including delays in scheduling and holding the planning meeting, were a primary factor in the length of stay at emergency shelters and psychiatric hospitals.

Delays in the matching process (matching a youth to an appropriate placement), including delays in scheduling and holding the planning meeting, were a primary factor in the length of stay at emergency shelters and psychiatric hospitals. DCFS lacked policies and procedures governing the timeliness of the matching process. (pages 13-16)

DCFS lacked internal procedures on the placement of children for two of the three areas specified in the audit resolution. In addition, for the one area that had procedures, the procedures were not followed. (pages 7-8)

RECOMMENDATIONS

This audit report contains four recommendations directed to the Department of Children and Family Services. The Department agreed with all of the recommendations. Appendix C to the audit report contains the Department's responses.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:DJB

AUDITORS ASSIGNED: This performance audit was conducted by the staff of the Office of the Auditor General.