Report of the Expert Panel

B.H. vs. Sheldon
Consent Decree

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INTRODUCTION

On April 10, 2015, Judge Jorge L. Alonso of the United States District Court for the Northern District of Illinois Eastern Division appointed a panel of four experts ("Panel") to assist the Court and the parties under the *B.H. vs. Sheldon* Consent Decree ("Decree") in determining how to improve the placements and services provided by the Illinois Department of Children and Family Services ("DCFS" or "the Department") to members of the plaintiff class ("children") with psychological, behavioral or emotional challenges.

The Department is responsible for ensuring safety, family permanence, and wellbeing for the children placed in its custody. Even when it is necessary to remove children from their homes to protect them, children are harmed and damaged by the disruption of that removal. Further movement of children from placement to placement compounds the damage and abuse they have already experienced, and inflicts further damage and abuse. It is evident to the Panel that children continue to suffer from the combined effects of the losses and abuses they have endured. Too many children in this class have experienced multiple disruptions of placement, services and relationships. They and their families endure indeterminate waits, month upon month, for services the child and family need, without a concrete plan or timeframe. For children, whether infants, preschoolers or teens, months can be a lifetime developmentally, especially when there is uncertainty about their future. Disruptions, delays, and inaction by Department officials exacerbate children's already serious and chronic mental health problems.

The harmful effects regarding lack of timely access to appropriate placements and services for youth in the child welfare system with complex emotional and behavioral problems are highly significant. These youth suffer from the pervasive impact of trauma due to neglect and abuse, and typically have lost a sense of trust in caregivers due to the combined effects of trauma and repeated placement and caregiver changes. Consequently, these youth are at much greater risk for not achieving the fundamental child welfare goals of safety, permanence, and well-being. Lack of access to critical supports, services and caregivers significantly erode youths' already pronounced distrust in the system due to feelings of being abandoned and in a "holding pattern," their capacity to engage and participate in relationships with new caregivers and treatment personnel when they move to the next setting is substantially compromised. Their feelings of hopelessness, frustration and anger become pervasive which often results in increases in aggressive and self-destructive behavior. Due to developmental factors common to youth in general, along with the effects of trauma on cognitive processes for these youth in particular, their sense of time is impacted such that periods of waiting weeks and months feel interminable.

The following is the report of the Panel's findings and its initial recommendations for reforms to improve the safety, family permanence, and social emotional well-being of children in the care and custody of the Department. The report places particular emphasis on the following components of the DCFS system: 1) the estimated size and characteristics of the population of children with emotional/behavioral problems; 2) the unique policy and programmatic context of child welfare service delivery in Illinois compared to public systems in the balance of the United States (BOUS); 3) the adequacy of specialized foster care, group homes, residential treatment and the quality of the Department's monitoring of the use of these resources; 4) the needs of special populations of youth, including adjudicated delinquents, commercial sexually exploited children, and other dependent youth who enter DCFS custody outside of the usual parameters of maltreatment by caregivers; 5) the design, capacity, and funding of the Department's system of care for addressing the needs of children with psychological, behavioral or emotional challenges; and 6) the quality of the data systems and their utilization in assessing, planning, implementing, evaluating, and improving the effectiveness of service delivery.

Following the presentation of findings, the Panel offers for consideration by the parties and the Court a set of initial recommendations to address several systemic deficiencies identified in the above areas of DCFS's work.

FINDINGS

The Department has not adopted a sustainable model of practice which incorporates evidence-supported, evidence-informed, and promising practices. Evidence-supported practices, such as subsidized guardianship for older youth, have fallen into disuse. Evidence-informed practices, such as performance-based contracting, are not fully implemented with fidelity to the proven design. Promising practices, such as home-based, "wrap-around" mental health services, are carefully developed but summarily discarded after a change in leadership. Many innovations are rushed into production and scaled-up with insufficient forethought given to evaluating their impacts on desired outcomes and determining whether the program actually worked. The end result is a "flavor-of-the month" approach to endorsed treatments and a system of practice that is shaped by crises, practitioner preferences, tradition, and system expediency.

Our experience, findings, and recommendations dictate that improving the placement and treatment of the plaintiff class of children requires that DCFS adopt, implement and evaluate a cohesive evidence-based practice model that incorporates, but is not necessarily limited to, the following core practice principles:

- **The social and emotional wellbeing of children is best assured within the context of safe and permanent family relationships with birth parents, legal guardians, or adoptive parents who participate in the planning and delivery of individualized permanency and treatment plans crafted by child and family teams.**
    - Children of appropriate age, extended kin, foster parents, service providers, legal representatives, and members of the family's informal support should be full participants on this team. Involvement should include regular participation in child and family team meetings as a point for engagement, assessment, planning, intervention and evaluation of progress.
    - The full array of concurrent permanency planning options should be considered and made available to all children and youth, including family reunification, adoption, and subsidized guardianship, regardless of whether these options are currently reimbursable under federal programs.
    - Children who cannot attain family permanence before reaching adulthood should be provided with transition services that prepare them for connecting or reconnecting with parents, relatives, mentors, and other caring adults to whom they can turn for help after foster care supports are no longer available.

- **Assessing and treating the social and emotional needs of children with psychological and behavioral challenges preferably should begin at the earliest point of contact with the child welfare system and certainly no later than their removal into state custody. The process of assessment and treatment should continue regularly after the children are transitioned to permanent homes with birth families, adoptive parents, and legal guardians.**
    - Assessment and treatment planning should include the contributions of the full child and family team and address the underlying conditions creating the challenges experienced by the child and family, not just the symptoms of functioning.

- The assessment and treatment process should ultimately be integrated into a unified system of care that is built on a platform of Medicaid-fundable services along lines similar to the New Jersey's Children's System of Care.
- The mix of services provided should be responsive to the strengths and needs of the child and family. Services should be flexible and adapted to child and family needs. Children and families should not be expected to adapt to ineffective services.
- Development of the needs-based plans should not be totally constrained by Medicaid funding requirements. Where needed services are unavailable, appropriate services should be created and supported with federal IV-E and state funds.

- **Services and treatments that are conducted outside the context of home and community-based settings should be temporary and delivered in the least restrictive, most normalized setting responsive to the child's needs.**

  - Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanence.
  - Treatment should avoid temporary, interim placements. To this end, the use of shelter care placements should be avoided in favor of family based settings.
  - Children should not be placed in group homes, residential institutions or other congregate settings unless that environment is the only setting in which needed services can be provided.
  - Regardless of treatment setting, the system should vigorously seek to ensure that children are integrated to the maximum extent feasible into normalized school settings and activities and achieve success in school.
  - Unplanned discharges of children by providers, which are not instigated by the Department for safety reasons, should be forbidden. The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child.
  - Services and treatment that must be conducted outside the context of home and community-based settings should be brief in duration and delivered in the least restrictive, most normalized setting responsive to the child's needs.
  - The choice of treatment setting and service intensity should be established using standardized clinical instruments and clearly delineated policies and procedures.

- **Promising innovations and evidence-supported practices that are translated to child welfare from related fields should first be pilot-tested for usability, and if deemed replicable, should be rolled-out in a phased approach that allows for structured implementation and evaluation of effectiveness prior to scaling the program up statewide.**

  - A sustainable model of practice in child welfare requires both the expansion of evidence-supported practices in child welfare and the phased implementation of evidence-based programs with fidelity to proven design.
  - Phased implementation and rigorous evaluation require a system of real-time data collection, outcomes monitoring, and low-cost experimentation and data analysis to support pilot testing and quality improvement of promising innovations and evidence-supported interventions.
  - The reliable measurement of child wellbeing using standardized instrument and assessment scales is essential so that progress towards improving the care and treatment

of children with psychological, behavioral or emotional challenges can be monitored and evaluated for service effectiveness.

SIZE AND CHARACTERISTICS OF POPULATION

Reliable estimates of the size and characteristics of the plaintiff class of children with psychological, behavioral, or emotional challenges are difficult to obtain. Whereas indicators of child safety and permanency planning are readily retrievable from existing administrative data systems, measures of child well-being have to be inferred from special surveys and psychological assessments. Fortunately the Panel was able to take advantage of a unique national survey that permits statistically valid comparisons to be drawn between representative samples of children substantiated for maltreatment in Illinois and in the balance of the United States (BOUS).

In 2007, the UIUC Children and Family Research Center commissioned the Research Triangle Institute (RTI) to augment the National Survey of Child and Adolescent Wellbeing (NSCAW) with a supplemental sample of substantiated cases of child maltreatment in Illinois. Between February 2008 and April 2009, a cohort 818 children were sampled from closed investigations in nine counties throughout Illinois. This 14-month cohort of children was assessed at baseline (Wave 1) for psychological, behavioral, and emotional problems using nationally normed, standardized measures of trauma, depression, and problem behaviors. 749 of the 818 (92%) Illinois cases were re-interviewed between October 2009 and June 2010, 18-months after the close of investigation, whether or not they remained in state custody or were discharged from the system (Wave 2). At 36 months (Wave 3), data collection in Illinois was restricted to a much smaller sample of children. Assessments were conducted with the infant cohort starting in June 2011 and with non-infants starting in August of 2011. All data collection ended in December 2012. Because of the smaller sample size at Wave 3, some age and placement-specific estimates for Illinois are suppressed in the tables.

Using the same definition of emotional/behavioral problems, which RTI uses for its report of child well-being to the federal Administration for Children and Families, it is estimated that between 29% and 36% of Illinois children aged 18 months to 17 years old, who were substantiated for maltreatment at baseline, continued to be at risk of emotional or behavioral problems 18 months after the close of investigation. This compares to between 32% and 42% of children substantiated for maltreatment in the balance of the United States (BOUS). Table 1 breaks-down these estimates by age group and the three waves of NSCAW. Controlling for child age, the estimates of the proportion of child victims at risk of emotional/behavioral problems are strikingly similar for Illinois and the BOUS. The lower percentages for younger children reflect the inapplicability of measures of depression, trauma symptoms, and behavioral self-reports for younger children.

Table 1 contains estimates for all children who have been substantiated for child maltreatment regardless of whether they were taken into DCFS custody. Similar age patterns are observable for only those children in DCFS custody using data from the DCFS Child and Adolescent Needs and Strengths (CANS 2.0) instrument. CANS 2.0 is a clinician-report measure developed by Northwestern University in collaboration with the National Child Traumatic Stress Network and IDCFS clinical staff. It is used for identifying needs and services for youth and families served by the child welfare system using a comprehensive trauma framework (Kisiel, Fehrenbach, Torgersen, Stolbach, McClelland, Griffin & Burkman, 2013). Table 2 presents a summary of tabulations supplied by the Mental Health Services and Policy Program at Northwestern University. The percentage estimates provide both a “snapshot” of children’s needs based on CANS received on a child within the last six months and a higher estimate

Table 1.— Percentage of 14-Month Cohort of Children at Risk of Emotional/Behavioral Problems by Age Group, Substantiated for Maltreatment in Illinois and the Balance of the United States, National Survey of Child and Adolescent Wellbeing, 2008-2012

Age Group	Area	Weighted N	Wave 1 Percent	Wave 2 Percent	Wave 3 Percent
18 months to 5 years old	BOUS	35,896	18.5%	17.3%	16.9%
	Illinois	2,884	21.9%	13.7%	--
6 to 11 years old	BOUS	70,394	49.1%	47.0%	40.5%
	Illinois	4,615	49.5%	50.5%	--
12 to 17 years old	BOUS	77,353	53.4%	57.4%	35.0%
	Illinois	2,372	44.1%	49.5%	--

Note: Sample estimates are based on the National Survey of Child and Adolescent Wellbeing (NSCAW). Illinois estimates are suppressed for wave 3 because of the small sample size. Risk of a behavioral/emotional problem was defined as scores in the clinical range on any of the following standardized measures among children 1.5 to 17 years old: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

based on any CANS received during the child's stay in DCFS custody. The CANS snapshot estimates are similar to the age-specific risk estimates presented in Table 1. According do both sets of data, over one-half of children aged 12 years old and older exhibit or are at risk of emotional, behavioral, or psychiatric problem at any one time. During their entire stay in DCFS custody, 80 percent of this age group exhibited an emotional, behavioral, or psychiatric problem at one time or another

Before considering the various options available to DCFS for addressing the needs of these at-risk populations of children, it is important to review the policy and programmatic context in which child welfare services have been delivered to the BH plaintiff class of children in Illinois.

POLICY AND PROGRAMMATIC CONTEXT

For the last 20 years, Illinois has been at the forefront of a nationwide transformation of the public child welfare system. It is evolving from a 20th century foster care system that was focused on the welfare of children in state custody to a 21st century "post-permanency" system that can be refocused on the wellbeing of children in safe and stable homes with birth families, adoptive parents and legal guardians. A major milestone in the shifting balance from long-term foster care to family permanence was reached in 2000 when the number of Illinois children in assisted adoptive and guardianship homes surpassed the number in publicly financed foster care (see Figure 1). The number of foster children fell from over 50,000 in 1997 to under 15,000 in 2014. The number in assisted adoptive and guardianship homes expanded from 12,000 to over 40,000 children in the mid-2000s. Currently there are almost 23,000 children in assisted adoptive and guardianship homes.

Table 2.— Percentage of Children in Open Legal Cases as of July 1, 2015 with Emotional/Physiological Dysregulation, Behavioral Concerns, or Psychiatric Diagnoses Based on CANS Administered in the Last 6 Month and Any CANS Administered while Child was in DCFS Custody by Age Group

Age Group	N of Open Cases	Period CANS Was Administered	N with No Missing CANS	N with Any Emotional, Behavioral, or Psychiatric Concerns	Percent
0 to 5 years old	6,281	Last 6 months	4,376	644	14.7%
		Any point in DCFS Custody	5,639	1,719	30.5%
6 to 11 years old	4,308	Last 6 months	3,090	1,227	39.7%
		Any point in DCFS Custody	4,032	2,735	67.8%
12 to 14 years old	1,763	Last 6 months	1,329	761	57.3%
		Any point in DCFS Custody	1,637	1,364	83.3%
15 to 17 years old	2,434	Last 6 months	1,934	1,278	66.1%
		Any point in DCFS Custody	2,344	2,080	88.7%

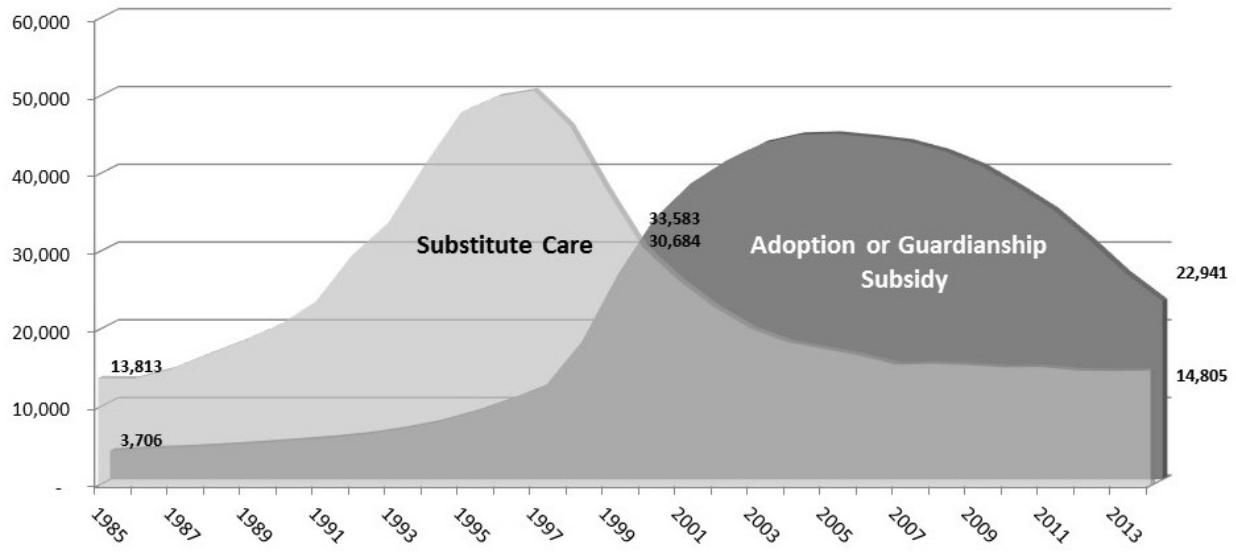
Source: Mental Health Services and Policy Program, Northwestern University. Based on CYCIS and CANS data received July 1, 2015.
Note: Percentage estimates are based on cases with a CANS received during the reporting period. Excluding cases with missing CANS provides plausible population estimates if it can be assumed that CANS are missing entirely at random. Because missing CANS appears to vary systematically by placement type and other possible characteristics, caution should be used in generalizing these age-specific estimates to the entire population of open DCFS cases.
Emotional/Physiological Dysregulation, Behavioral Concerns, or Psychiatric Diagnoses were defined as an actionable score (2 or 3) on the following items for any CANS administered during the relevant reporting period: *Emotional/Physiological Dysregulation:* Traumatic Grief/Separation, Re-experiencing, Avoidance, Numbing, Dissociation, Eating Disturbances, Affect Dysregulation, Behavioral Regressions, Somatization, Anger Control; *Behavioral Concerns:* Attention Deficit/Impulse Control, Oppositional Behavior, Conduct, Substance Abuse, Attachment Difficulties, Suicide Risk, Self-Mutilation, Other Self Harm, Danger to Others, Sexual Aggression, Runaway, Delinquency, Judgment, Fire Setting, Social Behavior, Sexually Reactive Behaviors; *Psychiatric Diagnoses:* Psychosis, Depression, and Anxiety.

With more children in assisted adoptive and guardianship homes than children residing in assisted foster care, it is now possible to imagine reconfiguring state and federal child welfare financing and policy so that the back door of the old 20th century foster care system becomes the front door of a new 21st century post-permanency system. More than 50 years of child welfare research demonstrates convincingly that children's health and socio-emotional wellbeing build upon meeting their primary needs for a safe, stable and lasting family life. For a majority of former foster children, the trauma of child maltreatment and its adverse effects on their future health and well-being may now be addressed within the context of safe and permanent family relationships.

Illinois is well positioned to lead the national effort in reconfiguring the old 20th century foster care system into a new 21st century tripartite system of family support and preservation, child protective custody and treatment, and post-permanency services and preservation. The opportunity to use Title XIX

(Medicaid) as the primary funding platform for a home and community-based system of care for children and youth both prior to the state's taking protective custody and after transitioning foster children to permanent family homes will help reduce inappropriate state reliance on congregate care to meet the mental health needs of children and youth. A variety of challenges, however, must be overcome before Illinois can complete this transformation.

Figure 1.—Children in Assisted Substitute Care and Adoptive or Guardianship Homes in Illinois



Loss of Focus

In the transformation from the old system of child welfare to a new system of child wellbeing, the Department appears to have lost sight of its core mission of advancing the safety, permanence, and wellbeing of children and youth within the context of safe and permanent family relationships. This loss of focus has been compounded by the numerous changes in DCFS leadership in recent years. A common theme among persons whom the Panel interviewed was their sense that the workings of the Department, even very basic functions such as child protection and case management, grind to a halt with changes in Department leadership until the workforce learns of the priorities of a new Director. Furthermore, the loss of focus on its core mission means that Departmental leaders cannot effectively prioritize new initiatives and take corrective actions in an organized way across multiple levels of administration and programming.

The old 20th century child welfare system was built on the assumption that meeting children's basic needs for food, shelter, and clothing constituted most of what was required to ensure child well-being. The primary public response to child dependency and neglect was to support or supplement the income of biological families by providing food stamps, unemployment insurance, job training, and welfare assistance. The secondary response was to substitute an alternative home for the biological one when children's removal from the home was judged necessary and placement in foster families, group homes, and residential treatment facilities was deemed the safer alternative.

For the first two-thirds of the 20th century, many child welfare advocates defined success in terms of the expansion of the federal role in the local administration of income assistance programs to prevent

the removal of dependent children from biological families for reasons of poverty. When children could not be safely maintained in their own home for reasons of neglect and abuse, advocates sought the expansion of the federal role in the funding of foster family and institutional care. Out of these twin efforts emerged titles IV-A and IV-B/E of the Social Security Act.

Disenchantment with the two federal programs accelerated during the 1990s as welfare critics faulted the family preservation aims of IV-A for encouraging single parenthood and eroding the American work ethic, and child welfare advocates faulted long-term foster care for ignoring the socio-emotional needs of children for sensitive and consistent parenting. The welfare reform act of 1996 replaced open-ended, family support with time-limited, income assistance. The following year, the Adoption and Safe Families Act replaced open-ended, foster care assistance with time-limited requirements to terminate parental rights for children who could not be reunified with their birth families and place them in assisted adoptive homes or transfer them to the legal guardianship of relatives.

Even though Illinois took the lead in championing the changes in policy priorities that contributed to the changes at the federal level in the 1990s and 2000s, the Department appears to have lost ground in recent years. DCFS has profound difficulties implementing and sustaining policy initiatives and programs. The lack of direction and appropriate supervision at all levels of the Department has far reaching consequences and affects all functions of the Department. It struggles to follow through with bringing promising evidence-based treatments to scale and, at times, takes a haphazard approach to the installation of new treatment models. This results in a succession of practice models and interventions that are inadequately implemented and quickly abandoned without learning whether the programs have been effective in achieving the desired outcomes.

FRAGMENTATION OF CASE MANAGEMENT RESPONSIBILITIES

Over 70% of case management responsibilities are delegated to purchase-of-services (POS), voluntary and private child welfare agencies in Illinois. The Department appears to be out of touch with POS contractual agents and no longer possesses efficient means of coordinating POS case management with central administrative activities to achieve common aims. The lack of clarity and coordination between DCFS caseworkers, POS workers, care providers/case managers at congregate care facilities, and community-based treatment programs results in a diffusion of responsibility for the management of an individual child's care. Child and family teams for high-risk youth and youth whose parents have had their parental rights terminated are highly ineffective (and often do not exist). Consequently, there is an absence of responsibility and accountability to ensure that each child receives the services that he/she actually needs, when needed, in the least restrictive, most normal setting appropriate for his/her needs, and at the intensity, frequency, duration and quality that is sufficient for meeting the child's needs. The current system of "managing" placement decisions through the circular "email streams" between central matching, DCFS caseworkers, POS workers, and others is broken and does not meet minimal practice standards, delays important planning and decisions for a child, and causes harm to the children caught in the "email streams."

When the Department's foster care caseload was in excess of 50,000 children, performance-based contracting (PBC) efficiently aligned financial incentives with the permanency outcomes of adoption and guardianship to curtail the drift of children in long-term foster care. As the foster care caseload has fallen to under 15,000 children, the Department has moved away from performance contracting for foster care. A previously effective method of enhancing permanency planning for foster children has fallen into disuse. Even though PBC still exists for transitional living and residential treatment programs, it is

unknown whether or not its implementation has been effective in enhancing the quality of services provided.

The residential providers who met with the Panel were unaware of any evaluations of the Residential PBC program and lacked a clear sense of direction as to how best to use the outcome indicators of Treatment Opportunity Days Rate (TODR), Negative Discharge Rate (NDR), and Sustained Favorable Discharge Rate (SFDR) to improve their delivery of residential services. The latest Quarterly Residential PBC Report (June 3, 2015) is an Excel spreadsheet that is chock-full of colored coded performance indicators but little in the way of interpretation and guidance for corrective action. It illustrates a slogan often heard when discussing the use of data: the Department is data rich but analysis poor.

PERMANENCY PLANNING INNOVATIONS

Most of the past success in permanency planning came from transitioning children from the long-term foster care system into permanent adoptive and kinship guardianship homes. It is mistakenly inferred from comparative state statistics that there is still a lot of "low-hanging fruit" that could be plucked in Illinois to hasten children's reunification with their birth families. Foster children in Illinois do spend an atypically long time in foster care: less than 14% of Illinois children are reunified within a year of removal compared to a median percentage of 39% for the U.S. as a whole. But this is partly an artifact of Illinois's past success in lowering the rate of removal of children into foster care. For example, the rate of substantiated child maltreatment in 2012 was almost identical at 9.0 per 1000 children in both Illinois and the BOUS. But the rate of removal into foster care in Illinois (1.7 removals per 1,000 children) was exactly one-half the removal rate for the BOUS (3.4 removals per 1000 children). As a result, length-of-care statistics in low-removal states like Illinois are inflated because the denominator omits the easier-to-reunify children that contribute to the lower median lengths of stay in higher removal states.

Table 3.—Living Arrangements of 14-Month Cohort of Children Substantiated for Maltreatment in Illinois and the Balance of the United States, National Survey of Child and Adolescent Wellbeing, 2008-2012

Living Arrangement	Area	Weighted N	Wave 1 Percent	Wave 2 Percent	Wave 3 Percent
Foster Family or Congregate Care	BOUS	58,937	10.5%	7.5%	5.0%
	Illinois	1,544	4.5%	5.7%	4.9%
Kinship Care	BOUS	76,109	13.6%	13.5%	14.4%
	Illinois	4,358	12.8%	15.0%	13.1%
Biological or Adoptive Parent	BOUS	425,670	75.9%	79.0%	80.6%
	Illinois	28,204	82.7%	79.4%	82.0%
Total	BOUS	560,715	100.0%	100.0%	100.0%
	Illinois	34,106	100.0%	100.0%	100.0%

Note: Sample estimates are based on the National Survey of Child and Adolescent Wellbeing (NSCAW).

The ramifications of the differences in removal rates can be seen in Table 3 that displays the living arrangements of three waves of NSCAW data. Only 4.5% of the estimated 34,100 children

substantiated for child maltreatment in Illinois in 2008 were living in foster family or congregate care at the close of the investigation (Wave 1). This compares to 10.5% of children in the BOUS, which reproduces the 2:1 difference in removal rates based on administrative data. The kinship care proportion for Illinois (12.8%) was approximately the same as the proportion in the BOUS (13.6%). This surprising similarity is due to the inclusion of children in informal kinship care with those in formal kinship foster care. The rapid growth of the home-of-relative program in Illinois during the 1990s was due in large part to the incorporation of the informal kinship care population into the formal foster care system. This practice was restricted in 1995 with the state's enactment of its Home of Relative (HMR) Reform program.

Further reductions in foster care intake resulted from DCFS's efforts to serve children in their own homes and improve safety assessment through its implementation of the Child Endangerment Risk Assessment Protocol (CERAP). The impact of these initiatives is visible in the low rate of child removal following a substantiated report of child maltreatment. As shown in Table 3, 82.7% of the children substantiated for maltreatment in Illinois were retained in the custody of birth or adoptive parents at the close of investigation (Wave 1). The 561,000 children substantiated for maltreatment in the BOUS didn't approach this level of family unification until three years after the close of investigation (Wave 3). Because the proportion of children removed from their biological families in the BOUS is twice the rate in Illinois, it is possible for the pace of reunification to clock much faster *not* because these other systems in the BOUS were more successful at reunification but because the overall rate of family unification was already high in Illinois. As a result, there is much less room in Illinois for closing the gap in reunification rates with other states. Instead permanency planning in Illinois needs to refocus on the intensive treatment of birth families at the early phases of their children's removal and accelerate the adoption or guardianship timetables for those children who cannot be safely reunified in a timely fashion.

HOME AND COMMUNITY-BASED MENTAL HEALTH SERVICES

No child should grow up in a residential facility or group home. Yet residential and group home care is functionally treated as a placement by the Department rather than as a place to receive intensive treatment for a brief time. There is no systematic way to manage utilization of residential services. Limited home and community-based placements and limited access to all levels of care and service intensities have resulted in a near standstill in placing children new to the system and in transitioning children from one level of care to another. Children are generally stepped down from more intensive residential facilities to less restrictive residential and group home settings. There is no protocol for transitioning children from psychiatric hospitals to traditional, specialized or home of relative foster care.

The process of stepping down from residential care to less restrictive, family-like settings is hampered by a marked shortage of high quality foster care homes. This is most notable for the older foster children and for foster children with emotional and behavioral problems. Both the Department and POS agencies have marked difficulties recruiting non-related foster parents willing to care for older adolescents. Furthermore, there is a lack of home and community-based services to support families and there is little accountability (or monitoring) of specialized foster care providers. The lack of home and community-based services has hit two new populations especially hard: delinquent youth assigned to DCFS custody and children and adolescents who are victims of, or at risk of, sex trafficking. As a consequence, delinquent children are being detained for considerably longer periods of time than sentenced, children in psychiatric hospitals are being hospitalized for longer periods of time than necessary, and adolescents are concentrated in congregate care settings that increase their risks of commercial sexual exploitation. Children who have successfully completed treatment in residential treatment facilities remain at that level longer than is necessary while they wait for a placement and

children remain in shelters for prolonged periods of time. The gridlock on transitions to less restrictive, more family-like settings not only harms and exposes children to unacceptable levels of risk and leads to feelings of demoralization and helplessness (with subsequent behavioral problems), but it has adverse effects on children's chances for reunification or permanence in adoptive and guardianship homes.

Scientific evidence and our experience dictates that mental health services cannot be limited to the time that children are in specialized foster care and residential treatment. Children entering DCFS for the first time are typically placed in home of relative foster care or residential treatment. If they are not returned home within 18 months they are unlikely to return to the custody of their parents. For children placed in home of relative foster care, neither they nor their relative(s) receive the duration and intensity of treatment and support services needed to create and sustain a safe, nurturing, therapeutic home for the child.

Table 4.— 14-Month Cohort of Children Substantiated for Maltreatment in Illinois and the Balance of the United States and Percentage at Risk of Emotional/Behavioral Problems by Living Arrangement, Ages 18 months to 17 Years Old, National Survey of Child and Adolescent Wellbeing

Living Arrangement	Area	Weighted N	Wave 1 Percent	Wave 2 Percent	Wave 3 Percent
Foster Family or Congregate Care	BOUS	20,880	35.4%	46.2%	31.6%
	Illinois	537	34.8%	41.1%	--
Kinship Care	BOUS	22,922	30.1%	35.7%	40.5%
	Illinois	1,325	30.4%	30.1%	--
Biological or Adoptive Parent	BOUS	139,506	32.8%	37.0%	28.8%
	Illinois	8,010	28.4%	32.3%	--
Total	BOUS	183,643	32.7%	37.5%	26.4%
	Illinois	9,872	28.9%	32.5%	--

Note: Risk of a behavioral/emotional problem was defined as scores in the clinical range on any of the following standardized measures among children 1.5 to 17 years old: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

Table 4 shows the estimated percentages of the 14-month cohort children who are considered at risk by living arrangement in Illinois and the BOUS. The estimated number of Illinois children at risk of emotional/behavioral problems (N = 537) refers only to the 14 month-cohort, but the percentages provide reasonable estimates of the overall risks exhibited by all foster children in Illinois. As shown in the table, children who are placed in kinship care or maintained in the homes of their biological or adoptive parents exhibit risks of emotional/behavioral problems at Waves 1 and 2, which are statistically indistinguishable from the risks for children who have been removed from their biological families and placed into foster family or congregate care. Approximately one-third of children substantiated for maltreatment score in the clinical range on any one of several standardized measures of emotional/ behavioral problems regardless of living arrangement. At wave 3, there is a slight flip in the proportions at risk in kinship care compared to foster family and congregate care. Even though the flip is statistically indistinguishable from

no difference, the similarity in at-risk level suggests that DCFS needs to develop alternative home and community-based treatments for meeting the mental health needs of children in kinship and regular foster care and avoid excessive reliance on specialized foster and residential care for the delivery of mental health service to children with psychological, behavioral or emotional problems.

Stays in group residential care should be based on the specialized behavioral and mental health needs of children and should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting. Prolonged stays are detrimental to the well-being of children. Group residential placements are not structured to deliver consistent and individualized treatment within a safe and nurturing environment. The kinds of treatment regimens that are offered in residential programs are geared largely to reinforcing behaviors that serve the needs of the institution to maintain order and control. The rotating shifts of caretakers, staff regulation of leisure time, and punishment-reward structures reinforce compliance behaviors. Little that is learned in these settings are directly transferrable to living in less restrictive, more family-like settings. Maintaining or building family connections that are a key requirement for a child's treatment are often given short shrift and not addressed for Illinois youth placed in group residential care. For children with siblings, they are likely to be separated if one or more is placed in congregate care, creating further disruption and loss for children. The evidence shows that children are harmed as a result of placement in congregate care in comparison to children who live and receive treatment in family settings. They lose or fail to make educational gains, they are more likely to drop out and less likely to graduate from high school, and they are more likely to be arrested. Even more troubling, children in congregate care are at greater risk of further physical, verbal and sexual abuse – from their peers as well as from the adults responsible for their care. Illinois data and reports reflect similar harm and poor outcomes for the children it places in congregate care.

Emotional and behavioral problems are best treated within the context of safe and permanent caring relationships. Evidence-based treatments should not be limited to specialized and residential care settings but should accompany children who step-down to kinship care or who are already in less restrictive, more family-like settings. DCFS workers and POS agencies do not develop sufficiently strong alliances with parents or family members caring for children in their home, and do not provide the services and supports necessary to maintain children with family, either prior to or after adjudication. There are limited services and supports to maintain a safe and nurturing environment for a child post-reunification or post-adoption.

The paramount function of public child welfare is child protection followed by permanency planning and then by the trauma-informed treatment of the adverse effects of maltreatment within the context of safe and permanent parenting relationships. Figure 2 illustrates that the largest numbers of children entering DCFS custody in both Cook County and Downstate regions are children under the age of 6 (with infants constituting the largest single age group.) The numbers gradually decline after age 6 but take an upward turn around 12 years of age. Many of the adolescents entering DCFS custody fall outside of the usual parameters of maltreatment by caregivers (e.g., juvenile delinquents, commercial sexually exploited children, and children with severe emotional disturbance). Given the current configuration of resources, the Department has difficulty placing adolescent in more treatment intensive placements as well as in less restrictive, family-like settings.

Figure 2.—Children Entering DCFS Custody by Region and Age

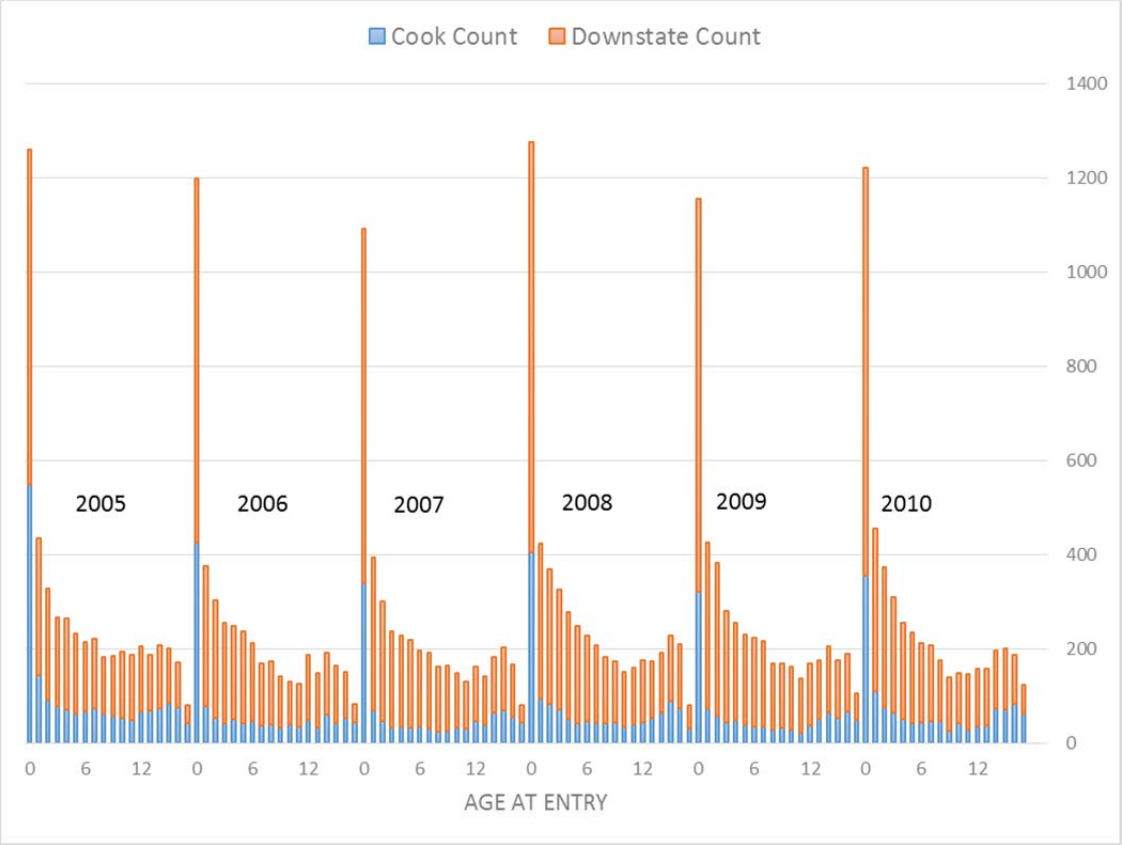


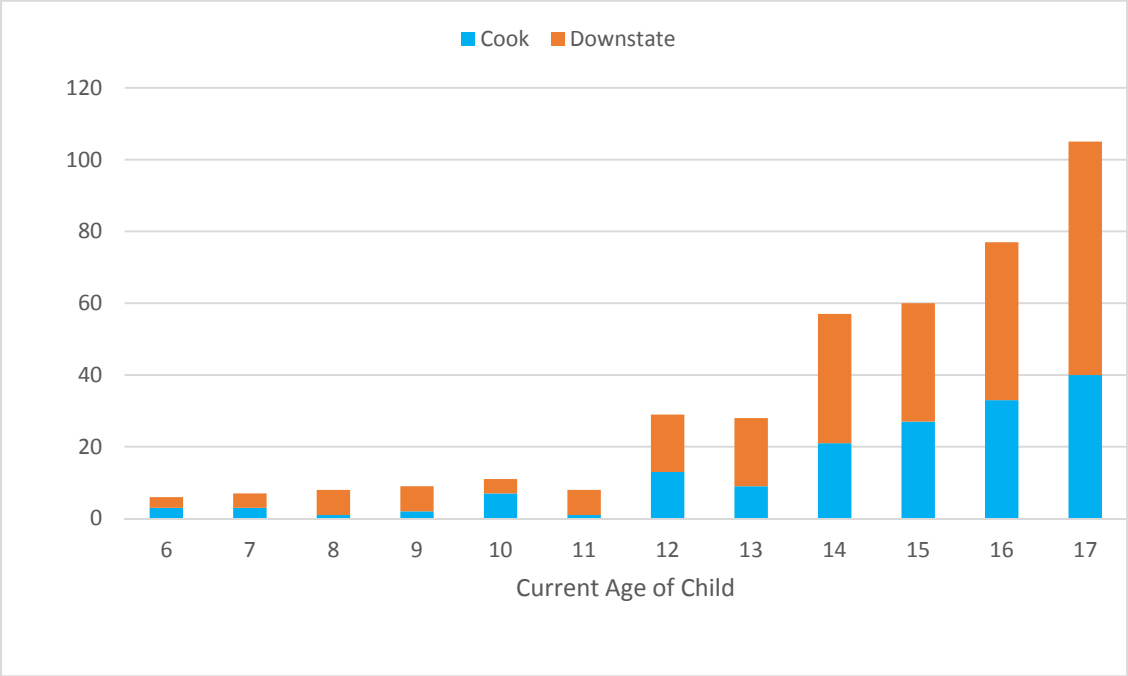
Figure 3 shows the age distribution of 405 children under 18 years old, who are awaiting a transition to another placement setting as of May of 2015. The age distribution is opposite to the profile of children entering DCFS custody with far more older children awaiting transition than younger children. Three-quarters of the children (300) are in shelters, psychiatric hospitals, residential treatment centers and group homes and awaiting step-down to a less restrictive setting. The median waiting time for children in residential treatment, group homes, and psychiatric hospitals is in excess of 100 days with one-third having waited for six or more months. The median waiting time (i.e., the duration of waiting for one-half of the population) corrects for the small number of youth whom the system records as waiting over 1000 days. Most of these youth have already reached their 21 birthday. The large number of adolescents' awaiting transition to another placement settings means they are unlikely to achieve family permanence prior to reaching adulthood, which create special difficulties that often outstrip DCFS's capacity to achieve the interlocking goals of safety, permanence, and wellbeing.

Shelter Care Stays in Excess of 30 Days

Youth shelters are designed to be very short term settings for youth who do not have placements pending a transition to foster care, residential treatment centers or other specialized living arrangements. By definition, these youth have experienced a major disruption in their lives, and can be considered to be in crisis. Of the 64 children that DCFS has identified as awaiting transition to a more appropriate setting, 54 (84%) have been waiting in excess of 30 days with one-half waiting in excess of 60 days. It is urgent that these youth obtain a placement where they can begin the treatment process and resume their lives in a stable setting. According to administrative personnel at the shelters, youth who wait for long periods in

shelters often become hopeless and present with major exacerbations of clinical symptoms and behavioral problems that impact subsequent placement stability and often resulting in future placement disruptions.

Figure 3.—Children Awaiting Transition to another Placement Setting by Region and Age of Child



Psychiatric Hospitalization beyond Medical Necessity

Youths who require this level of treatment present with extraordinarily serious mental health symptoms and risk behaviors. The psychiatric hospital is the most restrictive setting available and one that severely limits youth rights on a temporary basis with the goal of helping them rapidly achieve greater stability so that treatment can continue in the community. Of the 45 children that DCFS has identified as awaiting transition to a less restrictive setting, one-half have been waiting in excess of 100 days.

Wait List for Stepdown to Specialized Foster Care from Residential Treatment and Group Homes

Here, as well, youth considered appropriate for a community placement are held in residential programs and group homes awaiting a specialized foster home. There is great potential for institutionalization of youth who reside in these settings for long periods. Of the 190 children that DCFS has identified as awaiting transition to another setting, one-half are recommended for lateral transition to another congregate care setting, often without an explanation of why their needs cannot be met in a community setting, Only one-quarter are recommended for step-down to a specialized or adolescent foster home. Of the 46 institutionalized children recommended for family-based treatment, one-half have been awaiting transition in excess of 100 days. In these cases, youth do not have the opportunity to develop competencies that are developmentally appropriate and readily available in normalized settings. Consequently, these youth fall even farther behind their peers in areas pertaining to development of healthy autonomy and independence, interpersonal relationships, etc.

EXPERIENCES IN CARE BY AGE AT ENTRY INTO DCFS CUSTODY

It is sobering to compare Department statistics for children who enter DCFS custody at age 12 or older to children who entered at a younger age. Table 5 presents measures of key performance indicators from the

CFRC Data Center (http://www.cfrc.illinois.edu/outcomeindicators.php). Additional data analysis of permanency outcomes was conducted by the CFRC at the Panel's request. There are sharp discontinuities in performance indicators among children who enter DCFS custody before age 12 compared to adolescents who enter at age 12 years old and older. Over 40% of newly placed adolescents are already in a specialized foster or residential care setting at initial placement compared to 9% for younger children. Almost one-third of adolescents experience three or more placements during their first full year of care, and almost one-fifth runaway during their first year of out-of-home care. Children who enter at younger ages also experience unacceptably high levels of placement instability. Runways are not counted for younger children; most unauthorized absences involve abductions by parents.

Table 5.—Restrictiveness of Initial Placement, Placement Stability, and Permanence within Five Years of Removal, Children Aged Birth to 17 Years Old, CFRC Data Center, FY 2014

Measure	Age at Placement	N	%
Initial placement in specialized foster or residential care	0-11	442	8.9%
	12-17	432	43.2%
Hearing finding of delinquency or dependency	0-11	115	3.0%
	12-17	297	29.1%
Three or more placements during first year	0-11	589	19.0%
	12-17	242	27.4%
Ran from placement during first year	0-11	--	--
	12-17	204	19.3%
Reunification within five years of removal	0-11	1,816	48.2%
	12-17	383	34.9%
Adoption or guardianship within five years of removal	0-11	1,222	32.5%
	12-17	70	6.4%

Source: Children and Family Research Center. Data from the Illinois DCFS Integrated Database. Extract date: September 30, 2014.

Especially challenging is the large proportion of adolescents who fall outside the usual permanency planning parameters of reunification, adoption or guardianship. Far too many youth, particularly adolescents, are placed for extended periods of time in shelters or correctional settings "awaiting an available placement." More than 40% of children who come into care between the ages of 13 – 17 are placed in congregate care as their initial placement. Once children are placed in congregate care, their long-term trajectory as wards of the state is unlikely to include living with a family and having a permanent adult connection in their lives. Their chances of securing a permanent placement through adoption or guardianship are vanishingly small. The Panel's analysis of Department's data also shows that children who enter DCFS custody as adolescents are much less likely to be reunited with their family than children who are placed before the age of 12 years old. As displayed in Table 5, only 34.9% of children who enter custody at age 12 years old or older are reunified with their birth families within 5 years of case opening. Yet, the reality is also true that many adolescents will seek out their parents and relatives and reconnect with their family while still in care and after aging out of the child welfare system. Approximately 60% of adolescents who enter DCFS custody turn 18 years old while in state custody or else go missing, transfer to correctional facilities, or exit to other non-permanent settings. To the best of

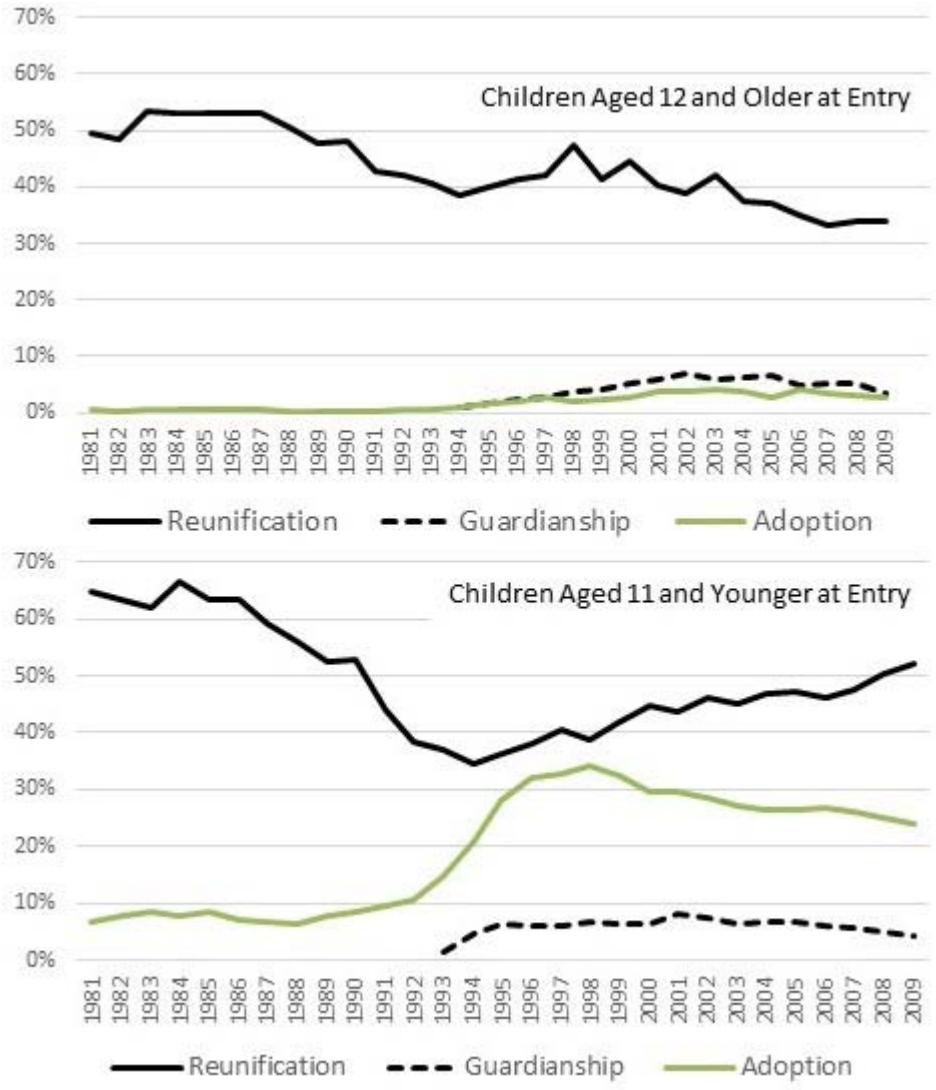
our knowledge, neither DCFS nor POSs engage in specific and focused steps to identify family members or support healthy contact and involvement with family, which is likely to continue once child welfare involvement ends.

Future progress in permanency planning must come from more intensive, evidence-based treatment and permanency planning at the early phases of child removal. Unfortunately, there are often lengthy delays, particularly in Cook County, between investigation and disposition in the abuse/neglect investigation, determination, adjudication, and disposition process. Children and parents are in a state of limbo for a number of months with limited or no services focused on what the child and family need during such a crucial time. For children, especially infants and preschoolers, months can be a lifetime developmentally, especially when there is uncertainty about their future. Further, DCFS administration has a very different perception of the effectiveness of various policies, procedures and programs than do POS agencies and DCFS caseworkers in the field. For example, some DCFS caseworkers expressed a great deal of frustration with the quality of the Integrated Assessments (IAs), whereas the DCFS central administration extolled the virtues of the IAs. The field also perceives that the Statewide Provider Database was outdated and ineffective in helping identify appropriate clinical resources, whereas representatives of the DCFS administration noted that the database is continually updated and, in fact, contains data about available clinical capacity in each agency. DCFS administration tends to view POS and other partner agencies as largely incompetent and "blame" these agencies for things beyond their control. This culture of distrust permeates all areas of DCFS's relationships with community providers. There is little recognition that the systems in place are broken, not the people. The disconnect between the central administration and the field on the functionality of IAs is unfortunate because early assessment and intensive service provision are even more critical now that the children who are removed from parental custody come from the most challenging of family circumstances.

As illustrated in Figure 4, the permanency options that are made available to adolescents who are unable to reconnect with their birth families are either few or insufficiently explored by DCFS. Less than 3% of adolescents who enter DCFS at age 12 or older are adopted within 5 years of case opening. Because adoption has always been a difficult choice for older youth to accept since it involves termination of parental rights (TPR), the Department promoted subsidized legal guardianship in the late 1990s as an alternative to long-term foster care precisely because it doesn't require TPR. In spite of evidence showing that subsidized guardianship is just as lasting a commitment as adoption, the frequency of the use of subsidized guardianship as a permanency option for adolescents in Illinois has decreased dramatically since 2008.

When Illinois pioneered subsidized guardianship under IV-E waiver authority, the option filled an important niche in the permanency continuum for older youth. Under the demonstration, there were two subsidized guardianships awarded for every subsidized adoption finalized for adolescents who entered care in 2002. With the creation of the federal guardianship assistance program, however, the federal government stopped reimbursing guardianship assistance made on behalf of children placed in unlicensed kinship care. As a result, the number of guardianships plummeted. Whereas 7% of adolescents who entered DCFS custody in 2002 were discharged to the permanent guardianship of relatives and foster parents within 5 years of case opening, nowadays only 2.8% of adolescents who entered in 2010 exited to legal guardianship within 5 years. Adoptions haven't filled the permanency gap. Only 2.4% of adolescents who entered care in 2010 were adopted within 5 years compared to 3.9% of adolescents who entered in 2002.

Figure 4 Permanency Outcomes within 5 years of Case Opening by Age at Entry into DCFS Custody



The reason for the falloff in legal guardianships is largely due to the restrictions imposed to keep the GAP program cost-neutral to the federal government. Prior to 2008, the federal government reimbursed Illinois for guardianship payments made on behalf of children residing in both licensed and unlicensed kinship homes. Section 302.410 of DCFS Rules and Procedures incorporated the GAP restrictions into the Illinois program. Both federal and state-funded guardianship assistance now excludes children in unlicensed kinship care. Not only does the rule unfairly deprive through no fault of their own a sizeable group of foster children and youth of an evidence-based permanency option, the restriction doesn't make fiscal sense. It is still cheaper to convert state-funded foster care payments into guardianship subsidies. The resulting administrative savings are well above the extra state costs for guardianship assistance payments. Further, federal regulations allow for the definition of kin to include the current foster parent of a child who has established a significant and family-like relationship with the child, whether related or unrelated by birth or marriage. An expansion of state and federally funded guardianship assistance in Illinois would allow for the delivery of trauma-informed treatment in more stable and permanent settings than retaining adolescents in residential care.

INTERNAL MANAGEMENT, EXTERNAL MONITORING, AND EVALUATION

The Department of Children and Family Services was established over 50 years ago. As frequently occurs with a large public agency, its capacity to advance its core mission became hampered over time by the proliferation of rules and regulation, the emergence of management silos, and the imposition of multiple-approval processes. Such "over-bureaucratization" leads to risk-adverse, compliance-oriented accountability in child welfare rather than results-oriented accountability that keeps the focus on children, checks whether they are being effectively served, and adapts flexibly when results are contrary to expectations. The Children and Family Research Center is an independent research organization that was created jointly under the BH Consent Decree by the University of Illinois at Urbana-Champaign and the Illinois Department of Children and Family Services to remedy some of the deficiencies of compliance-oriented accountability by providing independent evaluation of outcomes for children who are the responsibility of the Department. This type of outcomes-oriented accountability is important and helpful for tracking safety and permanence. Now that child wellbeing has become a more central focus for child welfare intervention, a different type of accountability system is needed to enact the recommendations of the Panel.

Result-oriented accountability requires a vastly improved capacity to access regularly and quickly available data and to develop new measurement systems to monitor progress and to identify problems. Persons responsible for DCFS data systems concede that internal capacity has seriously eroded over the years and are committed to its improvement. Further results-oriented accountability requires building evidence for the validity of the efficacy and effectiveness of promising interventions and continuously monitoring the integrity of their implementation to insure fidelity to the proven design. Dual accountability for both intervention validity and implementation integrity is the cornerstone for the new results-oriented accountability system advanced by the U.S. Children's Bureau in *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* (Framework Group, 2014). Any approach to accountability is counterproductive which does not address the dual problems of improving the validity of interventions and the integrity of their implementation. For example, the lack of an external, results-oriented accountability system for residential treatment facilities and group homes is highly problematic. Internal DCFS monitors are not required to have clinical expertise in evidence-based milieu management of youth. Except by word of mouth, the monitoring unit cannot identify poorly functioning programs that are having difficulties relative to their peers. Once identified, the Department has few options for improving the integrity of program implementation, except for the blunt solutions of removing its wards from the program or putting them on hold for new placements, which are seldom exercised.

The paucity of evidence-based treatment for commercially sexually exploited children as well as youth with severe emotional disturbance requires that the Department engage in the immersion process in order to refocus its mental health treatment on children within the context of safe and permanent family relationships. In order to contribute to the rapid build-up of evidence-based interventions, it will be imperative for the Department to ramp-up its piloting and testing of promising innovations through low-cost, randomized controlled trials (LC-RCTs) and other types of rigorous evaluation. Of the 342 programs listed on the California Evidence-Based Clearinghouse for Child Welfare, only 30 program (9%) are well-supported by research evidence and only two (2) of these evidence-supported programs—Attachment and Biobehavioral Catch-up (ABC) and Trauma-Focused Cognitive-Behavioral Therapy (TC-CBT)—were specifically designed, or are commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services.

Illinois has a distinguished past history of piloting and rigorously testing promising programs before scaling-up their widespread use or else stopping short of full implementation if the intervention is found to be ineffective either because of faulty implementation or weak internal validity. Among the successful evidence-based programs are: subsidized guardianship, performance contracting, and alcohol and other drug abuse recovery coaches. Among those found to be less efficacious include: Intensive Family Preservation Services (IFPS) and differential response (DR). Among those still being tested at the formative phases of implementation and evolution include: Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET), Child Parent Psychotherapy (CPP), Nurturing Parenting Program (NPP), and Safe Families for Children (SFC).

The phased approach to evidence building along the lines recommended in *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* (Framework Group, 2014) released by the U.S. Children's Bureau should become standard operating procedure before scaling-up any promising innovation. There are still a number of obstacles, however, that must be overcome before the Department can increase its implementation of LC-RCTs. These include: practitioner resistance to RCTs, lack of adequate training in and fidelity of program implementation, incomplete take-up of assigned treatments, and inadequate administrative information systems to track child welfare outcomes in real time. Each of these deficiencies hampers building-up credible evidence for what works and for weeding out what doesn't. Illinois is fortunate to have a network of universities and voluntary agencies, which has contributed to evidence-building in the past. It should continue to capitalize on these resources by consolidating university and voluntary agency partners into a coordinated network of evaluation, training, and implementation centers. These centers should specialize in various technical components of evidence-building, training, and implementation, including the conduct of LC-RCTs, the training of practitioners in the delivery of evidence-supported interventions (ESIs), and the scaling–up of ESIs in a way that promotes continuous quality improvement and results-oriented accountability.

Integrated Assessment

The DCFS Integrated Assessment (IA) process is a well-intentioned effort to provide a greater clinical focus on children entering care, additional information about the child and family, mentoring to child welfare caseworkers and a more comprehensive overview of child and family functioning for the case planning process. In its realization, however, it has only a modest influence on system decision-making and can be disconnected from ongoing practice. Caseworkers, who are expected to participate jointly in the assessment process, do not consistently have time to participate in child and family interviews. Because DCFS and POS supervisors have final responsibility for choosing case plan recommendations, case plan expectations may be different than those in the IA. And because of the length of the Individualized Assessment reports, which can be 70 pages or more, they are not consistently and fully reviewed by some staff. Elements of any initial assessment like the IA can be obsolete within months, given the rapidly changing dynamics of children and their families.

IA staff acknowledge that IA recommendations may be limited by the availability of services, and when that occurs, it undermines the ability to respond to underlying needs and conduct effective individualizing case planning. While the IA process does add value, system challenges limit its contribution to good practice and successful outcomes. To address these challenges, it is recommended that as the Panel's strategy about front-line practice improvement is implemented, meaning in a geographically staged manner over time, IA clinicians join child and family teams as participating members. This would assist in moving the assessment and planning process and integrate assessment into the teaming process, which would become the locus of assessment. IA staff should also serve as local coaches on clinical issues.

To implement the proposed practice model, considerable retraining and coaching of staff will be required. Staff will need to strengthen their skills in child and family involvement, develop mastery in the child and family team meeting process and have the ability to identify underlying needs and create individualized plans. It is recommended that new and experienced staff and supervisors receive extensive training and coaching in the areas described above as their region begins the staged implementation process.

Measuring Child and Adolescent Wellbeing

As Departmental staff undergoes retraining and coaching, there remains a pressing need to conduct valid and reliable assessments of the wellbeing of children and youth in the aggregate using standardized instruments and trained external reviewers. A well-designed, but dated measurement system that provided much of the wellbeing data utilized in this report is Illinois's replication of the National Survey of Child and Adolescent Wellbeing (NSCAW).

The NSCAW is the only source of nationally representative data on the well-being of children and families in the child welfare system. While administrative data systems provide critically important reports on the safety and permanence of children in the child welfare system, there is no equivalent source of data on the social and emotional well-being of the victims of child maltreatment.

The Illinois replications were previously conducted for DCFS by the UIC Survey Research Laboratory and the Research Triangle Institute (RTI). Reinstating the Illinois Survey will not only provide valuable data on the wellbeing of a representative sample of the plaintiff class of children, but it will also provide a testing ground for determining the validity and reliability of various assessment instrumental and wellbeing scales for use in the field. As noted in ACF Information Memorandum on Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services:

> Rather than using a "one size fits all" assessment for children and youth in foster care, systems serving children receiving child welfare services should have an array of assessment tools available. This allows systems to appropriately evaluate functioning across the domains of social-emotional well-being for children across age groups (O'Brien, 2011).

Chart 1 lists the kinds of measurement tools that are candidates for testing in an Illinois survey.

Chart 1—Instruments for Assessing and Monitoring Child and Adolescent Wellbeing

Instrument
Battelle Developmental Inventory (BDI) & Screening Test, 2nd Edition
Achenbach Scales: Child Behavior Check List; Youth Self Report ; Teacher Rating Form
Kaufman Brief Intelligence Test 2nd Ed (K-BIT-2), 2004
Bayley III Screening Test, 2005
Preschool Language Scales-5 (PLS-5), 2011
Woodcock-Johnson IV (WJ-IV), 2014/2015
Vineland Behavior Scales, Second Edition (Vineland II) 2005
Children Depression Inventory 2 (CDI 2), 2010
Child & Adolescent Needs & Strengths (CANS)
Child & Adolescent Functional Assessment Scale (CAFAS
Behavior & Emotional Rating Scale (BERS)
Child and Adolescent Service Intensity Instrument (CASII)

Early Childhood Service Intensity Instrument (ECSII)
North Carolina Family Assessment Scale (NCFAS)
Parenting Stress Index (PSI)
Adult-Adolescent Parenting Inventory (AAPI) -2
Devereux Early Childhood Assessment (DECA)
Infant Toddler Symptom Checklist (ITSC)
Denver II Developmental Screener
Ages & Stages Questionnaire

Use of Federal Funds

The Department has not fully accessed available matching federal funds, including Title XIX and IV-E funds. Even though Illinois could support the implementation of these recommended initiatives on a pilot basis entirely from state resources, full implementation would benefit from the more flexible use of federal resources. A disproportionate share of federal dollars is still locked up in the maintenance of the old 20th century foster care system. The so-called "look-back" provision that ties IV-E program eligibility to the income assistance standards that were in effect in 1996 will continue to deplete the future supply of federal child welfare dollars that flow to the states. The denial of IV-E administrative reimbursement and federal guardianship assistance for children in unlicensed kinship homes also saps federal aid and withholds an important permanency option from children in safe and stable kinship care. Further, the opportunity to use the diminishing supply of federal dollars more flexibility through IV-E waivers has been closed off twice—first in 2006 and then again in 2013. Illinois should take active steps to remove these obstacles to federal financial participation in state child welfare programs and seek immediate restoration of the IV-E waiver program.

RECOMMENDATIONS

1. **Institute a children's system of care demonstration program that permits POS agencies and DCFS sub-regions to waive selected policy and funding restrictions on a trial basis in order to reduce the use of residential treatment and help children and youth succeed in living in the least restrictive, most family-like setting.**
    - Waivers should be granted for the flexible use of past or projected funding levels provided that demonstration sites participate in the same kind of structured experimentation and roll-out that the U.S. Children's Bureau outlines in *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* (Framework Group, 2014).
    - Examples of waivers that could be granted include, but are not limited to, the following types:
        - Recruitment of therapeutic foster homes for adolescents who enter state custody outside of the usual parameters of maltreatment by caregivers (e.g., juvenile delinquents, commercial sexually exploited children) and are unlikely to achieve family permanence prior to reaching adulthood.
        - Department should work with HFS to obtain waivers or change funding for piloted therapies to incentivize the adoption of preferred clinical models. With appropriate documentation, for example, providers could bill at a higher rate for a unit time of Trauma-Focused Cognitive Behavioral Therapy.

- The Department of Children and Family Services, the Department of Juvenile Justice, the Division of Mental Health of the Department of Human Services, the Juvenile Court and the Department of Healthcare and Family Services could collaborate to develop and roll out a highly structured home-based system of care to address the needs of youth aged 12 years or older entering the Department of Children and Family Services for the first time. These youth are often coming from Juvenile Justice with a court order for residential care. Many of these older youth entering the system for the first time have a long history of psychiatric illnesses and behavioral problems resulting in lock-outs and Dependency Status. This structured rollout would be administered by a University partner. The program would be analogous to the structure of the CMHCs, but the interventions and the outcome and process measures would be more standardized to allow the investigators to determine empirically which interventions and processes enhance outcomes and which ones are unrelated to outcome. If this program proves to be effective it can be brought to scale system wide in the CMHCs and throughout the Department.
- There is a large overlap between the *B.H.* plaintiff class and the population covered under the *N.B.* Court Order. All members of the *B.H.* class are Medicaid eligible as are most former DCFS wards placed in permanent homes with adoptive and legal guardians. Both NSCAW and CANS data indicate that at single point in time at least one-half of B.H. class over the age of 12 years old and upwards of 80 percent at any time during their stay in foster care exhibit mental health and behavioral problems that could quality them under the EPSDT mandate for treatment in the least restrictive, most family-like setting possible. The Panel believes, based on experiences in other states such as New Jersey, that many of the recommendations advanced in this report would be easier to accomplish if B.H. were part of a court-supervised reform of children's Medicaid services in Illinois.

- Implementation of a highly structured home-based system of care will not succeed if DCFS attempts to implement them statewide simultaneously. Changing the practice culture to the extent needed will require extensive retraining and coaching at the front-line, infrastructure development among providers and creation of a QA and QI process that can faithfully measure outcomes, procedural performance and practice quality. No system can manage or support this amount of concurrent, system-wide organizational change with enough depth to assure sustainability. The strategies recommended should be tested, evaluated and refined in a phased sequence of usability testing, and formative and summative evaluation before implementing them statewide.
- Implementation of a new system of care should be rolled out in a structured fashion on a regional basis. This will permit local technical assistance, resource development, training and coaching to be provided in a manageable number of settings with enough duration and intensity to permit careful evaluation of effectiveness and impact. Several systems have labeled this phased implementation strategy the immersion process and identify early implementation sites as immersion sites.

- The increased availability of high intensity, high quality community services could go a long way towards alleviating the current gridlock on transitioning youth to home and community-based treatment settings.
  - Waivers could be granted to trusted providers in major population centers around Illinois to develop Community Mental Health Centers (CMHC) (See DHS/DMH

Rule 132 for children and youth). Ideally these provider agencies would be large agencies that already provide a wide range of services including services for youth with severe emotional disturbances. These child welfare CMHC's would be contracted to provide a full range of community-based mental health services prioritizing youth who are ready to step down from inpatient psychiatric units and institutional and group home settings and who can be managed in the community.

- These services should include the entire range of services, including but not limited to: therapeutic foster care, case management, care coordination, 24 hour mobile crisis response, respite care, home-based services for children placed in all family settings (to prevent removal, to support family placement and to maintain re-unification/adoption), high fidelity wrap around services, therapeutic mentoring, family therapy, evidence-based youth therapy, psychiatric consultation, educational liaison.
- In designing the service array, the Department should send a team to review two innovative service designs in Arizona and Los Angeles County, which provide highly individualized, intensive home and community-based services for children with high mental health needs on-demand 24 hours a day, 7 days a week. The Department should give strong consideration to adopting these models. The Panel can provide contact information for agency leadership.

2. **Engage Department offices in a staged "immersion" process of retraining and coaching front-line staff in a cohesive model of practice that provides children and their families with access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanence with adoptive parents or legal guardians.**
   - Changing the practice culture to the extent required will require extensive retraining and coaching at the front-line, infrastructure development among providers and the creation of a QA and QI process that can faithfully measure outcomes, procedural performance and practice quality.
   - The Panel believes that implementation of its recommendations cannot succeed if DCFS attempts to implement them statewide simultaneously. No system can manage or support this amount of concurrent, system-wide organizational change with enough depth to assure sustainability. Also, the strategies recommended should be tested, evaluated and refined before implementing them statewide.
   - The Panel recommends that the changes be implemented in groups of offices annually. This will permit local technical assistance, resource development, training and coaching to be provided in a manageable number of settings with enough duration and intensity to generate lasting improvements. Several systems have labeled this staged implementation strategy the immersion process and identify early implementation counties as immersion sites.
   - To implement the proposed practice model, considerable retraining and coaching of staff will be required. Staff will need to strengthen their skills in child and family involvement, develop mastery in the child and family team meeting process and have the ability to identify underlying needs and create individualized plans. It is recommended that new and experienced staff and supervisors receive extensive training and coaching in the areas described above as their sub-region begins the staged implementation process.

3. **Fund a set of permanency planning initiatives to improve permanency outcomes for adolescents who enter state custody at age 12 or older either by transitioning youth to permanent homes or preparing them for reconnecting to their birth families reaching adulthood.**
   - State-funded guardianship assistance should be extended to all children aged 12 and older regardless of IV-E eligibility.
   - The definition of kin should be revised to include the current foster parent of a child who has established a significant and family-like relationship with the child, whether related or unrelated by birth or marriage.
   - Both changes will result in a savings since the administrative savings are well above the state costs for guardianship assistance payments and the revision of definition of kin will qualify more assistance payments for IV-E reimbursement.
   - Implement specific "family finder" strategies as part of permanency planning for adolescents who do not have an obvious reunification plan.

4. **Retain an organizational consultant to aid the Department in "rebooting" a number of stalled initiatives that are intended to address the needs of children and youth with psychological, behavioral or emotional challenges.**
   - Full implementation of several excellently designed initiatives, including among others: the Illinois Birth thru Three Demonstration, Integrated Assessment, Residential Services Performance-Based Contracting, DCFS Monitoring of Residential Services, and Home-Based Mental Health Services, is being stalled or undermined by a variety of systemic and external factors, such as lengthy court delays to adjudication, categorical funding restrictions, challenges of client engagement, inflexible bureaucratic rules, and discontinuities in the handoff of case management responsibilities among public and private agencies.
   - The consultant should evaluate the organizational structure and culture of DCFS; the effectiveness of DCFS' policies, procedures and programs; the effectiveness of the Department's leadership and managerial structure and function and to assess the supervisory functions of the agency.
   - The Department should initiate a program for training and ongoing coaching of project administrators on how to provide effective coordination and supervision. This training should not only include supervision on completion of responsibilities but on clinical matters as well.
   - The training should emphasize that data should be used positively as a means for assisting managers in exploring new ways of improving program performance rather than negatively as an excuse for rendering unsatisfactory assessments of the performance of managers responsible for the program.
   - Development of new programs and retention of existing initiatives in DCFS should be done after determining how it fits in with the DCFS core mission, after a thorough review of other programs that may already be in existence to address the problem or need driving the new initiative, and that duplicate services and initiatives already in place be eliminated or revised to prevent inefficient use of resources. Mechanisms must be enacted to make effective programs and policies be self-sustaining such as through changing reimbursement strategies or revising job descriptions.
   - To oversee implementation of this plan, the Department should create a high level unit with cross-organization authority to develop an implementation plan, manage the implementation and resolve system barriers

5. **Restore funding for the Illinois Survey of Child and Adolescent Wellbeing that uses standardized instruments and assessment scales modeled after the national Survey of Child and Adolescent Wellbeing to monitor and evaluate changes in the safety, permanence, and well-being of children for a representative sample of DCFS-involved children and their caregivers.**
   - A representative sample of children (1200 or more) and their caregivers, investigators, and caseworkers should be regularly surveyed and interviewed prior to removal, while in state custody, and post-permanence.
   - DCFS and the community partners enlisted to establish CMHCs could identify several process and outcome variables to be incorporated into the ISCAW to assess the child's outcomes and experience of care. These outcome and experience of care measures should be evaluated for their validity and reliability in forming the performance measurement framework for several processes, including but not limited to: performance-based contracting for the CMHCs, measures of treatment progress that trigger processes for next steps (plans for step-down to traditional or home of relative foster care, independent living or transitional living), quality improvement initiatives at the programmatic level (program-based QI initiatives) and the system-level (dashboards).

6. **The Court should order the creation of several external monitoring mechanisms in addition to the Children and Family Research Center to ensure the effective implementation of Department initiatives to enact the reforms necessary for compliance with the BH Consent Decree.**
   - An external monitor/panel (whether an individual or group of child welfare and mental health professionals) and appointed by and answering to the Court, should be put into place to monitor the Department's progress and make recommendations towards implementing the recommended system reforms and to monitor their effectiveness in achieving compliance. The BH parties would propose and attempt to reach agreement on the membership of the panel.
   - The Department should, within the framework of this report, develop an enforceable implementation plan which identifies the tasks, responsibilities and time frames necessary to accomplish the objectives of the Consent Decree and the Order Appointing Experts. The experts will serve as advisors to the Court in the development of the plan. This implementation plan should be developed within four (4) months of the courts approval of the Expert's Plan and requires the approval of the experts before submission to the court. The implementation plan cannot possibly anticipate all of the obstacles the Department will encounter and it is inevitable that experience in the first year of implementation will identify necessary revisions of the initial plan. As a result, the implementation plan should be reviewed by the Department, plaintiffs' counsel, and the experts regularly, including at the end of the first year of implementation to identify needed revisions to the plan. Necessary revisions will be included in amendments to the plan, which will be reviewed by the parties and submitted to the experts, and thereafter to the Court for approval.
   - The Department should develop in partnership with one or more of its University partners a results-oriented accountability system that improves regular and timely access to available data, develops new measurement systems to monitor implementation integrity, evaluates intervention effectiveness in accomplishing intended results, and adapts program modifications flexibly when results are contrary to expectations.

- Residential and group home monitoring should be moved out of DCFS to an external partner. DCFS personnel rarely have clinical expertise, especially related to the milieu management of youth with severe emotional and behavioral disturbances and sequelae of trauma. The current Unusual Incident Reporting (UIR) system fails to capture consistent information. There is inadequate follow-up and follow-through on addressing the underlying issues that resulted in the UIR. Both monitoring and follow-up should function in conjunction with the Department's Division of Quality Assurance and Research, the Division of Clinical Practice and Development, the Division of Regulation and Monitoring and the Office of Information Technology. The residential monitoring program would work with the Department and the residential and group home providers to:
    - Design a series of measures that will used to identify outlier programs in terms of safety and clinical outcomes
    - Provide leadership to DCFS clinical staff in the conduct of on-site utilization reviews of agencies determined to be at high risk for harmful incidents, thus requiring a targeted intervention
    - Provide clinical and organizational technical assistance and consultation to residential and group home providers in the development of corrective action plans required to address the specific findings of these reviews
    - Monitor the providers' progress vis-à-vis the implementation of the corrective action plans
    - Develop an ombudsman function to solicit and facilitate feedback and problem-solving for stakeholders
    - Design and implement an intensive and highly specific consultation and training program for residential and group home facilities identified as having difficulties based on best practice and evidence-informed/evidence-based treatment approaches.

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