January 3, 2020– Legislative Report on Specialized Care

This report is being submitted by the Department of Children and Family Services (the Department) pursuant to the Children and Family Services Act, 20 ILCS 505/5.30, Specialized Care, which requires that the Department adopt a rule, or an amendment to a rule, regarding the provision of specialized care to a child in the custody or guardianship of the Department, or to a child being placed in a subsidized guardianship arrangement or under an adoption assistance agreement, who requires such services due to emotional, behavioral, developmental, or medical needs, or any combination thereof, or any other needs which require special intervention services, the primary goal being to maintain the child in foster care or in a permanency setting. The statute requires that the Department submit a report to the General Assembly, on or before September 1 each year.

The Department’s current rule, TITLE 89: SOCIAL SERVICES, CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES, SUBCHAPTER a: SERVICE DELIVERY, PART 301 PLACEMENT AND VISITATION SERVICES in section 301.90 specifically speaks to specialized foster care services.

PART 301 PLACEMENT AND VISITATION SERVICES   
SECTION 301.90 FOSTER FAMILY HOME CARE

b) The Department shall provide specialized foster care services for *a child in the custody or guardianship of the Department who requires such services due to emotional, behavioral, developmental or medical needs, or any combination thereof, or any other needs which require special intervention services, the primary goal being to maintain the child in foster care or in a permanency setting.*  [20 ILCS 505/5.30(a)] This section further establishes the criteria, standards, and procedures for specialized foster care.

The Specialized Foster Care Program provides services to youth with mental health/behavioral special needs and/or with medical/developmental special needs. This service is contracted out to Purchase of Service agencies (POS).

* **Mental health/behavior specialty**- serves youth with a history of placement instability/placement disruption; intermittent or chronic incidences of delinquency; substance abuse/misuse; aggressive or withdrawn behavior; chronic educational needs; and/or sexually active/reactive behaviors.
* **Medical/developmental specialty -** serves youth with serious medical/physical and developmental condition(s)/impairment(s).
* **Adolescent Foster Care specialty** - serves youth, ages 12-20, at risk of placement in residential treatment or group care, with a history of placement instability/placement disruption; intermittent or chronic incidences of delinquency; substance abuse/misuse; aggressive or withdrawn behavior; chronic educational needs; sexually active/reactive behaviors; and/or serious medical, physical, and/or developmental condition(s) and impairment(s).
* **Treatment Foster Family Homes (TFFH)** - Foster Care Specialty model with professional foster parents specifically trained to care and work with youth requiring intensive services to promote permanency, stability and well-being. These foster families will reside in an agency operated home. There is at least one caregiver available at all times, to actively participate in services and supports as an integral member of the child’s treatment team. Supports are in place to provide an intensive array of services to ensure the overall functioning and stability of the child and TFFH. TFFH foster parents will routinely participate in assessment and evaluation of their competencies to ensure their continued abilities to address the strengths and challenges of the youth presented for their care.

Youth appropriate for Specialized Foster Care must have documented impairments that are chronic in duration and nature impacting their functioning in multiple life domains i.e., home, school, community, and who require a highly structured program that can be provided in a home based setting.

* + **Inclusions**

The following categories of youth may be referred to Specialized Foster Care.

* + - Youth with severe, chronic medical or mental conditions (e.g., conditions lasting 24 months or longer) who require a highly structured program that can be provided in a home-based setting.
    - Youth stepping down from more structured living arrangements, such as residential treatment and group home programs when the treatment team has determined their needs can be met in a home-based setting.
    - Youth in Home of Relative (HMR) or Traditional foster care placements who received System of Care (SOC) services and/or other interventions that were insufficient to meet the youth and/or caregivers needs; and/or concerns that needs are chronic in nature and duration as documented by the provider and for whom the Department has determined would be best served in Specialized Foster Care.
  + **Exclusions** 
    - Youth who present a sustained and serious risk of harm to self or others even with intensive services and supports provided in the home environment are not appropriate for Specialized Foster Care services.

Private agencies with specialized foster care contracts continue to be responsible to provide adequate specialized training to foster parents in areas of mental health, behavior modification, trauma focus training, and crisis intervention. This training is specific to the unique special needs of the child (ren) placed in each foster home. For children with specialized medical needs, training will be completed prior to placement. All foster and relative caregivers serving children with specialized medical needs will receive certifications in Cardiopulmonary Resuscitation and First Aid, as well as training in proper medication dispensing and documentation. The specific nature of the training and number of hours required are described in the program plan for each specialized foster care contract.

Post adoption children continue to be considered to receive a specialized level of care and the services it provides. Should a family request their child be considered for the specialized level of care, a referral is made by the family’s post adoption worker to the DCFS Adoption Committee. The Committee consists of the Statewide Adoption Administrator, DCFS Nurse, and DCFS Clinical Staff. A conference is held with the adoptive parents to review the services and needs of the child. If it is determined that the child’s needs warrant an increase in the adoption subsidy a recommendation is made to be approved by the Specialized Foster Care Gatekeeper. The subsidy increase continues to be tied to the direct needs of the child and the services the adoptive parent must receive and have available to meet those needs.

In FY19, the Department offered additional services to Providers and to the foster caregivers for youth stepping down from residential facilities via enhanced Wraparound Services. When youth step down from residential facilities into foster care, they are offered foster homes and additional services from foster care agencies. The Enhanced Wraparound Service includes an immediate service authorization that is available for wraparound services provided to the youth, including additional respite services for the foster caregiver. The foster care agency provided an alternative to the foster parent/caregiver for relief and/or crisis supports to the foster parent. The intent was to create a pool of dollars to be able to be used flexibly for youth stepping down. Although the service authorization is based on revenue per youth, it is not restricted per youth (no per youth capitated amount) but was intended to meet a youth’s individualized needs as they step down. The Department understood that one youth may need more wraparound services, and another may need less. This fund was used to provide services above what is already contractually required. A customized service plan is to be developed with each case based on the specific needs of each child, family, and foster family. Agencies are to use the enhanced wraparound funds to access individualized services without delay. Services are to be family centered, trauma informed, and strength based and shall include, but not limited to:

* Crisis Response Plan
* In home services
* Traditional therapies
* Recreational therapies
* Behavioral interventions, supports, plans
* Peer support-youth, caregivers, birth parents
* Non-traditional therapies-art, dance, music, etc.
* Respite services, above what is already contracted
* Training & Support for youth and family.

To support and sustain the youth in placement a monthly stipend for the first twelve-month period is also available to the foster parent. The foster parent is to participate in the treatment and support of the customized service plan including but not limited to:

* Transportation
* Increased availability to participate in treatment and team meetings
* Participate in treatment sessions as required and requested on behalf of the youth and/or family therapy
* School meetings and/or activities
* Participate in required or recommended training.

To further support youth stepping down from residential a New Foster Home Recruitment will be paid to a foster care agency in support of the recruitment and retention of a new licensed foster home for residential step-down of youth.

Also, in FY16, The Department issued a Request for Proposal (RFP) for Therapeutic Foster Care (TFC). Illinois Senate Bill 1763 identified three groups that should be targeted with TFC, operationalized as follows:

1. **Trauma Group:** Children entering care with severe trauma histories. “Severe trauma histories” is defined as having 2 or more actionable or 1 extreme actionable experience from among the CANS-rated items Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity.
2. **Step Down Group:** Children who are ready to be discharged from congregate care settings. In the Department’s review of 1406 cases that had been in residential care for more than one year, a subset of cases was identified as “ready for discharge”. These cases should constitute the “step-down” subpopulation.
3. **Deflection Group:** Children who would be placed in congregate care but who the Department deems appropriate for home-based services. There are 2 sub-groups of the Deflection group: Direct Entry and Later Entry. The Direct Entry group refers to those youth who enter congregate care as a first placement. The Later Entry group is based on the Chapin Hall research documenting the risk factors for placement in congregate care settings; this group is defined as youth not currently in congregate care having 2 or more actionable items among the Integrated Assessment CANS (IA CANS) domains Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors, excluding youth who exhibit a high level of acute risk behaviors in the areas of Suicide Risk, Other Self-Harm, Danger to Others, and Sexual Aggression.

Proposals were to focus on meeting the needs of children and youth entering care at ages 6 – 12 years and/or 12 years and older who are included in one or more of the following 3 target populations:

* 1. Children and youth entering care with severe trauma histories, as defined by the having 2 or more “actionable” experiences, rated on the IA CANS, from among: Physical Abuse, Sexual Abuse, Emotional Abuse, Witness to Family Violence, and Witness to Criminal Activity or 1 severely actionable item from among these 5.
  2. Children and youth who are ready to be discharged from congregate care settings.
  3. Children and youth who would be placed in residential care but who may be stabilized in a home-based setting with the addition of appropriate, intensive supports for the child and the foster parent. These fall into 2 separate categories:
     1. **Direct Entry** – Direct Entry was defined as children and youth who enter residential as their first child welfare placement. Youth mostly come to the child welfare from hospitals, detentions, or home-based settings, most often under neglect or dependency cases. Proposals should discuss interventions for this category of children who would ensure that when the children exit the hospital or detention they are served in home-based settings with intensive services.
     2. **Deflection** – Deflection was defined as children and youth who have been identified by their clinical characteristics, as rated by their initial IA CANS, to be “at-risk” for residential/congregate care and who can be served in community settings with appropriate supports. The “at-risk” clinical characteristics include identification of two or more among the following IA CANS domains: Trauma Symptoms, Emotional Behavioral Needs, Life Domain Functioning, and Risk Behaviors”.

Proposals were to identify the Target Population intended to be served and were to identify the elements of the proposed models that will address the clinical needs of the children and youth in the categories defined above. At the time of the RFP, analysis of the DCFS population showed that the majority of children and youth in the above listed categories are currently in Cook County, Aurora, and Rockford. While proposals for services in other areas of the state may be submitted, the Bidder was to indicate how many children in the pilot area would be served in the proposed model and how the model would be sustainable and cost effective for the proposed area.

\*\*\*\* This was implemented already with one Agency no longer involved. The Department intended to implement 3 pilot programs for TFC for children and youth ages 6 – 12 years and 12 years and older throughout the state, with at least 1 of these models being Therapeutic Foster Care of Oregon (TFCO) or KEEP, which is an abbreviation for Keeping Foster Parents Trained and Supported. Bidders were also able to submit a proposal to provide multiple TFC models or other promising practices. The primary outcomes for the proposed program were to:

* Reduce the length of time youth spend in residential treatment facilities beyond clinical necessity;
* Decrease the number of youths placed in residential facilities;
* Increase placement stability; and
* Improve level of functioning of children and youth receiving TFC, including reduction of trauma symptoms.

Programs were to have a central family focus which is strengths-based and promotes safety, permanency, and well-being for children.

The Department also considered submissions from organizations proposing models’ other than TFCO and KEEP which followed the standards put forth by the Foster Family Treatment Association. Because of the high levels of trauma experiences and trauma symptoms in the target population, Proposals were to include trauma-informed interventions in their model of therapeutic foster care. The pilot programs will be subject to a full evaluation over 5 years. The evaluation will be conducted externally by Chapin Hall at the University of Chicago.

Three Foster Care agencies have been chosen to implement pilot programs. The models will be Together Facing the Challenge (TFC), Treatment Foster Care Oregon (TFCO) and the third pilot model integrates elements of the Agency’s Adolescent Foster Care model with evidence-based clinical interventions, such as Therapeutic Crisis Intervention for Families (TCI-F) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These Pilots began in FY17.

Across the state there are a total of 69 specialized foster care contracts with 41 foster care agencies. The categories under the specialized foster care service area are mental health/behavior (MH) medically complex/fragile (MD), medical/mental health (MD/MH), adolescent (AFC), Pregnant and Parenting (PPT), Medical/Mental Health/Developmental Delayed (MD/MH/DD), Mental Health/Developmental Delayed (MH/DD) and Treatment Family Foster Home (TFFH). Within the mental health/behavior category there are sub-specialty populations of youth that have an intellectual disability. There are 6 agencies that have a specialty in serving youth with an intellectual disability.

Currently we have

41 Foster Care agencies 69 with contracts

* 12 Adolescent Foster Care
* 26 Mental Health
* 13 Medical/Mental Health
* 5 Medical/Mental Health/Developmental Delayed
* 2 Mental Health/Developmental Delayed
* 4 Pregnant and Parenting
* 3 Adolescent Foster Care – Juvenile Justice
* 4 Treatment Family Foster Home

Total 69 contracts-check total

In FY19 there were 1552 unique cases served in specialized foster care. your report, FY18 number was higher at 2504