IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

B.H., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 88 C 5599
	)	Hon. Jorge L. Alonso
GEORGE H. SHELDON, Director,	)	Judge Presiding
Illinois Department of Children and	)	
Family Services,	)	
	)	
Defendant.	)	

DCFS B.H. IMPLEMENTATION PLAN

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DCFS B.H. IMPLEMENTATION PLAN

Introduction

In April 2015, this Court appointed a panel of experts pursuant to Federal Rule of Evidence 706 to evaluate the services and placements provided to plaintiff class members with psychological, behavioral or emotional challenges. In July 2015, the Expert Panel submitted a report to the Court outlining specific findings and making six recommendations for systemic change at DCFS. Under the leadership of then-newly appointed Director George H. Sheldon, DCFS did not dispute the factual findings and committed to address the challenges described by the Expert Panel. DCFS is committed to take immediate action to correct systemic deficiencies and to strive for the safety, permanence, and wellbeing of children in care.

In October, the Court adopted the Expert Panel's findings, subject to certain revisions proposed by the parties, and reappointed an Expert Panel. The Order contemplates collaboration of the parties and the Expert Panel to develop an implementation plan, preferably by agreement, for DCFS to follow as it addresses systemic reform.

Although Director Sheldon was initiating multiple steps to address the challenges and concerns he observed at DCFS, the July 2015 Expert Panel recommendations sparked further urgency and a broader approach to DCFS reform. DCFS now has a number of critical and innovative initiatives under way that are intended to address many of the underlying challenges referenced in the report, but there is still a long way to go to implement those initiatives fully in order to evaluate and sustain their success. Work has already begun to spread seeds of cultural change, a sense of urgency and clear planning and ownership at multiple levels of DCFS. Success in those efforts will be a critical factor as the broader work begins. In addition, DCFS continues its work to determine an overarching strategy that will connect projects and initiatives

together to truly reform the child welfare system and in so doing address the psychological, behavioral and emotional needs of the Plaintiff class.

This Implementation Plan sets forth the specific steps DCFS will take to begin addressing the six recommendations and the specific needs of children and youth in care with psychological, behavioral or emotional challenges. The Plan represents a core component of the overarching DCFS strategic plan which will be developed between February and July 2016. The direction of DCFS is to embed child and family centered practice into a system where all leaders, administrators and staff have a sense of urgency toward reaching the best possible outcomes for children and families in Illinois.

I. Overarching Outcome Measures

As a result of collaboration with the Expert Panel and DCFS consultant Dr. Mark Courtney, DCFS identified specific outcome metrics to assess the safety, permanency and wellbeing of class members. These metrics are intended to monitor changes in both the quality of, and capacity to provide, services and supports for children and families in the Illinois child welfare system. Notably, every state child welfare system is measured by the United States Department of Health and Human Services, Administration for Children and Families. For purposes of this Implementation Plan, DCFS will use the same safety and permanency outcome measures that are currently utilized by the federal government in the Child and Family Service Review (CFSR) process. The data for the safety, permanency, and stability metrics will be drawn from existing DCFS data sources and based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS). Though not as a measure of compliance with the Expert Panel's report, DCFS will routinely track and monitor other data indicators as part of this Implementation Plan that are discussed under Recommendation #4. See discussion *infra* at pp. 39-40.

The CFSR, however, does not track wellbeing outcomes with specificity. Therefore, DCFS will use wellbeing measures that were developed by the Illinois Child Welfare Advisory Committee (CWAC) Sub-Committee on Wellbeing. CWAC was established pursuant to executive order and provides counsel regarding emerging policy issues and best practices in child welfare. The CWAC Sub-Committee on Wellbeing is comprised of experienced, credentialed DCFS and private agency stakeholders and child welfare experts at Northwestern University. See description of CWAC Sub-Committee and Sub-Committee membership list, attached as Exhibit A.

A. Safety

The selected safety measure from the CFSR is maltreatment in foster care:

"Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?"

See Final Notice of Statewide Data Indicators and National Standards for Child and Family Services Reviews, attached as Exhibit B.

B. Permanency and Stability

The selected permanency and stability measures are:

1. Permanency in 12 months for children entering foster care: "Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care?"

2. Permanency in 12 months for children in foster care 12 to 23 months: "Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the period?"

3. Permanency in 12 months for children in foster care 24 months or more: "Of all children in foster care on the first day of a 12-month period, who had been in foster care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?"

4. Re-entry to foster care in 12 months: "Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a

relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?"

5. Placement stability: "Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?"

C. Wellbeing

Because the CFSR process does not provide for specific data measures for child wellbeing, DCFS will measure wellbeing based on a matrix that was developed by the CWAC Sub-Committee. The matrix is premised on the four functional domains (cognitive functioning; physical health; emotional/behavioral functioning; and social functioning). DCFS is working to further define measures of all aspects of wellbeing described in the matrix and has brought on national expert, Dr. Mark Courtney, to support this effort. With Dr. Courtney's support, DCFS and the CWAC Sub-Committee will specifically identify indicators of the domains of wellbeing by June 2016.

The current wellbeing matrix identifies developmentally-sensitive measures for children and youth ages 0-3 through young adulthood, and is consistent with the federal framework set forth in "Promoting Social & Emotional Wellbeing for Children and Youth Receiving Child Welfare Services." (April 17, 2012, https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf.) See CWAC Wellbeing Matrix, attached as Exhibit C.

D. Action Steps for CWAC Wellbeing Matrix

Many, but not all, of the wellbeing indicators in the matrix will be gathered from existing DCFS data sources. For the indicators that are not currently available because DCFS does not have accessible data sources, the DCFS Office of Information Technology will develop and incorporate data sources in order to measure the outcomes associated with the wellbeing matrix.

One of the existing DCFS data sources from which the wellbeing indicators will be gathered is the Child and Adolescent Needs and Strength Assessment tool (CANS). In order to

assess the validity of CANS findings, DCFS will develop and implement in the selected immersion sites (discussed *infra* at pp. 22-30) an independent quality service and progress review consisting of the periodic collection of data from external sources, such as children and youth, foster parents and teachers to compare to CANS findings. CANS data-capturing and reporting activity is maintained by the Northwestern University Illinois Outcomes system. The Psychiatric Hospital database has been finalized. It permits DCFS to collect data regarding youth who have been and are currently psychiatrically hospitalized, critical information to confirm the CANS.

In addition, DCFS is developing a database for data from the Illinois State Board of Education (ISBE) that will include the Student Information System that monitors a student's progress over time and tracks school enrollment, attendance and progress. The DCFS technology upgrade required to allow the acceptance of this data into the Statewide Automated Child Welfare Information System (SACWIS) is due to be completed in 6-12 months.

II. Implementation of Specific Recommendations of the Expert Panel

A. Recommendation #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.*

DCFS will begin implementing Recommendation #1 through four pilot projects targeted at populations of children with emotional and behavioral needs and/or youth involved in both the juvenile justice and child welfare systems ("dually involved"). The goal of the pilot projects is to reduce lengths of stay in residential facilities and increase placements in community and home-based settings. DCFS is committed to the pilot project process, and three of the four pilots described below have been launched. The fourth pilot, Therapeutic Foster Care, is in the Request for Proposals (RFP) phase and is expected to launch this summer. Each of these pilots will be rigorously evaluated. If the evaluation demonstrates that the pilots are meeting stated

goals, it is anticipated that they will be rolled out more broadly across the state. If they are not effective, they will be modified or discontinued, and alternative approaches will be pursued as appropriate and necessary.

1. Therapeutic Foster Care Pilots

a. Pilot Overview

DCFS will pilot the use of therapeutic foster care through evidence-based or evidence-informed models in three sites over the next five years. Therapeutic Foster Care (TFC) is a community-based service for children and youth whose emotional or behavioral health needs can be met through services delivered primarily by foster parents, as an alternative to residential and other forms of congregate care. TFC involves homes where at least one parent does not work outside the home, and no more than one or two children are placed in the home.

b. Requests for Proposals

DCFS issued requests for proposals for the development of TFC pilot programs. Based on an analysis of the current DCFS population by Chapin Hall at the University of Chicago (Chapin Hall), the TFC pilot programs are targeted for Cook, Kane and Winnebago counties because these areas have the highest need for alternative placements for youth with serious emotional or behavioral health needs. The RFP asked the proposing entities to identify the target population and number of youth to be served; the geographic region to be served; the particular model of TFC to be implemented; the trauma-informed interventions to be implemented; a model of sustainability including plans for recruitment and retention of foster parents; and the identification of key staff along with the qualifications of staff members and an explanation of cost efficiency.

Twenty-six responses to the RFP were received and are being evaluated. DCFS plans to complete the evaluation process, including oral presentation by finalists, and will begin contract negotiations no later than April 1, 2016.

c. Oversight of TFC Implementation Steps

After the TFC providers are selected and contracts with them have been negotiated, DCFS will take steps to ensure timely and appropriate implementation of the chosen TFC programs, using demonstrated strategies that have proven successful in implementing TFC nationwide. Unlike traditional foster homes, TFC is a treatment intervention through which the foster parent is the primary provider of mental health services and supports to the child. DCFS will set specific targets and, working with the selected providers, develop strategies for the recruitment and retention of TFC homes, the placement of children in those homes, and the services and supports those children receive. DCFS will have a structure for identifying children and youth most appropriate for TFC placement no later than April 30, 2016. In addition, DCFS will begin contract negotiations with TFC Purchase of Service (POS) providers no later than April 1, 2016, and will have developed implementation plans with those providers no later than April 30, 2016.

DCFS set a two-year goal for each program for the recruitment of therapeutic foster parents and placements. This two-year goal will include the placement of a minimum of 40 children and youth in TFC licensed homes at the end of the first contractual year; and placement of a minimum of 100 children and youth in TFC licensed homes at the end of the second contractual year. At least 60% of the youth served in TFC licensed homes will be aged 12 years and over.

d. Initial Placement and Placement Stability

TFC pilot programs will establish placement and assessment criteria, including adherence to the clinical needs of the individual child, as the main determination of the placement and development of individualized service planning to meet the specific and changing needs of the child. Participating entities in the TFC pilot programs will be required to serve all children and youth assigned to their program—there will be a "no eject, no reject" policy for children assigned to each agency.

e. Evaluation by Chapin Hall

The evaluation of the TFC pilot programs will be conducted by Chapin Hall. While the evaluation component is not complete, wellbeing measures will be included. Other outcome measures will focus on reduced length of stay and number of placements in residential facilities, number of children stepped down to traditional foster care and the number of children achieving permanency.

f. DCFS Leadership of the TFC Pilot

The implementation of this project will be led by Peter Digre, Deputy Director of Placement and Community Resources with the support of an outside expert consultant who will be hired by April 15, 2016. Mr. Digre has extensive experience in developing and implementing child welfare programs in Illinois, Philadelphia, Florida and Los Angeles, including specialized, intensive and therapeutic foster care programs. He will lead a team that will include managers from Clinical, Licensing, Operations and Training divisions. Twana Cosey will be the Strategic Planning liaison on this project.

2. Care Management Entity Pilot

a. Pilot Overview

Illinois Choices is the organization selected to be the Care Management Entity (CME) for this specific pilot. As the CME, Illinois Choices provides care coordination services based upon Systems of Care principles to children with severe and complex behavioral health concerns. The pilot serves children in DCFS custody who have a head of household address or legal county of origin in Champaign, Ford, Iroquois or Vermilion counties and who are either: 1) in psychiatric hospitals, residential /group home facilities, or specialized foster care; or 2) have been screened due to a psychiatric crisis; or 3) in traditional foster care and are experiencing placement stability issues. The four counties for the pilot were selected based upon high intake rates and long lengths of stay for children in those areas.

b. Child and Family Teaming Model

The CME's care coordination services are provided through an intensive Child and Family Teaming (CFT) model that is implemented according to High Fidelity Wraparound standards. See National Wraparound Standards, attached as Exhibit D. When a child is enrolled in the CME pilot, a care coordinator is assigned and begins an engagement process to establish a CFT that includes the child, the permanency worker, any available family members, and other natural supports, such as teachers, friends, mentors and neighbors. The care coordinator facilitates a meeting with this CFT at least every 30 days to ensure that the child's and family's needs are being met. The CFT uses the strengths and needs that are identified through completion of a CANS when the child is enrolled to develop a Plan of Care that authorizes all services required for the child and family. Those services are provided by agencies who are members of the CME's Provider Network.

Each member of the CFT has specific responsibilities. The care coordinator is responsible for scheduling and facilitating the CFT, for ensuring that all necessary services are properly authorized and that access to services is streamlined. The assigned permanency worker is responsible for ensuring that the permanency goal drives all of the CFT planning and that DCFS rules, procedures and policies and all court orders are being met. The permanency worker and care coordinator work as a team.

c. CME Provider Network

The CME provides care coordination, administration and oversight of the Provider Network, which is comprised of community-based providers who are willing to offer services to children and families enrolled in the program. Importantly, the CME is not a direct provider of therapeutic services. This permits "conflict-free" care coordination.

The CME pays providers directly, thus maintaining control of the network and allowing for flexibility to add new providers and services as needed for an individual child. The Provider Network began with only providers who had existing contracts with DCFS for both placement and therapeutic services. The CME has expanded the network to include other non-traditional providers (e.g., equine therapist, mentors, family peer supports, etc.) not previously under contract with DCFS. The CME Provider Network continues to expand to cover additional service types and providers.

Home and community-based behavioral health services currently available within the CME Provider Network include, but are not limited to: therapy – individual, family, group, and specialty (e.g., equine); community support – individual and group; evaluation and testing services; and behavior management services. Expanded child welfare support services include, but are not limited to: team meeting participation; court hearing attendance; mentoring – educational, social, recreational, life coach, independent living skills, family and parent; tutoring;

supervised visitation; shared parenting and coaching; family support services including camp; childcare reimbursement; transportation; incentives; utilities; supplies; activities; medical; clothing; and restitution and damage repaid.

d. Flexible Funding

The CME manages specific funds for "flexible spending" for each child enrolled in the program. These funds are pooled across all children providing the opportunity to secure additional creative and flexible services and supports for children with higher needs. The CME accesses Medicaid reimbursed services whenever possible to ensure that flexible funds are only utilized for services and supports not already available in the community.

Mental health services currently available through flexible funding include home-based services (utilizing evidence-informed practices), enhanced mobile crisis response, crisis stabilizers, crisis respite, therapeutic mentoring services, peer support and non-crisis respite. The goal is for such services to be integrated by the Illinois Department of Healthcare and Family Services (which is the Illinois State Medicaid agency) into the federally approved Medicaid service array.

e. Goals and Outcomes for CME Pilot

The CME pilot is intended to keep children stabilized in the least restrictive placement possible, to move children to sustained permanency as soon as they are ready, and to ensure children's and families' interests and participation directly influence the planning and delivery of services. The goal is to develop a network of community providers who offer a long-term community-based support system after the children achieve permanency.

f. DCFS Leadership of CME Pilot

The CME pilot is administered by DCFS's Care Coordination Office, overseen by Kristine Herman, Associate Deputy Director of Medicaid Behavioral Health and Care

Coordination within the Strategic Planning and Innovation Division. The Care Coordination Office authorizes all referrals to the CME, oversees the implementation of the pilot program and ensures that administrative issues are addressed at the field level by interacting directly with both private agency and DCFS permanency workers and other staff.

The Care Coordination Office is also responsible for ongoing oversight of the implementation of the pilot through CME compliance reviews and quarterly and annual outcomes reports by the CME. Additional baseline data, outcomes and performance benchmarks will be reported by the university partner tasked with evaluating the CME project. These reports will be used to assess the impact of the pilot as it continues to be implemented and before the final evaluation is completed.

g. CME Pilot Time Frames and Capacity

The CME pilot started in February 2014 and is currently scheduled to last for three years. The pilot is designed to serve approximately 200 children annually and 600 during the course of the three year pilot. The daily census as of February 5, 2016 is 170, and a total of 255 children have been served in the pilot since February 2014.

Lessons learned from the two years of the CME pilot have been applied to the development of the immersion sites as set forth in Recommendation #2. See discussion *infra* at pp. 22-30. Through the CME pilot, DCFS has begun to localize processes within the regional structure of the CME allowing more local control and further empowering CFTs to make decisions regarding the best services and placement types for children. For example, the Clinical Intervention for Placement Preservation (CIPP) has been eliminated for children enrolled in the CME and the centralized process for placing children in substitute care (Central Matching) is being replaced. DCFS is committed to continuing the process of reinforcing local control of

various policies and processes, since this local integration has been shown to be effective in the CME pilot.

In addition, DCFS recognizes that any system change processes, such as those undertaken in the CME pilot, must have strong administrative oversight and support. Because changing the culture of a system takes time and consistent messaging, a single administrator of the program with direct access to executive leadership was established. This administrative structure has allowed policy, procedural and other system barriers to be addressed in the pilot helping to propel culture change. This also ensures that both DCFS and private agency staff are held accountable for honoring the CFT model integral to the pilot, which represents a completely new way of doing business.

h. CME Evaluation

A full evaluation of the CME pilot project will be completed by a university partner, to be identified by March 15, 2016, at the end of the three year pilot period.

3. Dually-Involved Youth Pilots

Dually-involved youth are involved with the child welfare and juvenile justice systems simultaneously. These youth face complicated challenges and generally require a more intense array of services and supports than other youth known to each system individually. There is little cross-systems collaboration between the child welfare and the juvenile justice systems.

To address the unique challenges of this population, DCFS has initiated two separate pilots to determine the most effective strategies for attaining better outcomes for these youth. The Regenerations pilot provides intensive placement finding with additional supportive services to move children out of detention as soon as possible. The Pay for Success pilot is funded by private dollars and offers intensive care coordination through a fidelity wraparound process to dually involved youth. Both pilots are running simultaneously to determine which model

produces the best outcomes for dually-involved youth. The pilots are described in more detail below.

a. Regenerations Pilot Project for Dually-Involved Youth at Cook County Juvenile Detention Center

i. Pilot Overview

The Regenerations/RUR (Release Upon Request) pilot began July 6, 2015, and serves youth ages 12 - 18 years old who are 1) in the custody of DCFS, 2) are detained in the Cook County Juvenile Temporary Detention Center (JTDC), and 3) have been determined by a judge to be ready for release (RUR). Based upon the evaluation of dual ward detention data in previous years, the pilot was developed to serve a total of 65 youth, and 38 youth are currently enrolled. Youth in this pilot receive specialized services including intensive mentoring services and priority placement in home and community settings.

Upon the notification from the courts that a youth is eligible for RUR, DCFS Legal notifies a DCFS Child Protection Supervisor and the Regenerations pilot program manager to open the case. Regenerations pilot staff interview the youth within 24 hours of notification. Immediately upon assignment to the Regenerations pilot, an assessment is initiated to identify the youth's strengths and needs, while still detained at JTDC. Family and court-appointed stakeholders are also engaged in this assessment. Shortly after the initial assessment begins, a CIPP meeting is held also at JTDC to establish a Child and Family Team (CFT), which is led by the Regenerations staff assigned to the case and includes a CIPP Facilitator. The CIPP Facilitator completes the Child and Adolescent Service Intensity Instrument (CASII) to document the youth's service intensity level. The CFT utilizes the CASII to develop an Individualized Service Plan that identifies the services required to support the youth's strengths and needs. The Individualized Service Plan is completed within 30 days.

At least quarterly, continued CFTs take place to provide care coordination, assuring the Individualized Service Plan is implemented according to the youth's case plan action steps and timeframes for implementing those steps. The plan includes additional services such as comprehensive mental health assessment, mentoring and advocacy services at a minimum 7 ½ to 30 hours a week, program-funded employment, crisis intervention, and flexible funding to meet the needs of individualized youth.

ii. Evaluation

Chapin Hall anticipates finalizing its evaluation for the Regenerations Pilot by April 2016. The key outcome measures will focus on the reduction in the days youth are detained in the JTDC beyond their release date, increase in the number of youth released directly to home and community-based settings, increase in the provision of needed community-based behavioral health services, and child welfare support services resulting in a reduction in the days youth reside in a residential placment.

iii. DCFS Leadership

This project is being led by Peter Digre, Deputy of Placement and Community Services. The Strategic Innovation and Planning Division liaison for this pilot is Twana Cosey.

b. Illinois Pay for Success Pilot for Dually Involved Youth

i. Overview

The Pay for Success pilot serves dually-involved youth who are not in Regenerations. This pilot utilizes the Crossover Youth Practice Model (CYPM), developed by the Georgetown University McCourt School of Public Policy – Center for Juvenile Justice Reform. This pilot provides intensive care coordination through a fidelity wraparound model that ensures youth have access to evidence-based, community-based and non-traditional treatments and supports that address the individual's and family's behavioral health needs.

Youth aged 11 to 17 who are in DCFS legal custody who are arrested for a crime or youth who are in the juvenile justice system and placed into the legal custody of DCFS are eligible for the pilot. When a youth is assigned to the Pay for Success pilot, a Wraparound Facilitator coordinates the CFT process, which includes a thorough and joint assessment of the youth's strengths and needs and the development of a service plan within 30 days. In addition, the pilot provides access to evidence-based services through a network of home and community-based service providers along with flexible funds that are utilized to fund specialized services when needed. The Wraparound Facilitator also supports the permanency worker by identifying resources, sharing information, and connecting youth to non-traditional programming.

The pilot supports collaboration between governmental systems to rapidly identify issues, engage in case coordination, and provide increased access to therapeutic programs.

The ramp-up phase of the pilot began January 2016 with children from Cook and Lake counties. In March 2016, referrals will begin for dually-involved youth in Franklin and Jefferson counties. The ramp-up phase will serve approximately 50 children and is designed to refine project operations, including the referral mechanisms, and the intake and service enrollment processes. At the end of the ramp-up phase, additional counties will be added starting in May 2016, and the pilot will serve approximately 800 youth over seven and a half years.

ii. Service Array

Youth enrolled in the Pay for Success pilot will have access to the following services: functional family therapy; multi-systemic therapy; brief strategic family therapy; Attachment, Regulation and Competency (ARC); Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS); academic supports; counseling/therapy; recreational activities; substance abuse treatment; workforce development; and other services that will benefit the youth's functioning.

iii. Pay for Success Payment Structure and Evaluation

The Pay for Success project is funded through a social impact bond that is supported by private investors, philanthropies and foundations. The private funds are used to pay for the pilot services ensuring that DCFS has no fiscal investment in the project while the project is in operation. DCFS only pays if it is clearly demonstrated that the services that were provided had a statistically significant impact on the outcomes of the youth that are enrolled in the program.

The evaluation is being designed by the University of Michigan School of Social Work and will include outcomes focused on the reduction in the number of days youth are placed in residential facilities and an increase in home and community-based service capacity and provision.

c. DCFS Leadership of the Pay for Success Pilot

Larry Small, DCFS Deputy Director of Clinical Practice and Development, is the DCFS point person for the Pay for Success project. The Strategic Planning and Innovation Division liaison for this pilot is Kristine Herman.

B. Panel Recommendation #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.*

Child welfare best practice requires intensive family engagement, comprehensive assessment of family strengths, and development of service plans with realistic goals that can be achieved through access to home and community-based services. DCFS will implement a Core Practice Model that includes each of these elements utilizing the Family-Centered, Trauma-Informed, Strength-Based (FTS) curriculum. To assure sustainability of the FTS, the Core Practice Model will also include a Model of Supervisorial Practice (MoSP). The MoSP teaches

supervisors how to manage, coach and evaluate frontline caseworkers in their daily engagement and decision-making with children and families.

DCFS will operationalize the Core Practice Model in identified individual counties ("immersion sites"). Immersion sites will be rolled-out in a staged manner with three or four initial immersion sites being selected that collectively serve five to ten percent of children in DCFS care. Selection will be based upon criteria that include but are not limited to: geographic distribution, leadership capacity, staffing capacity and caseloads. Additional immersion sites will be rolled-out on a regular basis, as discussed below.

In each of these sites, DCFS will implement an intensive training and coaching process to ensure that all permanency workers understand and can execute FTS and that all supervisors are proficient in MoSP. In addition, DCFS will partner with its contracted private agencies, home and community-based service providers and other non-traditional providers to broaden the array of services that are available to children and families at the immersion sites. By April 2016, DCFS will retain a Core Practice Model expert to lead and direct the implementation of the model and the roll-out of the immersion sites. Under current planning, but subject to the recommendation of the Core Practice Model expert, the initial immersion sites will commence in August 2016. Additional immersion sites will launch in six month increments thereafter in different geographic locations, with statewide implementation to be completed by January 2019.

All of the pilot programs described in connection with Recommendation #1 above, support the central tenets of the Core Practice Model, such as developing family and youth voice in case planning, establishing new services within the community, creating alternative placements for children to reduce reliance on residential placements, and breaking down communication barriers between child-serving systems.

1. Description of Family-Centered, Trauma-Informed, Strength-Based (FTS) Practice Model

The FTS component of the Core Practice Model sets forth clear guidelines for caseworkers and supervisors that establish a more effective process of family engagement, assessment and case planning. The FTS requires caseworkers to engage with youth and families in a continuous, rather than episodic, manner that ensures open, honest, and culturally-aware communication with children and families. This level of engagement requires seeking out and listening to the opinions and goals of the children and families, respecting and implementing their suggestions whenever possible, and providing them with essential information and education in a respectful and understandable way. The FTS model requires that children and families are treated as full partners in assessment, planning, intervention, review, evaluation and decision-making. FTS also requires caseworkers to collaborate with all individuals who are involved with a child and family in the planning, delivery, coordination and management of services.

A key component of the FTS model is that caseworkers must establish and facilitate Child and Family Teams (CFT) that plan and coordinate interventions. The child's permanency worker is responsible for facilitation of the teams, which include the child, the family, any natural supports identified by the family and all providers of services to the child and family. The CFT is responsible for assessment, case planning and monitoring progress of permanency goals. The FTS model establishes accountability of everyone involved, because it requires a continuous review of the plans and responsibility for implementation.

a. Individualized Case/Service Planning

FTS provides guidance to ensure that all assessment and planning is backed by clearly identified goals that are measured, reviewed and revised to meet children and families' changing

needs and strengths. Individualized plans will include deliberate action steps that explain which specific individuals are responsible for implementing distinct steps. All plans must set forth meaningful and well-articulated timeframes. Relevant action steps are reviewed regularly by the permanency worker with the CFT (e.g., a minimum of every three months) to evaluate the feasibility of existing goals and appropriateness of services as the youth progresses.

b. Safe and Sustained Transition to Permanence and/or Adulthood

FTS focuses on early and meaningful engagement of the family to develop pathways to permanency or transition to adulthood. FTS requires the identification and engagement of formal and natural supports to maintain the child's connections to their community, culture, relatives and fictive kin, which is critical to ensuring that children transition to adulthood with a robust support network.

c. Disproportionality/Disparity

Issues of disproportionality and disparity are also addressed by FTS. Disproportionality relates to the under- or over-representation of a particular racial or ethnic group involved in child welfare compared to their representation in the general U.S. population. Disparity refers to the unequal treatment of individuals across racial and ethnic groups. FTS strives to reduce, if not, eliminate disproportionality and disparity through the reform of permanency workers' engagement practices. Under FTS, permanency workers and supervisors will be trained, coached and evaluated on their ability to interact with children and families in a continuous, open, honest, culturally-aware manner, with the aim of eliminating cultural biases.

2. Description of Model of Supervisory Practice

The Model of Supervisory Practice (MoSP) is the second component of the Core Practice Model. The MoSP requires the supervisor to continuously coach the permanency worker through reflective supervision. The MoSP clearly defines the duties and boundaries of supervisors, and

facilitates their ongoing learning of social work best practices. The model trains supervisors as coaches of their staff, giving supervisors enhanced techniques for teaching staff the skills to engage families, facilitate CFTs, and develop comprehensive assessments that lead to strengths-based, individualized case planning with clear pathways to permanency.

Supervisors will be trained to conduct case-specific supervision that includes:

- a brief historical summary of the case,
- the current level of engagement and any additional engagement strategies that could be explored,
- current safety and risk factors or concerns,
- protective factors,
- follow-up on previous case instruction,
- a review of the child and family's progress toward meeting case planning goals, timeframes and supports in light of changing needs and strengths of the child and family.

In the event case planning goals have not been accomplished, the supervisor will be trained to evaluate with staff why the plan was not successful; in retrospect, what specific steps could have been taken earlier to achieve success; and, what specific changes to the plan are needed to ensure the family's success.

3. Initiation of MoSP Training Model

DCFS began to train 45 supervisors in MoSP in January 2016. Participants in the initial cohort include volunteers and staff from both DCFS and POS agencies. Training extends over a six-month period, with two days of classroom instruction every three weeks. Between classroom sessions, learning is reinforced by coaching and everyday practice. Upon completion of the classroom training, supervisors receive ongoing coaching and support from the MoSP training staff. MoSP training and coaching elements will be revised based on lessons learned from the initial implementation. When the training of the initial cohort of supervisors is complete, DCFS will implement future training through the roll-out of immersion sites, as outlined below.

4. Core Practice Model Expert

Because the Core Practice Model represents a fundamental shift in casework and supervisory practice in Illinois, DCFS will retain an expert to lead and direct the implementation of the model. DCFS anticipates that an expert will be retained by April 2016. The expert will assist DCFS with development of the curriculum, development and implementation of the training model, and training logistics at immersion sites. The expert will be responsible for the ongoing integration of lessons learned from the roll-out at previous immersion sites.

5. Statewide Summit

In July 2016, a statewide Summit will be held in partnership with DCFS, the courts, contracted private agencies and other community stakeholders. The Summit will include an announcement of the implementation of the Core Practice Model and the immersion site process. The Summit will provide an opportunity for all stakeholders to be introduced to the common language and principles of the Core Practice Model and will encourage a sense of shared mission. The Summit will include participants from throughout DCFS and its private agency partners. It will also include representatives from involved youth, families, members of the Illinois Children and Family Services Advisory Council and members of CWAC committees, State's Attorneys, Guardians ad Litem, Court Appointed Special Advocates, and public defenders.

6. Core Practice Model Immersion Sites

DCFS will select three or four initial sites that collectively serve five to ten percent of DCFS children and youth based upon criteria that include but are not limited to: geographic distribution, leadership capacity, staffing capacity and caseloads. Before rolling out additional immersion sites, DCFS will evaluate and integrate lessons learned from the initial roll-out.

All DCFS and POS staff at the selected immersion sites will complete training in the Core Practice Model. To ensure that all community stakeholders have an understanding of the Core Practice Model, training at the selected immersion sites will be provided to DCFS Deputy Directors, private agency executive staff, Guardians Ad Litem, Court Appointed Special Advocates, youth, birth parents, foster parents, court officers, care coordinators, and residential and group home agency staff.

a. Identification and Timetable for Immersion Sites

With the recommendation of the retained Core Practice Model Expert, DCFS expects to identify the initial wave of three or four immersion sites in June 2016. These immersion sites will incorporate a total of approximately 5% to 10% of children in care (approximately 750 to 1500) and approximately 200 DCFS and private agency staff. DCFS expects the second wave will incorporate an additional 10% of the total children in care, with each subsequent wave thereafter incorporating an additional 20% of children in care.

In August 2016, pending recommendations of the Core Practice Model Expert, DCFS will initiate training and coaching in the initial immersion sites. Every two months thereafter, a new wave of immersion sites will be identified. Training and coaching in each immersion site will begin four months after their identification. Statewide roll-out of the Core Practice Model will require a minimum of six waves, each involving at least three to four sites over an anticipated 29 months.

b. Development of Regional Capacity to Expand Service Array

Within the immersion sites, DCFS will build sufficient capacity within the community to provide services to meet the unique needs of the children and families. To accomplish this, the regional offices within the immersion sites will have the authority to conduct a "gap analysis" to determine what services are currently being used, what services are available but not used, and

what services are unavailable in the community. The regional offices will also have the authority to identify barriers to expansion of needed services and to contract with providers for new services that are effective in keeping children stable in their homes. To alleviate and close regional service gaps, the regional offices will work with private providers and community stakeholders to develop the necessary service array.

Examples of potential enhanced child welfare support services that could be developed within a regional area include, but are not limited to: 1) enhanced visitation support, shared parenting and coaching services for families of origin; 2) educational supports, including services designed to enhance educational stability; 3) emergency foster care available 24/7, which will be a critical service to keep children in home-like settings; 4) increased availability of respite care for intact and foster families; and 5) in-home supportive services for intact and foster families.

DCFS children and families may also require enhanced behavioral health services and interventions to address concerns that are impeding permanency. DCFS will begin to offer these enhanced behavioral health services in the immersion sites by utilizing existing Intensive Placement Stabilization (IPS) contracts. Currently, IPS contracts provide community-based, in-home therapeutic interventions to children in traditional foster care who are experiencing trauma reactions, emotional and/or behavioral problems putting them at risk of losing their current placement. To enhance the availability of evidence-based/trauma-informed services, IPS recently integrated Trauma Affect Regulation: Guide for Education and Therapy (TARGET), an evidence-based psycho-educational approach to treat trauma symptoms, into the available service array.

Within the immersion sites, DCFS will expand the availability of IPS programs and services to DCFS children who are in psychiatric hospitals, residential placements, or group

home placements to assist in their transition to a less restrictive setting. DCFS also will use the existing IPS contracts and providers to develop additional critically-needed behavioral health services such as home-based services, family and youth peer support, crisis and non-crisis respite, and evidence/trauma-informed services.

c. Use and Oversight of Flexible Funds

As another avenue of ensuring that children and families receive needed supports and services, immersion sites will incorporate the use of flexible funding as part of the Core Practice Model. Flexible funds will allow permanency workers to respond to the unique needs of children and families by purchasing goods and services beyond what is available through existing contractual services. Beginning in March 2016, the DCFS Division of Budget and Finance will determine the amount of funding that will be available for flexible funding, and the DCFS Central Payment Unit will develop an approval and payment mechanism for the actual disbursement of flexible funds. Permanency workers and supervisors will be trained on appropriate services and supports that can be purchased with flexible funding, as well as on mechanisms that ensure the funds are readily available and monitored for appropriateness. With the guidance of the Core Practice Model expert, DCFS will establish time frames for the finalization of flexible funding policies and procedures.

d. Immersion Site Policy and Review Process

DCFS recognizes that there are inadequacies with the current centralized processes in Central Matching, CIPP, Integrated Assessment and Residential Monitoring. The centralization of these processes led to unintended negative consequences for children and families. To address these flaws, DCFS will establish local control of these processes, thus integrating the functions of Central Matching, CIPP, and Integrated Assessment in the regional offices of the immersion

sites. To ensure that statewide systems are not handicapped before local systems are prepared, DCFS will strategically transition to local control.

Through the Core Practice Model, caseworkers will change their level and depth of engagement with families, allowing them to gather assessment information that is relevant to the current and changing service needs of the family. This will eliminate the need for a separate Integrated Assessment process within the immersion sites.

The permanency worker will then facilitate a CFT that will have the responsibility for determining the child's placement level and the services that should be provided to that child and family. Should the CFT determine that additional assessment or clinical expertise is needed to finalize a determination of placement level and/or services, the CFT will have access to clinical and assessment resources that will help them gather additional information to complete their decision-making process. This will eliminate the need for a CIPP process within the immersion sites.

Within the immersion sites, each regional office will be responsible for recruiting, developing, and maintaining current information on placement capacity and other needed support services. Each regional office will have a primary focus on keeping children placed in close proximity to their family, fictive kin and other natural supports. Regional offices will have the authority to authorize and ensure placement in accordance with CFT recommendations. This will eliminate the need for the Central Matching process within the immersion sites.

The regional offices will also have responsibility to ensure that children are receiving adequate services while they are placed in residential or other congregate care settings. Looking to the future, the focus will be on keeping children as close to their home communities as possible, permanency workers will 1) have ready access to the facilities where children are placed, 2) visit the children regularly, 3) receive updates from children and residential staff

regarding the children's progress and obtaining information about what the children need in order to be served in a more home-like setting, 4) regularly discuss the children's progress with the CFT, and 5) notify their supervisors and CFT when issues arise with the children's treatment and placement at the residential facility. Should permanency workers determine that children were placed inappropriately at residential facilities, they will work with the CFT to identify action steps and the specific CFT member and staff person responsible for each step, as well as the timeframe to place the children in a more appropriate setting.

In addition, each regional office will have dedicated residential monitoring staff who will be responsible for reviewing the facilities within their region utilizing monitoring tools described below in Recommendation #6. They will also be responsible for following up on any issues with individual children's treatment and placement that are identified by permanency workers and CFTs. Regional residential monitoring staff will report to the Residential Monitoring Unit who will be responsible for tracking and addressing system-wide issues and intervening with residential providers who do not provide adequate services to children. This monitoring process will ensure that feedback from permanency workers, CFTs and monitoring staff is fully utilized to ensure that children receive the highest quality treatment possible while in residential settings. The interim structure of residential monitoring oversight in conjunction with UIC partners, described below at pp. 43-46, will be maintained throughout the development of work by regional office residential monitoring staff.

DCFS also will review and revise other current policies and procedures, such as Procedures 315, Permanency Planning, to ensure regional control over placement and resource decisions. The regional offices will act as a nucleus where policies and procedures that might otherwise be a barrier to services or permanency, can be waived if the safety of the child can be established.

e. Development of Regional Continuous Quality Improvement Capacity

Each immersion site will have an Immersion Site Director who will oversee all site functions ensuring fidelity to the Core Practice Model. The reporting structure will be established to ensure that when barriers to implementation of the Core Practice Model are identified, the Immersion Site Director can immediately access DCFS's Executive-level staff and propose appropriate solutions when necessary. It is anticipated that the DCFS Divisions will collaborate with the Immersion Site Director to work through barriers as they emerge.

Weekly meetings will be held with Strategic Planning, Immersion Site Directors and DCFS Executive-level staff to review barriers, determine action steps to be taken, the specific staff person responsible and the timeframe for the completion of the action step. The Immersion Site Director will be responsible for ensuring that action steps required within the immersion site are completed.

The Immersion Site Director is also responsible to ensure that when areas for improvement are identified, or corrective actions are recommended, those recommendations are, in fact, implemented. The Immersion Site Director will have the authority to initiate Quality Service Reviews (QSR) on individual cases; conduct follow-up reviews; and implement programmatic reviews as needed.

The Immersion Site Director will also receive all Administrative Case Review (ACR) reports for children within the immersion site. The Immersion Site Director will regularly communicate with supervisors to ensure that any problem area identified in the ACR report is addressed within the timeframe identified in the ACR. Should areas of weakness continue to be reported in an ACR, the Immersion Site Director will be responsible for informing DCFS Executive-level staff to ensure that the staff performance issues are addressed.

In addition, each immersion site will have a Quality Assurance (QA) coordinator who will work directly with the Immersion Site Director and private agencies' QA staff to support implementation of the Core Practice Model, thus creating a QA team. Although QA staff will be embedded in the immersion sites and will work with front line staff, they will continue to report to the central QA office.

The immersion site QA team will:

- ensure data is communicated effectively at all levels by completing weekly, monthly, quarterly and yearly analysis of data;
- prepare standardized reports that use a combination of outcome, practice, and compliance progress;
- complete QSRs on a random sample of cases on a quarterly basis;
- complete monthly case reviews and peer reviews within the immersion sites;
- complete regularly scheduled surveys of staff, stakeholders, families and youth;
- coach staff regarding utilizing data to improve practice, including residential facility staff;
- produce a real time profile/dashboard of all families and children served in the immersion sites.

All immersion site barriers and solutions to those barriers will be tracked by the Strategic Planning Division, which will assess what overarching changes in policy and procedure are required. The Strategic Planning Division will then ensure that those changes are executed in a timely and thoughtful manner with input from all necessary divisions.

7. Evaluation

Implementation of the Core Practice Model will comprise both a process and outcomes-based evaluation. Prior to the implementation of the immersion site coaching and training, Chapin Hall will complete a statewide baseline analysis for all areas anticipated to be impacted by the Core Practice Model including:

- Web-based survey of DCFS and POS caseworkers and supervisors around knowledge, beliefs, and practices to assess congruence with the new practice model.

- Surveys of parents (in-home and permanency planning cases) to assess their strengths and needs as well as their experience of their caseworker and services they receive through DCFS. Sample sizes within immersion sites to provide estimates that are accurate enough to allow for comparison to later assessments at the immersion site level.

- Assessment of children's functioning, and, for age-appropriate youth, their experience of their caseworker and services they receive through DCFS, through measures used to audit CANS going forward (i.e., from independent sources such as caregivers, teachers, and children). Sample sizes within immersion sites to provide estimates that are accurate enough to allow for comparison to later assessments at the immersion site level.

Once the Core Practice Model is implemented at immersion sites, Chapin Hall will evaluate DCFS's and provider staff's fidelity to the Core Practice Model, utilizing audits of immersion sites that measure staff adherence to the model through assessments of staff engagement, assessment, and case planning with children and families. Chapin Hall assessments will include reviews of individual children's files, interviews of children and families, and interviews of DCFS and provider staff. In addition, Chapin Hall will evaluate outcomes for children and families based on the implementation of the Core Practice Model. Against established baselines for each immersion site, Chapin Hall will evaluate children's absence of maltreatment, placement stability, permanency, foster care re-entry, and wellbeing as defined by the overarching metrics outlined in Section I above.

C. Panel Recommendation #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."*

Youth over the age of 12 require additional services and assistance to achieve permanency so they do not age out of the system without substantial relationships and community-based supports. DCFS is focusing on this population through statutory, policy and practice initiatives. Specifically, DCFS is expanding age eligibility for state-funded guardianship regardless of Title IV-E eligibility, and DCFS is expanding the definition of 'fictive

kin' to include current foster parents. Both of these efforts may result in cost savings through fully-funded Kinship Guardianship ("Kin Gap"). Finally, DCFS is implementing Procedure 315, Permanency Planning, to expand and improve its family finding strategies.

1. State-funded guardianship assistance should be extended to all children aged 12 and older regardless of IV-E eligibility.

Current state law does not limit the age group required for state-funded guardianship. DCFS will propose a modification to Rule 302.10, which will lower the eligibility age for state-funded guardianship from 14 to 12, regardless of Title IV-E eligibility. In addition, the rule will also be modified to clarify that unlicensed relatives qualify for state-funded guardianships. The process for modifying a rule in Illinois takes approximately 9-12 months due to the public comment process.

2. 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.

Effective January 1, 2015, the Children and Family Services Act was amended to expand the definition of "relative" for placement purposes to include fictive kin. Fictive kin "means any individual, unrelated by birth or marriage, who is shown to have close personal or emotional ties with the child or the child's family *prior* to the child's placement with the individual." 20 ILCS 505/7 (emphasis added). DCFS is seeking a statutory amendment that further expands the definition of fictive kin to include current foster parents. The proposed amendment may become law in 2016 and, thereafter, DCFS will engage in the rule-making process described above.

3. Both changes will result in a savings since the administrative savings are well above the state costs for guardianship assistance payments and revision to the definition of kin will qualify more assistance payments for IV-E reimbursement.

After the above-described rules are amended, many current foster parents will qualify for KinGap, a federally-funded reimbursement program for guardians. The foregoing rule changes

thus should enhance the flexibility of parents to move from traditional foster care to subsidized guardianship. Conservative estimates indicate that 85 youth who are between ages 12 to 14 would be eligible for subsidized guardianship as a permanency option. This expansion would save DCFS an estimated $600,000 a year.

4. Implement specific "family finder" strategies as part of permanency planning for adolescents who do not have an obvious reunification plan.

In 2015, DCFS proposed revised Procedures 315 related to permanency planning for all youth and children in care. These procedures provide an updated definition of permanency, to include reunification, as well as the guidelines to help children and youth achieve permanency at a timeframe in their best interest. These procedures also enhance and highlight new family finding strategies that must begin early and continue throughout the life of every child's case. Workers must speak with the youth throughout the process. ACR sets out a formalized process for semi-annual reviews of progress towards permanency. When staff have not taken the necessary steps to locate and engage family and fictive kin, ACR will flag the case and alert the worker, supervisor and DCFS or Purchase of Service manager. The training and procedures incorporate the Kevin Campbell model, "Six Steps to Find a Family." http://www.nrcpfc.org/downloads/SixSteps.pdf.

In order to expedite permanency DCFS has automated the family finding forms and tools as a step toward achieving these permanency goals. Training on Procedure 315 of all DCFS and POS permanency staff began in February 2016. Based upon feedback from the initial training cohort, the training is currently being revised and will continue upon finalization. In addition, new software that allows staff to search for family and fictive kin, referred to as family finding, is being vetted by DCFS to ensure robust technological searching support. DCFS anticipates this new software will be in place by July 2016.

D. Panel Recommendation #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."*

1. Reorganization, Strategic Planning and Cultural Change

- *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*
- *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.*

Director Sheldon obtained approval for a departmental reorganization of leadership and managerial structure from the Illinois Civil Service Commission. The final organization structure was implemented in October 2015. See DCFS Organizational Structure, attached as Exhibit E. As part of the process of reorganization and structural change, the Director formed the Strategic Planning and Innovation Division ("Strategic Planning") in September 2015. This division focuses on driving the implementation of innovation for DCFS, and is headed by Jody Grutza, Deputy Director of Strategic Planning and Innovation and Andrew Bridge, Senior Innovation Advisor. Strategic Planning will ensure that DCFS does not take a siloed approach to initiatives. Strategic Planning has cross-divisional authority and has responsibility for reform, including the BH Implementation Plan.

The Strategic Planning Division is expanding to include both internal and external experts to guide initiatives and act as liaisons to the projects, stakeholders and DCFS divisions. The division will partner with DCFS leadership and staff, POS providers, and other external stakeholders to support and drive consistent progress toward the goals envisioned in this Plan. Each initiative identified in the Implementation Plan will be assigned to one division member. That Strategic Planning Division member will meet with initiative leads weekly and report to

Jody Grutza during bi-weekly supervision meetings. Initiative leads will support and collect reports from each university or external partner at least quarterly as well as ensure compliance with the four-month implementation plan status reports. Ms. Grutza is responsible for tracking data and outcomes for each initiative and for supporting consistent evaluation of success, progress and lessons learned in conjunction with the contracted expert support and other members of the Strategic Planning team.

2. Full Implementation of Designed Initiatives

- *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.*

- *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.*

DCFS has multiple initiatives in progress across the state. The Strategic Planning Division has been put into place to help drive those initiatives, assess barriers, and track outcomes so that staff can update the program plans quickly to determine if strategies are productive. The Expert Panel mentions numerous specific initiatives that are currently designated as stalled, many of which are addressed in other areas of this report.

The initiatives including Integrated Assessment (Recommendation #2), Residential Services Performance-Based Contracting (Recommendation #6), DCFS Monitoring of

Residential Services (Recommendation #6), and Home Based Mental Health Services (Recommendation #1) are discussed in the other sections of this plan. The additional stalled initiatives, Illinois Birth thru Three Demonstration Project and SAFE Families for Children, are detailed below. Barriers to successful implementation of both of these initiatives persist.

a. Illinois Birth Thru Three Demonstration Project

The Illinois Birth thru Three Demonstration project constitutes the State's fourth Title IV-E waiver demonstration focused on developmentally informed child and family interventions. The demonstration project targets caregivers and their children aged from birth through three years of age who enter out-of-home placement regardless of Title IV-E eligibility. DCFS's demonstration project in Cook County focuses on children at risk of, or who have experienced, physical and psychological trauma as a result of early exposure to maltreatment. The evidence-based practices utilized include Child Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP). Children are identified by an enhanced screening protocol. The Demonstration Project has been in place for over two years. Although implementation challenges still exist, the intervention group demonstrates a statistically significant difference in permanency outcomes. While both CPP and NPP have progress to report, known challenges include:

- CPP continues to experience a waiting list for clients in need of services. For example, fee-for-service contracts do not allow for billing for the intensive engagement work required to get families involved in treatment and, as a result, providers are struggling.

- Challenges in engaging foster parents also exist. As the pilot shifts additional responsibility to the caregivers, additional foster parent training and supports are needed.

The Strategic Planning and Innovations Division will drive progress in overcoming the barriers discussed. Kristine Herman will be the Strategic Planning and Innovations Liaison. The

operations lead for this project is Kimberly Mann, Project Director for the IB3 Title IV-E Waiver.

b. SAFE Families for Children

Under SAFE Families for Children (SFFC), DCFS assists families in need with services to protect children and support keeping families together. SFFC places children at risk of removal in vetted volunteer families to avoid their placement into foster care. SFFC strives to meet three objectives: child welfare deflection, child abuse prevention, and family support and stabilization. SFFC has been in operation in Cook and Northern regions of Illinois for thirteen years. Due to a grant from the Arnold Foundation, SFFC was recently expanded state-wide to provide services to children and to evaluate the program. Challenges with the roll-out of the program evaluation include:

- Lack of anticipated participation by workers and identified candidates given limited education about the benefits of SAFE Families as well as various case issues related to the SAFE Families model.
- Reluctance of workers to refer children to SAFE Families out of concern that a child would be assigned to the control group and not to SAFE Families.

The operations leader on this project is Denise Gonzalez. The Strategic Planning team will drive the continued progress of this initiative by breaking down barriers to success. The Strategic Planning and Innovation liaison will be April Curtis.

c. Information Systems

DCFS is reviewing the updated regulations on SACWIS to replace the existing SACWIS system to improve integration of information through web services to third parties, other internal systems, and to enhance its caseworkers' business processes through mobility. DCFS will receive federal reimbursement for the majority of this investment.

https://www.federalregister.gov/articles/2015/08/11/2015-19087/comprehensive-child-welfare-

information-system. Given the investment in a new SACWIS system, all current IT projects are being evaluated by the Technology Governance Board (TGB).

The TGB is comprised of the Director, Chief of Staff, Chief Deputy Director, all Senior Deputy Directors and several other key executives and advisors. The State CIO, Director of HHSi2 and Director of Enterprise Applications also participate. TGB prioritizes all technology-based project work and aligns DCFS and Governor's Office strategy. TGB directs OITS to maximize technology and human capital.

i. Near Term Plan (6-12 months)

DCFS will enhance SACWIS while it evaluates and selects a replacement system. It is expected that the following SACWIS updates will be made:

- Education Data Feed from ISBE
- Unusual Incident Reporting

In addition, the following projects are also in process to support DCFS's improved technology.

- Mobile Application
- On-line Licensing Application
- Tablet Application for Licensing Site Inspections

ii. Long Term Plan (Beyond 12 months)

The SACWIS replacement system will include all existing systems, such as Child and Youth Computer Information System, and other case management reporting systems. Resources will be redirected to the new system other than those previously mentioned. Selection of the new SACWIS system will be the result of an RFP process. This RFP will be released within the next twelve months. The time frame for activating the new system will be determined when the vendor is selected.

d. Predictive Analytics

DCFS is officially establishing an internal team in OITS to bring the reporting needs and the data analytics into a centrally managed organization.

i. Short Term

While positions are being established and filled, there will be some transitional activity including a recent sole source procurement with MindShare to provide interim services. MindShare will collaborate with the Division of Quality Assurance and Division of Strategic Planning and Innovation. This contract will be in place not later than February 15, 2016, and be in place for 18 months to help with the transition and to provide additional assistance.

MindShare will provide a dashboard view of DCFS key outcomes in real time. The CFSR measures will be delivered by MindShare via dashboards within 30 days of the finalized contract. There will be additional dashboards delivered to include the Director's 26 Metrics and others. See Contract Cover Page and Scope of Services for the ICARE Program, attached as Exhibit F.

ii. Long Term (Beyond 18 Months)

The State of Illinois is establishing a state-wide enterprise data analytics platform ("Enterprise IT"). DCFS intends to reduce reliance on external entities to collect and analyze data to drive outcomes. DCFS expects to reduce, but not eliminate, the need for occasional external services. Enterprise IT is currently under review by the State CIO's office and the Health and Human Services Innovation Incubator's (HHSi2) office. DCFS will continue to work closely with the state's new CIO to adopt an interoperable Health and Human Services framework that will be conducive to data sharing and integrated service delivery across state agencies. The TGB will prioritize IT initiatives to ensure alignment with the state's vision for Enterprise IT.

e. Data Not Included in Overarching Outcome Measures

DCFS recognizes that the safety and permanency outcome measures currently utilized by the federal government in the CFSR process do not capture other relevant information related to safety and permanency. The Children and Family Research Center (CFRC) publishes its annual Monitoring Report of the B.H. Consent Decree entitled *Conditions of Children In or At Risk of Foster Care In Illinois*. This report tracks data indicators related to child safety; children in substitute care; legal permanence; and child wellbeing. Though not as a measure of compliance with the Expert Panel's report and recommendations, DCFS will obtain from CFRC and track additional indicators of re-entry, stability and maltreatment for the B.H. class. Additional indicators include, but are not limited to: re-entry rates for children in foster care 12 to 23 months and longer than 23 months who are discharged to reunification, adoption, living with a relative, or guardianship; rate of placement moves per day for all children in foster care; and maltreatment recurrence for all children within 12 months of a substantiated report (including those children who remain at home, those served in intact family cases and those who do not receive services; any maltreatment recurrence for children who leave substitute care through adoption, guardianship, and return home).

3. Training and Coaching Program

- *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.*

DCFS is initiating the MoSP as detailed in Recommendation # 2 that includes in-depth training and coaching in recognition of the need for mid-level managers to have appropriate skills and training to manage projects from planning to implementation and for ongoing success. DCFS will implement additional training to: 1) build the knowledge and skill set of mid-level DCFS managers, 2) educate DCFS managers on the use of data to improve performance, 3) foster collegiality among DCFS managers, and; 4) enhance the effectiveness of managers as they safely and appropriately reduce the number of children and youth in care in Illinois. The additional training will include ten workshops over a six-month period, eventually including all mid-level managers, with the first cohort of up to 25 individuals starting in March 2016. Monico Whittington-Eskridge, Statewide Administrator DCFS/CSU IS & STEP Programs, will lead the project. Jody Grutza is the liaison from Strategic Planning and Innovation Division.

E. Panel Recommendation #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.*

1. Illinois Survey of Child and Adolescent Wellbeing (ISCAW)

DCFS is working with the Children and Family Research Center to plan for reinstituting the Illinois Survey of Child and Adolescent Wellbeing. The contract is currently under negotiation. It is anticipated that the plan for data collection and analysis will take at least 60 days to complete following execution of all necessary contracts.

F. Panel Recommendation #6: ***The implementation plan will provide for the Department to contract with an external partner to perform an effective residential and group-home monitoring program. The Department shall use an external partner for that function until such time as the Department has sufficient staff with the necessary experience and clinical expertise to perform the function internally and further has developed an in-house program that can monitor residential and group-home placements effectively.***

As described in the response to Recommendation #2 above, residential monitoring responsibilities will be integrated into immersion sites as they are rolled out statewide. However, the residential monitoring system will still need to be revised and an interim process will need to be in place while the immersion sites are being implemented.

DCFS will team with its university partners from the University of Illinois at Chicago (UIC), Northwestern University and Chapin Hall at University of Chicago to develop a comprehensive long-term residential monitoring system that is a partnership of DCFS and university partners. The therapeutic residential (TR) monitoring plan will be submitted by the university partners in May 2016 with implementation to begin in July 2016. An interim monitoring plan will be used until the redesign is completed.

1. Long Term Therapeutic Residential Monitoring Plan

The monitoring system will include internal and external monitoring of TR services programs and will assess the safety, wellbeing, quality of services and progress of youth in TR facilities. Further, it will be integrated into DCFS's overall strategic plan to reform residential services and assist DCFS in assessing its progress towards reform. Specifically, the university partners will work with DCFS to:

- Design a series of standardized measures and systematic assessments that will be used to identify outlier programs in terms of safety, clinical outcomes, organizational capacity, and ability to effectively address problems as they arise. This will include revision of the current Performance Based Contracting measures to understand and accurately assess residential program performance.

- Provide leadership and training to DCFS staff in how to conduct on-site utilization reviews of agencies determined to be at high risk for harmful incidents, thus

requiring a targeted intervention. This would include working with DCFS Monitoring supervisory staff to improve monitoring processes and techniques and assess the need for additional training.

- Provide clinical and organizational assistance and consultation to TR 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.

In addition to the above functions, the residential monitoring system will include;

- An ombudsman function to solicit and facilitate feedback and problem-solving for stakeholders; and

- An intensive and highly specific consultation and training program for TR facilities identified as having difficulties based on best practice and evidence-informed/evidence-based treatment approaches.

The DCFS ombudsman function will include administering youth and family satisfaction surveys to all youth upon discharge from the TR and at selected intervals during the TR episode as well as obtaining feedback from primary stakeholders. This information will be made available to Chapin Hall for aggregation to provide data for the monitoring system to guide interventions and assess outcomes. The consultation and training component will include development of a technical assistance clearinghouse which would identify TR providers implementing best practices and provide support for them to develop targeted technical assistance, certified by UIC, that can be incorporated into program improvement or corrective action plans for eligible agencies.

The internal DCFS monitoring component will be adjusted as necessary to ensure development of a comprehensive and integrated monitoring system that is consistent with the TR monitoring plan designed by the university partners.

Chapin Hall will develop an evaluation methodology to detect differences between historical trends in practice and adherence to new residential monitoring protocols. A baseline

will be established using both existing monitoring tools and new tools to capture data on performance expectations. The evaluation will assess organizational culture in TR facilities as well as consumer satisfaction with the services provided. The evaluation should inform DCFS of the impact of TR monitoring on the quality of care and child and youth outcomes and help guide ongoing development of the monitoring system.

2. Interim Therapeutic Residential Monitoring Plan

While the above comprehensive TR monitoring system is being developed, DCFS will implement an interim monitoring plan that includes the continued use of professionals affiliated with UIC to externally monitor the quality of care provided to youth in residential facilities. DCFS and UIC will meet monthly to review and assess agencies, contracts and/or sites.

The following key changes will immediately be made to DCFS's current monitoring under this interim plan:

- Increased Observational Oversight: Unannounced on-site monitoring visits will increase to a minimum of one time per month during after school and evening hours while youth are present and a minimum of one visit per quarter during overnight or on the weekend. Thus, monitors will conduct a minimum of 16 visits per year at each facility/site as necessary to meet established standards and/or support intensive monitoring activities.

- Improved Unusual Incident Report (UIR) Audits: Monitors will review all facility/site UIRs prior to each visit. Monitors will speak to involved youth and staff about the incident to ascertain whether there are any safety concerns, case management intervention needs or operational deficiencies requiring technical assistance.

- Inclusion of the Youth Voice: Monitors will collect the comments left in the youth suggestion boxes during each site visit. Monitors must read, address and refer all suggestion box comments to the appropriate entity. All comments must be entered in the database so that Chapin Hall can aggregate the types of issues raised. Monitors will engage youth during each site visit, as appropriate.

- Increased Supervision: DCFS will increase direct supervision of monitors to three times a month in order to more readily and more quickly identify potential safety concerns and programmatic deficiencies, as well as discuss trends seen at a

facility or site. Supervision will include on-site coaching for monitors who require additional support.

- Comprehensive Administrative Oversight: Monthly assessment of each agency's sites and units, discharges, UIRs, licensing reports and other reported concerns. Administrative meetings, at a minimum, will include the program director and quality improvement staff along with other key program staff.

In addition to these key changes to internal monitoring, UIC and DCFS will conduct an initial assessment of each TR provider contract and/or site, place each contract and/or site on a level system and complete monitoring plans that will most effectively utilize limited resources. Numerous factors will inform the determination of a TR contract and/or site level (e.g. performance based contracting report, monthly monitoring reports, monthly agency reports, UIR reporting, Medicaid billing reports, licensing reports, provider matching and admission information, etc.). DCFS will ensure access to available information regarding TR provider and contract performance as requested by DCFS monitoring staff and UIC, and will include access to additional relevant data normally collected by DCFS that may inform the monitoring process. The contract/site's initial level will determine the intensity of intervention by UIC and DCFS and the development of a contract-specific TR monitoring plan that may also incorporate resources from the Clinical Division to assist in collaboration and technical assistance with TR providers, caseworkers/supervisors, and child specific consultation when appropriate.

Upon implementation of the monitoring plans by level, DCFS and UIC will integrate findings and additional information as it becomes available to adjust the levels and target monitoring activities when necessary, such as when additional safety concerns are identified. Emergent issues will be addressed immediately. Thereafter, UIC and DCFS will conduct monthly triage meetings and ensure all provider contract levels are reassessed at least quarterly. The following is a snapshot of the minimum monitoring intervention required for each level:

Level 1:

- Monthly unannounced visits by DCFS monitor to each TR site
- Monthly triage meetings between UIC & DCFS to assess the strengths and deficiencies
- Monthly administrative meetings with TR providers
- UIC will randomly and periodically conduct unannounced on-site reviews, at its discretion

Level 2:

- Monthly unannounced visits by DCFS monitor to each TR site which may be increased pursuant to the program's monitoring plan
- Monthly triage meetings between UIC & DCFS to determine the technical assistance needs and review of corrective action and/or quality improvement plans
- Monthly administrative meetings with TR providers
- UIC will randomly and periodically conduct unannounced on-site reviews at its discretion and with support from DCFS monitors when indicated by the monitoring plan

Level 3:

- Monthly unannounced visits by DCFS monitor to each TR site which may be increased pursuant to the program's monitoring plan
- Monthly triage meetings between UIC & DCFS to execute technical assistance plan and review of corrective action and/or quality improvement plans
- Monthly administrative meetings with TR providers
- UIC will conduct unannounced on-site reviews and with support from DCFS monitors when indicated by the monitoring plan

A high level of coordination and communication between DCFS monitoring staff and UIC to implement the interim plan is required. This process will also offer opportunities for UIC to work with monitoring supervisors and managers to identify training needs and develop ongoing process improvements to identify safety concerns and specific programmatic deficiencies. In addition, UIC and DCFS monitoring staff will focus on developing procedures for drafting and implementing corrective action and quality improvement plans.

The interim TR monitoring plan will also include the following activities:

- DCFS and UIC will assess additional resource requirements to support UIC's role and subsequently develop a timeline and action plan.

- DCFS will provide timely access to data pertinent to the ongoing assessment of TR provider performance and develop mechanisms to facilitate data integration.
- DCFS and UIC will initiate efforts to develop residential technical assistance and training capacity that would include provision of direct technical assistance by university partners and monitors with access to additional support including case specific consultation from the DCFS Clinical division when appropriate.
- Regular communication between DCFS Monitoring/UIC and DCFS leadership regarding identification and planning around significant system barriers that have a deleterious impact on TR providers and the effective delivery of TR services. In addition, the combined DCFS/UIC team will address issues that interfere with the operations of specific providers identified during monitoring activities that include facilitation of problem solving via the chain of command and working with DCFS staff to address barriers.

All interim TR monitoring activities will inform development of the comprehensive TR monitoring system that will be concurrently under development by the university partners.

3. Timeline

January 2016 -	DCFS & UIC monitoring meetings commence
	DCFS & UIC begin initial level assessment
	Medicaid behavioral health billing training
February 2016 -	Increased unannounced and off-hour visits by DCFS monitors
	Initial level assessment (triage) completed for all TR contracts
	UIC continues external monitoring activities guided by triage process until the TR monitoring plan developed by the University partners is implemented.
	Comprehensive TR administrative meetings commence
March 2016 -	Initial comprehensive TR monitoring planning meeting between university partners
	Stakeholder focus groups or summits on TR monitoring
	Child wellbeing and safety metrics for TR finalized

May 2016 -	University partners submit TR implementation and monitoring plan to DCFS
June 2016 -	TR Implementation plan initiated
July 2016 -	TR external monitoring plan initiated according to implementation plan
November 2016 -	Chapin Hall interim evaluation report
March 2017 -	Chapin Hall interim evaluation report
July 2017 -	Chapin Hall final evaluation report

Exhibit A

DCFS Child Welfare Advisory Committee
CWAC Sub-Committee Organization

George Sheldon
Director

Trish Fox
CWAC Chair
Zack Schrantz
CWAC Chair

Well-Being/ Outcomes
Margaret Vimont
Larry Small - DCFS

Oversight and analysis of data needs and system performance outcomes for indicators of youth well-being across levels of care/ treatment to include but not limited to: specific developmentally sensitive indicators for 0-3 early childhood pre-school/school readiness, elementary age, middle school age, high-school age and young adult/youths in transition; Indicators for outcomes for these developmental/age groups should follow the ACYF* well-being framework for outcome domains.

System of Care
Arlene Happach
Kristine Herman - DCFS

Monitors performance and makes recommendations regarding pilot programs and new methods of service delivery. Identifies and addresses inter-agency service delivery gaps and duplications in order to ensure the best care for children, youth and families in child welfare.
Oversees Medicaid Workgroup.

Finance & Administration
Melissa Riddle
Matt Grady - DCFS

Provides input, oversight, and monitoring that supports overall improvements in efficiency and accountability across broad functional areas:
-- DCFS budget review and recommendations
-- Reasonable rates and reimbursement
-- IT/SACWIS* planning and priorities
-- Workforce development and training
-- Diversity and inclusion (including Transformation Teams)

Front-End/Intact
Kathy Grzelak
Nora Harms-Pavelski - DCFS

Monitors, reports on and makes recommendations related to front-end/intact service delivery needs, initiatives and performance outcomes. Works closely with DCP Leadership to identify Front-End system improvement opportunities.

Foster Care
Hope Carbonaro
Deborah Kennedy -DCFS

Monitors, reports on and makes recommendations related to foster care service delivery needs, initiatives, outcomes, rule, monitoring, and contracts. Makes recommendations related to Foster Parent recruitment, licensing, development and retention. Bridges with Residential and Front-End as needed to strengthen transition process and client outcomes.

Residential/ Transitional & Independent Living
Ann Pearcy
Michael C. Jones - DCFS

Monitors, reports on and makes recommendations related to service delivery needs, initiatives and performance outcomes in residential treatment, transitional and independent living programs/ opportunities. Reviews service needs/outcomes related to psychiatric hospitalization utilization. Considers implications related to possible development of PRTF* and locked facilities. Bridges with Foster-Care to strengthen transition process and client outcomes.
Identifies and makes recommendations for 18+ population service delivery reform and federal reimbursement opportunities.

Workforce Development Ad Hoc
Bev Jones
Pete Digre

* ACYF – Administration of Children, Youth & Families - US Department of Health & Human Services
* IT/SACWIS – Information Technology/Statewide Automated Child Welfare Information System
* PRTF – Psychiatric Residential Treatment Facilities

Updated February 2016

	Name	*Agency*	*Email Address*	*Contact Number*	*Sub-Committee Co-Chairs*	*Tenure Class*
1	Andrea Durbin	Illinois Collaboration on Youth	adurbin@icoyouth.org	312-718-6085		2019
2	Ann Pearcy	One Hope United	apearcy@onehopeunited.org	217-354-6554	Residential/TLP/ILO	2018
3	Arlene Happach	Children's Home + Aid	ahappach@childrenshomeandaid.org	312-424-6803	System of Care	2018
4	Beverly Jones	Lutheran Child & Family Services	bev_jones@lcfs.org	708-488-5547	Workforce Development	2018
5	Christopher L. Cox	Hoyleton Ministries	ccox@hoyleton.org	618-493-9409		2017
6	Debbie Reed	Chaddock	dreed@chaddock.org	217-222-0034 x- 333		2017
7	Dan Kotowski	ChildServ	dkotowski@childserv.org	773-693-0300		2019
8	John Schnier	Lutheran Social Services of Illinois	john.schnier@lssi.org	847-635-4682 630-797-6104 - cell		2017
9	Kara Teeple	Lawrence Hall Youth Services	kteeple@lawrencehall.org	773-769-3500		2019
10	Kathy Grzelak	Kaleidscope	kgrzelak@kaleidscope4kids.org	773-292-4076	Front End/Intact	2019
11	Malia Arnett	ChildLink	malia.arnett@childlnk.org	312-377-4735 312-339-5508 - cell		2018
12	Margaret Berglind	Child Care Association Illinois	ilccamb@aol.com	312-819-1950		2019
13	Margaret Vimont	Jewish Child and Family Services	margaretvimont@jcfs.org;	312 673-3230	Well-Being/Outcomes	2018
14	Mary Shahbazian	Allendale Association	mshahbazian@allendale4kids.org	847-245-6218		2017
15	Nancy Hughes	Volunteers of America of Illinois	nhughes@voail.org;	312-564-2300		2018
16	Raul Garza	Aunt Martha's Youth Services	rgarza@auntmarthas.org	708-747-7100		2017
17	Rick Velasquez	Youth Outreach Services, Inc.	rickv@yos.org	773-777-7112		2017
18	Steve Budde	Juvenile Protective Association	sbudde@juvenile.org	312-698-6945		2019
19	Toleda Hart	Methodist Youth Services	thart@myschicago.org	773-846-4600 x-2224		2017
20	Tricia Fox	The Center for Youth and Family Solutions	tfox@cyfsolutions.org	309 657-3076		2018
21	Zack Schrantz	Uhlich Children's Advantage Network (UCAN)	zack.schrantz@ucanchicago.org	773-588-0180		2018
22	Open					
23	Open					
24	Open					
	Appointed Advisors ~ Non-Providers					
25	Allison Cugier	Foster Parent Advisory Council	Allison.cugier@illinois.gov	618-213-3170 x-1205		2017
26	Darrin Holt	Foster Parent Advisory Council	darrin_holt@lcfs.org	618-234-8904 x-38		2018
27	Elizabeth Richmond	IL Adoption Advisory Council	erichmondf2f@yahoo.com	309-697-9720		2017
28	Fred Long	Former Youth in Care		773-419-0015		2019
29	Layla Suleiman-Gonzalez	Illinois Latino Family Commission	layla.suleiman@illinois.gov grace.leon@illinois.gov	312-758-9352		2019
30	Roxy Kozyckwj	IL Assoc. Rehabilitation Facilities	rkozyckwj@iars.org	217-753-1190 x109		2017
31	Michael Holmes	African American Family Commission	mholmes@aafc.org	312-326-0368		2018
32	Yvonne Zehr	Cook County Public Guardian Office	yvonne.zehr@cookcountyil.gov	312-433-5174		2018

Name	Agency	Email Address	Contact Number	Sub-Committee Co-Chairs	Tenure Class
DCFS Staff					
George Sheldon	Director	george.sheldon@illinois.gov	312-814-6800		
Andrew Flach	Chief of Staff	andrew.flach@illinois.gov	312-814-9208		
Cynthia Tate	Senior Deputy Director	cynthia.tate@illinois.gov	312-808-5000		
Carolyn Ross	Chief Deputy Director	carolyn.ross@illinois.gov	312-814-5983		
Deborah Kennedy	Associate Deputy Director	deborah.kennedy2@illinois.gov	309-794-3500	Foster Care	
Debra Dyer	Guardian	debra.dyer@illinois.gov	312-814-8600		
Keith Schoonover	CIO	keith.schoonover@illinois.gov	217-558-5066		
Larry Small	Deputy Director	larry.small@illinois.gov	312 590-7274	Well-Being/Outcomes	
Matthew Grady	Deputy Director, CFO	matthew.grady@illinois.gov	312-814-4339	Finance & Admin.	
Michelle Jackson	Deputy Director	michelle.d.jackson@illinois.gov	312-814-2367		
Pete Digre	Deputy Director	michael.C.jones2@illinois.gov	312-814-6848	Workforce Development	
Michael Ruppe	Senior Deputy Director	michael.ruppe@illinois.gov	217-785-5277		
Kristine Herman	Associate Deputy Director	kristine.herman@illinois.gov	217-278-5540	System of Care	
Nora Harms-Pavelski	Deputy Director	Nora.Harms-Pavelski@illinois.gov	217-785-4015	Front End/Intact	
Michael C. Jones	Deputy Director	Michael.C.Jones2@illinois.gov	312-814-6848	Residential/High End	
Jody Grutza	Deputy Director	jody.grutza@illinois.gov	312-758-3216		

Updated February 23, 2016

Exhibit B

Final Notice of Statewide Data Indicators and National Standards for Child and Family Services Reviews
Executive Summary–AMENDED May 13, 2015

On October 10, 2014, and May 13, 2015, the Administration for Children and Families (ACF) published public notices in the Federal Register of statewide data indicators and national standards that the Children's Bureau will use to determine substantial conformity with titles IV-B and IV-E of the Social Security Act through the Child and Family Services Reviews (CFSRs).

Background

The Children's Bureau (CB) implemented the CFSRs in 2001 in response to a mandate in the Social Security Amendments of 1994. The legislation required the U.S. Department of Health and Human Services to issue regulations for the review of state child and family services programs under titles IV-B and IV-E of the Social Security Act (see § 1123A of the Social Security Act). CB uses the required reviews to determine whether such programs are in substantial conformity with title IV-B and IV-E plan requirements. The review process, as regulated at 45 CFR § 1355.31-37, grew out of extensive consultation with interested groups, individuals, and experts in the field of child welfare and related areas.

The CFSRs enable the CB to: (1) ensure conformity with federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist states in enhancing their capacity to help children and families achieve positive outcomes. We conduct the reviews in partnership with state child welfare agency staff and other partners and stakeholders involved in the provision of child welfare services. We have structured the reviews to help states identify strengths as well as areas needing improvement within their agencies and programs.

The CB uses the CFSRs to assess state performance on seven outcomes and seven systemic factors. The seven outcomes focus on key items measuring safety, permanency, and well-being. The seven systemic factors focus on key state plan requirements of titles IV-B and IV-E that provide a foundation for child outcomes.[1] If we determine that a state has not achieved substantial conformity in one or more of the areas assessed in the review, the state must develop and implement a program improvement plan within two years addressing the areas of nonconformity. The CB supports the states with technical assistance and monitors implementation of their program improvement plans. We withhold a portion of the state's federal title IV-B and IV-E funds if the state is unable to complete its program improvement plan successfully.

The CB uses national standards for state performance on statewide data indicators to determine whether a state is in substantial conformity with two outcomes. Statewide

[1] See the Quick Reference Items List at http://kt.cfsrportal.org/action.php?kt_path_info=ktcore.actions.document.view&fDocumentId=73093 for a brief summary of the items subject to review in the CFSR.

data indicators are aggregate measures, and we calculate them using administrative data available from a state's submissions to the Adoption and Foster Care Analysis and Reporting System (AFCARS),[2] the National Child Abuse and Neglect Data System (NCANDS),[3] or a CB-approved alternate source for safety-related data. If we determine that a state is not in substantial conformity with a related outcome due to its performance on an indicator, the state must include that indicator in its program improvement plan. The improvement a state must achieve is relative to the state's baseline performance at the beginning of the program improvement plan period.

In the April 23, 2014, Federal Register notice (79 FR 22604), the CB proposed statewide data indicators and an approach to national standards for the third round of CFSRs that differed from that used for the second round of reviews. In that notice we provided a detailed review of the consultation with the field and information considered in developing the third round of the CFSRs. We reviewed research literature, consulted with an expert panel, considered the availability and quality of data available, and conducted statistical testing to examine relationships between available data and outcomes. During the 30-day public comment period following the notice, we received 52 unique responses from state and local child welfare agencies, national and local advocacy and human services organizations, researchers, and other interested persons. CB reviewed and considered all public comments and questions before making final decisions regarding the statewide data indicators and the methodology.

We considered all public comments and issued a final notice in the October 10, 2014, Federal Register (79 FR 61241). That public notice includes a summary of our response. The public comments and questions that were submitted are available in their original form (http://www.regulations.gov). CB made some corrections to the October notice and published a new notice in the Federal Register on May 13, 2015. The May 2015 notice is published at https://federalregister.gov/a/2015-11515.

Summary of Final Statewide Data Indicators and Methods

Most commenters expressed strong support for the proposed statewide data indicators and national standards. We changed two indicators in response to the public comments. We will measure the recurrence of maltreatment instead of repeat reports of maltreatment, as we proposed in the April 2014 Federal Register notice. We will also add a new indicator to measure permanency in 12 months for children who have been in foster care for 12 months to 23 months.

Therefore, our final plan is to use two statewide data indicators to measure maltreatment in foster care and recurrence of maltreatment in evaluating Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. We will use statewide data indicators to measure achievement of permanency in 12 months for children entering foster care, permanency in 12 months for children in foster care for 12 months to 23 months, permanency in 12 months for children in foster care for 24 months or more, re-

[2] AFCARS collects case-level information from state and Tribal title IV-E agencies on all children in foster care and those who have been adopted with title IV-E agency involvement. Title IV-E agencies must submit AFCARS data to the Children's Bureau twice a year.

[3] NCANDS collects child-level information on every child who receives a response from a child protective services agency due to an allegation of abuse or neglect. States report these data to the Children's Bureau voluntarily. In FFY 2013, all 50 states, the District of Columbia, and Puerto Rico submitted NCANDS data.

entry to foster care in 12 months, and placement stability. We will use these five permanency indicators in evaluating Permanency Outcome 1: Children have permanency and stability in their living situations.

A description of each of the seven statewide data indicators, how we will calculate them, our rationale for each indicator, inclusions, and exclusions is provided in the final public notice and notice of corrections. These Federal Register notices include our approach to measuring a state's program improvement on the indicators should the state not meet a national standard. We provide information on how we will share data and information related to state performance as well as data quality issues that may affect the indicators and methods.

On May 13, 2015, CB issued CFSR Technical Bulletin #8A, which provides additional technical information and discussion relevant to the statewide data indicators, national standards, and states' performance on them. Technical bulletin #8A is available on the CB's website at http://www.acf.hhs.gov/programs/cb/laws-policies/technical-bulletins/cw-monitoring.

The seven statewide data indicators are described briefly below.

Statewide Data Indicators for CFSR Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

Maltreatment in foster care
This indicator is described as: Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?

Numerator: Of children in the denominator, the total number of substantiated or indicated reports of maltreatment (by any perpetrator) during a foster care episode within the 12-month period (NCANDS, AFCARS)

Denominator: Of children in foster care during a 12-month period, the total number of days these children were in foster care as of the end of the 12-month period (AFCARS)

We include this indicator to measure whether the state child welfare agency ensures that children do not experience abuse or neglect while in the state's foster care system. The indicator holds states accountable for keeping children safe from harm while under the responsibility of the state, no matter who perpetrates the maltreatment while the child is in foster care.

Recurrence of maltreatment
This indicator is described as: Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month reporting period, what percent were victims of another substantiated or indicated maltreatment report within 12 months of their initial report?

Numerator: The number of children in the denominator who had another substantiated or indicated maltreatment report within 12 months of their initial report (NCANDS)

Denominator: The number of children with at least one substantiated or indicated maltreatment report in a 12-month period (NCANDS)

We include this indicator to measure whether the agency was successful in preventing subsequent maltreatment of a child if the child was the subject of a substantiated or indicated report of maltreatment.

Statewide Data Indicators for CFSR Permanency Outcome 1: Children have permanency and stability in their living situations.

Permanency in 12 months for children entering foster care
This indicator is described as: Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care? Permanency, for the purposes of this indicator and the other permanency-in-12-months indicators, includes discharges from foster care to reunification with the child's parents or primary caregivers, living with a relative, guardianship, or adoption.

Numerator: The number of children in the denominator who are discharged to permanency within 12 months of entering foster care (AFCARS)

Denominator: The number of children who enter foster care in a 12-month period (AFCARS)

We include this indicator to measure whether the agency reunifies or places children in safe and permanent homes as soon as possible after removal.

Permanency in 12 months for children in foster care 12 to 23 months
This indicator is described as: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the period?

Numerator: The number of children in the denominator who discharged from foster care to permanency within 12 months of the first day (AFCARS)

Denominator: The number of children in foster care on the first day of a 12-month period who had been in foster care in that episode between 12 and 23 months (AFCARS)

We include this indicator to measure whether the agency reunifies or places children in safe and permanent homes timely if permanency was not achieved in the first 12 to 23 months of foster care.

Permanency in 12 months for children in foster care for 24 months or longer
This indicator is described as: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: The number of children in the denominator who are discharged from foster care to permanency within 12 months of the first day (AFCARS)

Denominator: The number of children in foster care on the first day of a 12-month period who had been in foster care in that episode for 24 months or more (AFCARS)

We include this indicator to measure whether the agency continues to ensure permanency for children who have been in foster care for longer periods of time.

Re-entry to foster care in 12 months
This indicator is described as: Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?

Numerator: The number of children in the denominator who re-entered foster care within 12 months of their discharge from foster care (AFCARS)

Denominator: The number of children who entered foster care in a 12-month period who discharged within 12 months to reunification, living with a relative, or guardianship (AFCARS)

We include this indicator to measure whether the agency's programs and practice are effective in supporting reunification and other permanency goals so that children do not return to foster care.

Placement stability
This indicator is described as: Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?

Numerator: Among children in the denominator, the total number of placement moves during the 12-month period (AFCARS)

Denominator: Among children who enter foster care in a 12-month period, the total number of days these children were in foster care as of the end of the 12-month period (AFCARS)

We include this indicator to measure whether the agency ensures that children whom the agency removes from their homes experience stability while they are in foster care.

National Standards and State Performance

The national standard is set at the national observed performance for each of the seven indicators. The following tables show the national standards for each indicator.

National Standards for CFSR R3 Statewide Data Indicators: Safety Outcome 1

Statewide Data Indicators for Safety Outcome 1	National Standard
Maltreatment in foster care	8.50 victimizations per 100,000 days in foster care
Recurrence of maltreatment	9.1%

National Standards for CFSR R3 Statewide Data Indicators: Permanency Outcome 1

Statewide Data Indicators for Permanency Outcome 1	National Standard
Permanency in 12 months for children entering foster care	40.5%
Permanency in 12 months for children in foster care between 12 and 23 months	43.6%
Permanency in 12 months for children in foster care for 24 months or more	30.3%
Re-entry to foster care in 12 months	8.3%
Placement stability	4.12 moves per 1,000 days in foster care

Calculation of the National Standards

For indicators in which the outcome for a child either occurred or did not occur, the standard is calculated as the number of children in the nation experiencing the outcome divided by the number of children in the nation eligible for, and therefore at risk, of the outcome. This is the case for the indicators that measure permanency (for all cohorts) in 12 months, re-entry to foster care in 12 months, and recurrence of maltreatment. The result of the calculation is a proportion. We present the standard as a percentage by multiplying the proportion by 100 to show a number that is more easily understood.

For indicators in which the outcome for a child is a count per day in foster care, the standard is calculated as the sum of counts for all children in the nation divided by the sum of days these children were in foster care. This is the case for the indicators for placement stability (moves per days in foster care) and maltreatment in foster care (number of victimizations per days in foster care). The result of the calculation is a rate. We multiply the rates to show more understandable numbers: for placement stability by 1,000 to yield a rate of moves per 1,000 days, and for maltreatment in foster care by 100,000 to give a rate of victimizations per 100,000 days in foster care.

Multi-Level Modeling Approach

State performance on each statewide data indicator will be assessed using a multi-level model appropriate for that indicator. The multi-level model that we employ when assessing each state's performance takes into account: (1) the variation across states in the age distribution of children served for all indicators, and the state's entry rate for selected indicators (risk adjustment); (2) the variation across states in the number of children they serve; and (3) the variation across states in child outcomes. The result of this modeling is a performance value that is a more accurate and fair representation of

each state's performance than can be obtained by simply using the state's observed performance.

Risk Adjustment

We will risk-adjust on child's age for each indicator (depending on the indicator, it is the child's age at entry, exit, or on the first day). We will also risk-adjust on the state's foster care entry rate for two indicators: permanency in 12 months for children entering foster care, and re-entry to foster care in 12 months. Adjusting on age allows us to control statistically for the fact that children of different ages have different likelihoods of experiencing the outcome, regardless of the quality of care a state provides. Adjusting on foster care entry rate allows us to account for the fact that states with lower entry rates tend to have children at greater risk for poor outcomes.

After we perform all the calculations in the model, the result will be the state's risk-standardized performance. The risk-standardized performance is the ratio of the number of predicted outcomes over the number of expected outcomes, multiplied by the national observed performance.

State Performance Relative to the National Standards

A state's risk-standardized performance can be compared directly to the national observed performance to determine whether the state performed statistically higher or lower than the national observed performance. To make this assessment, the CB calculates approximate 95 percent interval estimates around each state's risk-standardized performance.

The CB will compare each state's interval estimate to the national observed performance, and assign each state to one of three groups:

- "No different than national observed performance"
- "Higher than national observed performance"
- "Lower than national observed performance"

Whether it is desirable for a state to be higher or lower than the national observed performance depends on the indicator. For the indicators assessing permanency by 12 months for the three cohorts, a higher value is desirable and will be considered to have met the national standard. For the remaining indicators, a lower value is desirable and will be considered to have met the national standard. For all indicators, we will consider states that are "no different than national observed performance" to have met the national standard.

Sources and Data Periods

The datasets used for the national standard calculations depend on the indicator. Some indicators require more data periods than others. For example, the re-entry to foster care in 12 months indicator requires six report periods of AFCARS data. This is because the cohort of children used requires a look at all children who enter foster care over a 12-month period; then they are followed for another 12 months to establish whether they have exited to permanency; then they are followed for a subsequent 12 months after their exit to see if they re-enter foster care.

Monitoring Statewide Data Indicators in Program Improvement Plans

The CB will require a state that does not meet the national standard for any indicator to include improvement on that indicator in its program improvement plan. If we are unable to determine a state's performance on an indicator due to data quality issues, we will also require the state to include that indicator in its program improvement plan.

Companion Measures
If a state has a program improvement plan that includes improving on the indicator of "Permanency in 12 months for children entering foster care," the CB's determination of whether the state has improved successfully will take into consideration its performance on the "Re-entry to foster care" indicator as a companion measure. The reverse is also true. Specifically, the state must not allow performance on the companion measure to fall below a certain level from its baseline performance.

Thresholds are established as the inverse of performance goals. For example, a state must stay below a threshold for the companion "Re-entry to foster care" indicator as well as achieve its goal on the "Permanency in 12 months for children entering foster care" indicator to successfully complete the program improvement plan. If a state must improve on the "Re-entry to foster care" indicator in its program improvement plan, it must not fall below the threshold established for permanency in 12 months for children entering foster care.

Setting Goals and Monitoring Progress
The key components for setting improvement goals and monitoring a state's progress over the course of a program improvement plan involve calculating baselines, setting improvement goals and, when companion measures are included in an improvement plan, also establishing thresholds.

The CB will set the baseline for each statewide data indicator included in a program improvement plan at the state's observed performance on that indicator for the most recent year of available data at the beginning of the program improvement plan. Because the CFSR schedule is staggered, the applicable year or data periods used in establishing the baseline will vary from state to state.

We will establish improvement factors for program improvement goals and thresholds (if applicable) for the data indicators based on the variability in a state's observed performance in the three most recent years of data. The resulting improvement goal or threshold may be limited or increased for a state based on the floor and cap for improvement that we have set for each indicator. We set the floors and caps such that no states are required to improve by more than the amount of improvement at the 50th percentile, and all states engaged in a program improvement plan are to improve by at least the amount of improvement at the 20th percentile (or 80th percentile, depending on whether higher or lower performance is preferable on the indicator).

The following tables show the floor and cap for program improvement goals for each indicator.

Improvement Goals for CFSR R3 Statewide Data Indicators: Safety Outcome 1

Statewide Data Indicators for Safety Outcome 1	Floor	Cap
Maltreatment in foster care	0.904	0.812
Recurrence of maltreatment	0.951	0.902

Improvement Goals for CFSR R3 Statewide Data Indicators: Permanency Outcome 1

Statewide Data Indicators for Permanency Outcome 1	Floor	Cap
Permanency in 12 months for children entering foster care	1.031	1.063
Permanency in 12 months for children in foster care 12 to 23 months	1.046	1.082
Permanency in 12 months for children in foster care 24 months or more	1.042	1.091
Re-entry to foster care in 12 months	0.891	0.834
Placement stability	0.959	0.904

Successful Completion of Program Improvement Plans

A state can complete its program improvement plan successfully with regard to the indicators in one of two ways: (1) the state can meet its improvement goal and not exceed the threshold for its companion measure, if applicable, at some point before the end of the program improvement monitoring; or (2) the CB can relieve the state of any further obligation to improve for CFSR purposes if the state meets the national standard for an indicator before the CB approves a program improvement plan or during the course of program improvement monitoring.

Data

Setting national standards and measuring state performance on statewide data indicators for CFSR purposes relies upon the states submitting high-quality data to AFCARS and NCANDS. We have set data quality limits for calculating the national standards and estimating states' risk-adjusted performance. We will exclude states that have data quality issues that exceed the data quality limits established from the model we use to calculate the national standard (i.e., the national observed performance) and estimate states' risk-adjusted performance. Data quality issues can also prevent us from using child-level records in our calculations.

We will provide data profiles of state performance to each state before the state's CFSR on all seven of the statewide data indicators and other contextual data available from AFCARS and NCANDS. This data profile will assist the state in developing its statewide assessment and beginning to plan for program improvement, if appropriate. In addition, we will provide data profiles semi-annually to assist states in measuring progress toward the goals identified in their program improvement plans.

Exhibit C

CWAC Outcomes/Well Being Subcommittee

Well Being Outcomes for DCFS Youth Matrix

Measures chosen based on applicability to domain and availability of data for all DCFS involved youth, regardless of geographical location or placement. Multiple data sources used when possible.

Domain-->	Cognitive Functioning (Education)	Physical Health	Emotional/Behavioral Functioning	Social Functioning
Infancy and Early Childhood (0-5)	• CANS: Developmental Needs, Young Child Development Needs • *Informed by Ages and Stages (ADQ and ASQSE)*	• CANS: Medical/Physical Health, Young Child Physical Health • Growth/Development • Combination chronic health dx and acute HHF visits	• CANS: Emotional strengths, traumatic stress symptoms, emotional/behavioral needs, select risk behaviors • *Informed by ITSC, DECA, ASQSE for under 5 group* • 906 for Psych Hosp.	• CANS: Social Functioning Strengths, Social Functioning Behaviors, and Young Child Social Behaviors • *Informed by Ages and Stages (ADQ and ASQSE)*
Middle Childhood (6-12)	• CANS: Developmental Needs and School Achievement • GPA • Standardized testing scores in reading and math	• CANS: Medical/Physical Health • Combination chronic health dx and acute HHF visits	• CANS: Traumatic Stress Symptoms, Emotional/Behavioral Strengths, Emotional/Behavioral Needs, select Risk Behaviors • School attendance • 906 form for detention • 906 and Psych Hospital Database (PHT): psychiatric hospitalization/readmission • Child Intake and Recovery Unit (CIRU) and 906: Running away	• CANS: Social Functioning Strengths and Social Functioning Behaviors
Adolescence 13-18				Added for Adolescence: • CANS: Intimate Relationships
Measurable factors that can affect each wellbeing domain	*Quality of Educational Context*: CANS: Educational Setting *Outcomes in other domains*	*Health Service Quality Indicators* (e.g., immunizations, timely well child visits, regular dental appointments, etc..) *Outcomes in other domains*	*Continuity/Quality of Care*: Family and Living Situation (CANS), Placement disruptions (906); staying in psychiatric hospital Beyond Medical Necessity (PHT) *Family Involvement/Support*: Substitute Caregiver Strengths and Needs, Biological Parent Strengths and Needs (CANS) *Outcomes in other domains*	

CWAC Outcomes/Well Being Subcommittee

Analysis of Factors Affecting Implementation of Proposed Instruments/Measures

Instrument or Measure	CURRENT STATE	BARRIERS	RECOMMENDATIONS
CANS	A plus that it is already expected on every child Questions of reliability/ validity given an uneven understanding of meaning of each item by rater. Uneven timeliness of submission Uneven perspective given the range of roles of rater (caseworker vs. clinician) Gaps of information held by rater	Overload of system Need for a team approach to completion for full view Desire/ investment of raters given the incentives present for other measures and the seeming lack of use of CANS data Logistical problems in having a feedback loop so that data can be used by person affecting youth	Based on the success of the system that is used by IPS (SOC), Integrated Assessment and Pregnant and Parenting, expand centralized system to maintain timeliness and quality. Re-energize educational efforts to boost meaningfulness with staff and supervisors to use in the work. Provide implementation support on site with coaching/ consultation. Use well-being measure to assess individual youth's progress and for assessing the system overall. Use of wellness measure to assess professionals or agency success has substantial risk of positively skewing ratings. Do periodic checks of reliability and validity of ratings. Integrate team approach to completion as common practice Remove less critical data reporting to lessen reporting burden Implement CANS 3/1 to reduce reporting burden
CASEY	Uneven compliance, not a reliable source of wellbeing. Currently missed often unless needed for life skill referral.	Could be problematic to use given episodic administration of the tool and its usefulness as big pools of data are rolled up to understand larger trends.	Given the heavy intervention that would be necessary to enforce compliance across the system, not advised for measuring well being at this time.
GPA & Math/ Reading Scores, School Attendance		ISBE and DCFS data communicating. And understanding what the scores mean	Tiffany may be a resource to help translate scores. Need to resolve the inter-system communication issues.
Chronic health dx and HHF visits	Very reliable and consistently entered data set.	Would be enhanced further if the record of all ER visit included the dx of what was treated (only present 40% of the time now.	Use ER visit frequency and DX. Some believe that BMI would be good addition, but further discussion with Dr Jaudes is necessary given her objections.
906, Psych Hosp Report, Run unit data	*This set of data sources seems more complete and reliable.*		

Exhibit D

The Principles of Wraparound: Chapter 2.1

Ten Principles of the Wraparound Process

Eric Bruns, Co-Director, National Wraparound Initiative, and Associate Professor, University of Washington School of Medicine

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

National Wraparound Initiative Advisory Group

The philosophical principles of wraparound have long provided the basis for understanding this widely-practiced service delivery model. This value base for working in collaboration and partnership with families has its roots in early programs such as Kaleidoscope in Chicago, the Alaska Youth Initiative, Project Wraparound in Vermont, and other trailblazing efforts.

Perhaps the best presentation of the wraparound value base is provided through the stories contained in *Everything is Normal until Proven Otherwise* (Dennis & Lourie, 2006). In this volume, published by the Child Welfare League of America, Karl Dennis, former Director of Kaleidoscope, presents a set of stories that illuminate in rich detail how important it is for helpers to live by these core principles in service delivery. As described in the *Resource Guide*'s Foreword, these stories let the reader "experience the wraparound process as it was meant to be" (p.xi).

For many years, the philosophy of wraparound was expressed through the work of local initiatives and agencies such as Kaleidoscope, but not formally captured in publications for the field. Critical first descriptions were provided by VanDenBerg & Grealish (1996) as part of a special issue on wraparound, and by Goldman (1999) as part of an influential monograph on wraparound (Burns & Goldman, 1999).

These resources presented elements and practice principles that spanned activity at the team, organization, and

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This is an updated version of *The Ten Principles of the Wraparound Process*, which was originally published in 2004.

system levels. In other words, some elements were intended to guide work at the team level with the youth, family and hands-on support people, while other elements described activities at the program or system level. For many, these documents were the best means available for understanding the wraparound process. They also provided the basis for initial efforts at measuring wraparound implementation. (See the chapter on wraparound fidelity in chapter 5e.1 of this *Resource Guide.*)

The Ten Principles as Presented by the National Wraparound Initiative

At the outset of the National Wraparound Initiative's work, it was recognized that presentation of the principles of wraparound would be a central part of the NWI's mission to enhance understanding of wraparound and support high-quality wraparound practice. So what, if anything, was needed to communicate the principles clearly?

In the first place, the early descriptions of wraparound's philosophical base included a series of elements that were described only briefly, or not at all. If these values were truly to guide practice, it seemed important to provide some information about what was meant by key terms and phrases like "culturally competent," "based in the community" and "individualized." Secondly, since the principles were intended to serve as a touchstone for wraparound practice and the foundation for the NWI's subsequent work, it was important that a document describing the principles receive formal acceptance by the advisors who comprised the NWI. Finally, for clarity, it seemed optimal to express the principles at the level of the family and team. Once the principles were clarified and written in this way, descriptions of the organizational and system supports necessary to achieve high-quality wraparound practice (see Chapter 5a.1 of this *Resource Guide)* could be presented as *"what supports are needed to achieve the wraparound principles for families and their teams?"* Furthermore, descriptions of the practice model for wraparound (See chapter 4a.1 of this *Resource Guide)* could be presented as *"what activities must be undertaken by wraparound teams to achieve the principles for youth and families?"*

The current document began with the efforts of a small team of wraparound innovators, family advocates, and researchers working together over several months. This team started with the original elements and practice principles, reviewed other documents and training manuals, and drafted a revised version of the principles as expressed at a family and team level. These descriptions were then provided to a much larger national group of family members, program administrators, trainers, and researchers familiar with wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on wording, and participated in a consensus-building process.

Though not complete, consensus on the NWI principles document, initially created in 2004, was strong. Nonetheless, there were several key areas where the complexity of wraparound made consensus difficult within our advisory group. In many cases, advisors were uncomfortable with brief definitions of the principles because they did not acknowledge tensions that could arise in "real world" efforts to put the principles into practice. These tensions were acknowledged and addressed in the consensus document in several ways:

- First, in addition to the one- to two-sentence definition for each principle, more in-depth commentary is also provided, highlighting tensions and disagreements and providing much greater depth about the meaning of each principle.
- Second, we have allowed our NWI "community of practice" to revisit the principles. Most notably, at the behest of a number of advisors, the NWI revisited the principle of *Persistent*, and asked whether the original name for the principle, *Unconditional Care*, might be more appropriate and a new definition possible. The results of this 2008 survey of advisors are reflected in the definitions presented here, and a description of this process is presented for your information in Chapter 2.5 of this *Resource Guide.*
- Finally, true to the wraparound model, all the materials of the NWI are intended to be resources for use by local initiatives, families, and researchers to use as

they see fit. Thus, documents such as this one, as well as the *Phases and Activities of the Wraparound Process*, are conceived as "skeletons" to be "fleshed out" by individual users. For example, in Canada, a new nationwide initiative north of the border has adapted the NWI principles. As a result, they have used the NWI principles to describe the value base in ways to suit their purposes, such as a description of the paradigm shifts necessary for wraparound and the personal values expected of participating helpers.

Many have expressed a need to move beyond a value base for wraparound in order to facilitate program development and replicate positive outcomes. However, wraparound's philosophical principles will always remain the starting point for understanding wraparound. The current document attempts to provide this starting point for high-quality practice for youth and families.

Considered along with the rest of the materials in the *Resource Guide to Wraparound*, we hope that this document helps achieve the main goal expressed by members of the NWI at its outset: To provide clarity on what it means to do wraparound, for the sake of communities, programs, and families. Just as important, we hope that NWI documents such as this continue to be viewed as works in progress, updated and augmented as needed based on research and experience.

The Ten Principles of the Wraparound Process

1. Family voice and choice. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

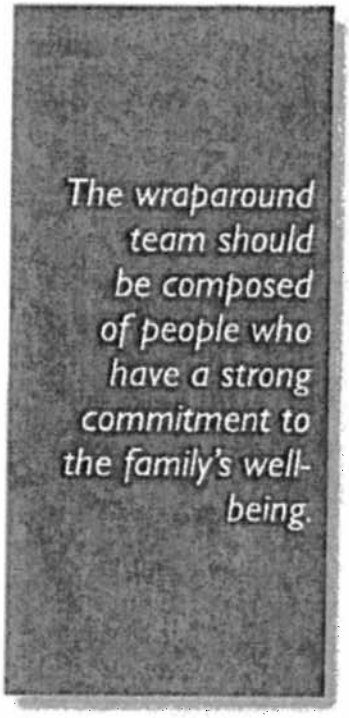
The wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in wraparound stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes. This principle further recognizes that a young person who is receiving wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the wraparound plan are increased when the wraparound process reflects family members' priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during wraparound activities—and family choice—the structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members' perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during wraparound unless *intentional* activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children's difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to "fix" the family—can lead teams to discount, rather than prioritize, family members' perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present.

Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the prin-

ciple of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of wraparound. Further intentional activity must take place to ensure that this perspective has sufficient impact within the collaborative process, so that it exerts primary influence during decision making. Team procedures, interactions, and products—including the wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.



While the principle speaks of *family* voice and choice, the wraparound process recognizes that the families who participate in wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified "family" perspective expressed during the various activities of the wraparound process.

Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on caregiving and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within wraparound. In conducting our review of opinions of wraparound experts about the principles, this has been one of several points of contention: How best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the wraparound process must place special emphasis on the perspectives of the people who will still be connected to the young person after agency involvement has ended.

> *2. Team based.* The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The wraparound team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person— e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse— to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers

will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency.

Not inviting a particular professional to join the team may also bring undesired consequences, for example, if participation of the probation officer on the wraparound team is required as a

condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in wraparound.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

3. Natural supports. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

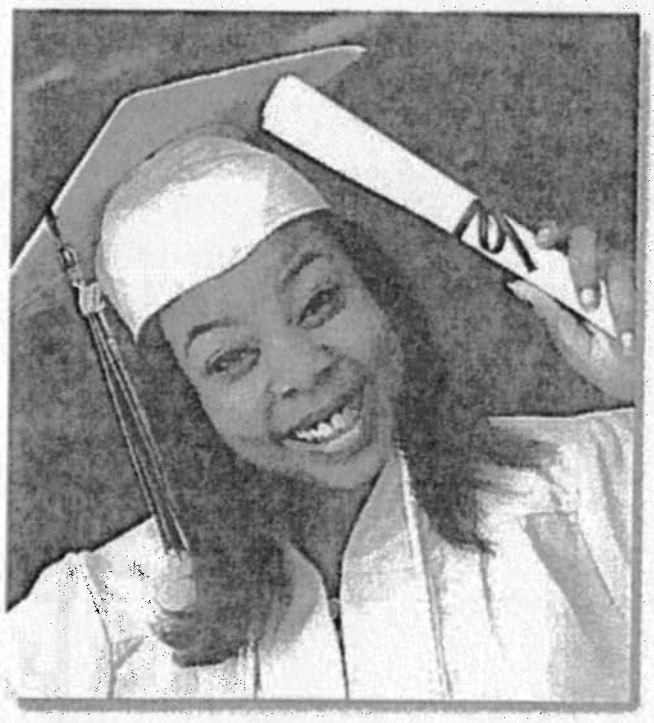
This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, libraries, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on wraparound teams. This

principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

4. Collaboration. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.



Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear that wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis, and is best accomplished when team members, providers, and community members are well supported to fully implement wraparound in keeping with all its principles.

5. Community based. The wraparound team implements service and support strategies that take place in the most in-

clusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. Culturally competent. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

The perspectives people express in wraparound—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often "natural" in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its goals, and help the family sustain positive momentum after formal wraparound has ended.

Undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings.

7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when wraparound is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation for individualization. That principle requires that wraparound must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter.

Practical experience with wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal ser-

vices. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

> *8. Strengths based.* The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

> *9. Unconditional.* A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of youth or family "failure" and are not seen as a reason to reject or eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

At the same time, it is worth noting that many wraparound experts, including family members and advocates, have observed that providing "unconditional" care to youth and families can be challenging for teams to achieve in the face of certain system-level constraints. One such constraint is when funding limitations or rules will not fund the type or mix of services determined most appropriate by the team. In these instances the team must develop a plan that can be implemented in the absence of such resources without giving up on the youth or family. Providing unconditional care can be complicated in other situations, such as the context of child welfare, where unconditional care includes the duty to keep children and youth safe. Regardless, team members as well as those overseeing wraparound initiatives must strive to achieve the principle of unconditional care for the youth and all family members if the wraparound process is to have its full impact on youth, families, and communities.

10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for wraparound teams throughout the community.

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Wraparound Practice: Chapter 4a.1

Phases and Activities of the Wraparound Process: Building Agreement About a Practice Model

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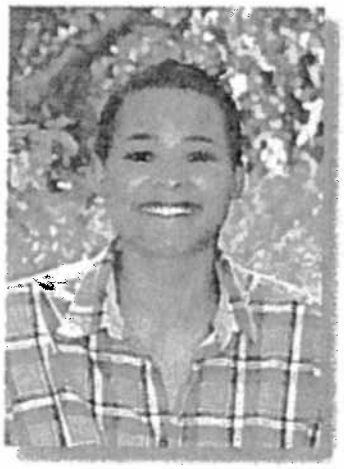

In 2004, the National Wraparound Initiative (NWI) focused its attention on building agreement about essential elements of wraparound practice.[1] To begin this work, a small core group came together to review existing wraparound manuals and training materials. This core group, which included researchers, trainer/consultants, family members and administrators, used these materials as the basis for an initial version of a practice model. This initial version saw the wraparound process as consisting of a series of activities grouped into four phases: engagement, initial plan development, plan implementation, and transition.

This initial version of the practice model was circulated by email to an additional ten NWI members, primarily administrators of well-regarded wraparound programs. These stakeholders provided feedback in written and/or verbal form. This feedback was synthesized by the NWI coordinators and incorporated into a new draft of the practice model, which was reviewed and approved by the core group. The practice model that emerged from this process did not include any activities that were completely new (i.e., all the activities had appeared in one or more of the existing manuals or materials). However, the overall model was still quite different from any single model that had been described previously.

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1 A more detailed description of the process for defining the practice model can be found in Walker, J. S., & Bruns, E. J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57*, 1579-1585.

national wraparound initiative

As a next step in building agreement about practice, the core group sought feedback from the entire NWI advisory group which, at the time, had grown to include 50 members. Advisors were asked to rate each activity in the model in two ways: first, to indicate whether an activity like the one described was essential, optional, or inadvisable for wraparound; and second, whether, as written, the description of the activity was fine, acceptable with minor revisions, or unacceptable. Advisors were also given the opportunity to provide open-ended feedback about each activity, about the grouping of activities into phases, and about whether or not there were essential activities missing from the practice model.

Teams may use a variety of processes or procedures for eliciting needs or goals.

Overall, the 31 advisors who provided feedback expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there all or all but one of the advisors agreed that the activity was essential. Advisors also found proposed descriptions of the activities generally acceptable. For 20 of the 31 proposed activities, the advisors were unanimous in finding the description acceptable.

The coordinators again revised the phases and activities, incorporating the feedback from the advisors. A document was prepared that described the phases and activities in more detail, and provided notes on each activity. These notes provided additional miscellaneous information, including the purpose of the activity, documentation or other products that should emerge from the activity, and/or cautions or challenges that might arise during the course of the activity. This document was reviewed by the core group and accepted by consensus.

The practice model, together with some of the commentary that accompanied it in its original form, is reproduced in the pages that follow. The final model included 32 activities grouped into the four phases. The intention was to define the activities in a manner that is sufficiently precise to permit fidelity measurement, but also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. The intention is to provide a "skeleton" of essential activities that can be accomplished or "fleshed out" in ways that are appropriate for individual communities or even individual teams. For example, an important activity during the phase of initial plan development is for the team to elicit a range of needs or goals for the team to work on, and then prioritize a small number of these to work on first. The practice model specifies that both of these two steps must happen, but does not specify *how* the steps should happen. Teams may use a variety of processes or procedures for eliciting needs or goals, and priority needs or goals can be selected using any of a variety of forms of decision making, including forms of voting or consensus building.

The remainder of this chapter is reproduced from the original *Phases and Activities* document. It begins with a few points that are important to keep in mind when reading about the phases and activities. Following these notes, the document lists and defines each of the four phases of the wraparound process. For each phase, the document describes the main goals to be accomplished in the phase and the activities that are carried out to meet each goal.

Phases and Activities of the Wraparound Process[2]

Some notes:

- The activities that follow identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities, and we have not tried to specify exactly who should be responsible for each activity. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a care coordinator is responsible for other activities. On other teams, a care coordinator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a care coordinator to a parent, family member, or other natural support person, during the course of a wraparound process.
- The families participating in wraparound, like American families more generally, are diverse in terms of their structure and composition. Families may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.
- The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.

2 The remainder of this article was originally published as Walker, J.S., Bruns, E.J., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Phases and Activities of the Wraparound Process: Phase 1

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation *During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.*		
1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.	*1.1 a. Orient the family and youth to wraparound* In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).	This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.
	1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.	Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.	*1.2 a. Ask family and youth about immediate crisis concerns* Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).	The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.
	1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.	Information about previous crises and their resolution can be useful in planning a response in 1.2.c.
	1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.	This response should describe clear, specific steps to accomplish stabilization.
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	*1.3 a. Explore strengths, needs, culture, and vision with child/youth and family.* Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).	This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.

Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. *(Continued from previous page)*	*1.3 b. Facilitator prepares a summary document* Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.	
1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles	*1.4 a. Solicit participation/ orient team members* Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.	The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.
1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective wraparound process.	*1.5 a. Arrange meeting logistics* Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.	

Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 2: Initial plan development *During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.*		
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles	*2.1 a. Determine ground rules* Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.	In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.
	2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.	While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.
	2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wraparound.	The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 d. Describe and prioritize needs/goals* Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.	The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.
	2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.	Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.
	2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.	This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles *(Continued from previous page)*	*2.1 g. Assign action steps* Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.	Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.
2.2. Develop crisis/ safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.	*2.2 a. Determine potential serious risks* Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.	Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.
	2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.	One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.
2.3. Complete necessary documentation and logistics	*2.3 a. Complete documentation and logistics* Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.	

Phases and Activities of the Wraparound Process: Phase 3

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 3: Implementation ***During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.***		
3.1. Implement the wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	*3.1 a. Implement action steps for each strategy* For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.	The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.
	3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.	Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.
	3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.	Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?
	3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.	Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.

Phases and Activities of the Wraparound Process: Phase 3 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.	*3.2. a. Consider new strategies as necessary* When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.	Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.
3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.	*3.3 a. Maintain awareness of team members' satisfaction and "buy-in"* Facilitator makes use of available information (e.g., informal chats, team feedback, surveys–if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.	Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.
	3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members–including new team members–about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).	Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work–and/or the overall mission or needs being currently addressed–is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.
3.4. Complete necessary documentation and logistics	*3.4 a. Complete documentation and logistics* Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.	Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.

Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 4: Transition *During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.*		
4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.	*4.1 a. Create a transition plan* Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.	Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.
	4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.	At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.
	4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.	Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.

Phases and Activities of the Wraparound Process: Phase 4 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
4.2. Create a "commencement" GOAL: To ensure that the cessation of formal wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	*4.2 a. Document the team's work* Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)	This creates a package of information that can be useful in the future.
	4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.	This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.
4.3. Follow-up with the family GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.	*4.3 a. Check in with family* Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.	The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.

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Michael Taylor
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This document was peer reviewed through the NWI.

Supporting Wraparound Implementation: Chapter 5e.4

Wraparound is Worth Doing Well: An Evidence-Based Statement

Eric Bruns, Co-Director, National Wraparound Initiative, and Associate Professor, University of Washington School of Medicine

"Anything worth doing is worth doing well." At some point, a parent, teacher, coach, or supervisor probably has given you this sage advice. Did you ever ask (maybe to yourself) whether there was evidence to support it?

In fact there is. Research tells us we should heed this guidance when delivering our children's behavioral health services. Meta-analyses of interventions delivered in "real world" systems have shown that "services as usual" are often no more effective than no service at all. Services based on evidence for effectiveness have a better chance of succeeding, but they must be delivered with quality and model fidelity if they are to produce positive effects.

Wraparound care coordination is no exception. Over 20 years, findings from controlled, peer-reviewed research articles (see Suter & Bruns, 2009; Bruns & Suter, 2010; Bruns, Walker, et al., 2014 for reviews) and federal evaluation reports (e.g., Urdapilleta et al., 2011) have consistently found wraparound to be associated with positive residential, functioning, and cost outcomes. Most of these studies were small pilot projects, however, in which implementation was tightly overseen and staff were well-trained and supervised (e.g., Bruns, Rast, Walker, Peterson, & Bosworth, 2006; Pullmann et al., 2006).

In 2014, two studies were published that provide cautionary notes to policymakers and providers involved in the increasingly common enterprise of taking wraparound programs to scale in real world public systems. The first study, funded by the National Institute of Mental Health, randomly assigned 93 youths with complex emotional and behavioral

needs and involved in the Nevada child welfare system to wraparound care coordination (N=47) versus more traditional intensive case management (N=46). The wraparound group received more mean hours of care management and services and demonstrated initially better residential outcomes. By 12 months, however, there were no group differences in functioning or emotional and behavioral symptoms (Bruns, Pullmann, Sather, Brinson, & Ramey, 2014).

The second study evaluated whether the addition of a wraparound facilitator to regular child protection services (CPS) in Ontario, Canada, improved child and family functioning over 20 months. While both groups improved significantly in child functioning, caregiver psychological distress, and family resources, addition of a facilitator did not improve outcomes above regular CPS (Browne, Puente-Dura, Shlonsky, Thabane, & Verticchio, 2014).

In addition to rigorously examining wraparound outcomes at some level of scale in "real world" systems, these two studies also shared another thing in common—both found Wraparound implementation quality to be poor.[1] In the Ontario study, fidelity as assessed by the Wraparound Fidelity Index (WFI) was found to be in the "below average" or "not wraparound" ranges for six of the scale's 10 subscales, per standards disseminated by the NWI (Bruns, Leverentz-Brady, & Suter, 2008). The authors concluded that "some of the major components of wraparound may not have been sufficiently provided in order to promote optimal support and care for families" and that "a little bit of wraparound fidelity may not be enough for optimal treatment success."

In the Nevada study, fidelity as assessed by the WFI was worse than 80% of sites nationally for parent reports and worse than 90% of sites nationally per a team observation measure. Parents and caregiver responses on the WFI and observation of team meetings suggested that the program did not consistently do things associated with high-quality implementation, such as:

- Involve youths and family members in the development of the wraparound team
- Actively engage and integrate the family's natural supports
- Develop proactive crisis plans based on functional assessments
- Link caregivers to social supports
- Involve youths in community activities
- Develop statements of team mission or family priority needs
- Brainstorming individualized strategies to meet needs
- Ensure team members followed through on tasks
- Develop effective transition plans

In contrast, earlier studies of smaller-scale wraparound initiatives in the same system with only 4-5 WSM facilitators and extensive training and coaching showed high levels of fidelity and far better residential and functional outcomes for wraparound than for a comparison group of similar youths (Bruns, Rast, et al., 2006; Mears, Yaffe, & Harris, 2009). To put the differences in perspective, youths enrolled in the pilot project improved by an average of 35 points on the Child and Adolescent Functional Assessment Scale (CAFAS), compared to only 13 points in the study of wraparound taken to scale.

Looking at the big picture, these two studies bring the total number of controlled (experimental or quasi-experimental) wraparound studies in peer reviewed journals to 12. Among these, only one other study (Bickman, Smith, Lambert, & Andrade, 2003) found uniformly null effects for the wraparound condition. Perhaps not surprisingly, this is also the one other study among the 12 that documented a lack of adherence to the prescribed wraparound model. In this study, the authors concluded, "many elements of the practice model of wraparound were not present" and that the wraparound condition "was not meaningfully different

1. Notably, both studies also applied wraparound facilitation to youth involved in child welfare. It is possible that this also played a factor in the finding of no significant effects over services as usual.

from the comparison condition."

Thus, many may initially interpret the results of these studies as evidence against the growing movement by states and large jurisdictions to invest in care coordination using the intensive procedures recommended by the National Wraparound Initiative (Walker & Bruns, 2006) for youths at risk for costly and disruptive out of community placement. Closer examination of the studies, however, suggests their findings may simply be an extension of hard lessons learned about implementation of evidence-based practices in general. *Not only is it worth doing these practices well, outcomes for youth and families probably depend on it.*

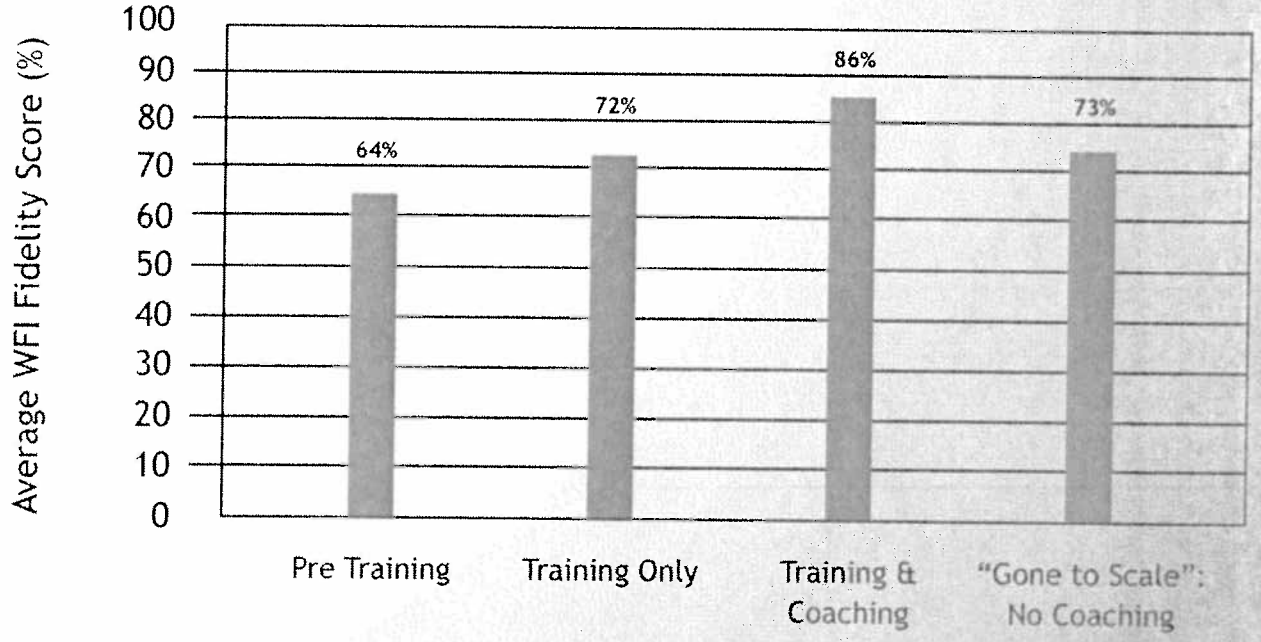
Doing Wraparound Well

So, what does it mean to "do wraparound well"? Obviously, the research summarized above suggests that implementation with fidelity to the prescribed practice model is critical. As has been described in multiple research articles and program descriptions (e.g., Walker & Bruns, 2006; Walker & Matarese, 2011), these practice-level elements must be in place for wraparound to live up to its theory of change and represent the well-coordinated, youth- and family-driven, multisystemic strategy that it is intended to be.

To achieve high-quality practice, system and program supports must be accounted for into the initiative. According to implementation science, the three big implementation drivers to keep in mind are Leadership, Workforce Development, and Program and System Support. Obviously, it would be ideal to do this from the beginning, but many wraparound projects have also successfully developed these "implementation drivers" over time.

Training, Coaching and Supervision. Wraparound projects require a thoughtful and deliberate approach to building staff and personnel capacity. This includes effective training, coaching, and supervision as well as other types of human resource decisions such as appropriate job descriptions, hiring practices, caseload sizes, performance systems, and staff support, including compensation.

Figure 1. Wraparound Fidelity in a System of Care with Variable Workforce Development Over Time



When it comes to training, coaching, and supervision, the evidence is growing crystal clear in human services that the "train and hope" model is destined to fail to achieve high-quality implementation. In the Nevada study cited above, for example, the drop off in fidelity and outcomes coincided with the withdrawal of resources for staff training and coaching that accompanied the national recession of 2007 that hit that states particularly hard (See Figure 1).

To help ensure states and systems understand what is important to attend to in workforce development, the National Wraparound Initiative (NWI) worked with its community of practice to develop

Figure 2. Workforce Development in Wraparound, from Orientation to Innovation

PHASE 1 → PHASE 2 → PHASE 3

	Phase 1: Orientation	Phase 2: Apprenticeship	Phase 3: Ongoing coaching and supervision
Main components	• Basic history and overview of wraparound • Introduction to skills/ competencies • Intensive review of the process	• Observation by the apprentice • Observation of the apprentice	• Ongoing coaching, informed by data • Periodic observation • Document review
Key features	• "Tell, show, practice, feedback" process	• Experienced coaches • Structured process • Use of reliable assessments	• Quarterly observations (minimum) • Intensity increased if data indicate challenges • Superior facilitators become innovators
Ends when...	• Training completed	• Observations completed • Score exceeds threshold • Apprentice passes knowledge test	• Ongoing

Throughout, training, coaching and supervision is provided in a way that is consistent with wraparound

2. See http://www.nwi.pdx.edu/pdf/wrap-training-guidelines-2013.pdf

guidelines for training, coaching and supervision for Wraparound Facilitators.[2] As shown in Figure 2, this guidance describes the types of content and practice activities to which facilitators should be exposed in initial training and orientation before they start to work with families. It goes on to describe the all-too-often neglected "apprentice" period, during which facilitators work in tandem with an experienced facilitator—a "coach"—who uses a structured process to help them gradually develop the ability to work independently with families. In a third phase of skill development, ongoing coaching and supervision should be provided to ensure that facilitators continually develop their skills and expertise. In each of the phases, the learning experience should be characterized by a "tell, show, practice, feedback" process, whereby training and coaching shifts gradually from imitation of skillful performance to production of skillful performance.

Program and System Supports. Critical though it may be, training and coaching alone is unlikely to ensure skillful practice and successful implementation. Over a decade ago, Walker, Koroloff, & Schutte (2003) showed that "doing wraparound well" is a complex undertaking that requires a focus on an array of systems-level structures, policies, and supports necessary to ensure quality practice-level implementation and positive outcomes. These "necessary support conditions" have since been codified by the NWI in the form of six themes, shown in Table 1.

Table 1. Necessary Support Conditions for Wraparound

Theme	Description
Theme 1: Community Partnership	Collective community ownership of and responsibility for wraparound is built through collaborations among key stakeholder groups.
Theme 2: Collaborative Action	Stakeholders involved in the wraparound effort translate the wraparound philosophy into concrete policies, practices and achievements.
Theme 3: Fiscal Policies and Sustainability	The community has developed fiscal strategies to meet the needs of children participating in wraparound and methods to collect and use data on expenditures for wraparound-eligible youth.
Theme 4: Access to Needed Supports and Services	The community has developed mechanisms for ensuring access to the wraparound process and the services and supports that teams need to fully implement their plans, including evidence-based practices.
Theme 5: Human Resource Development & Support	Wraparound and partner agency staff support practitioners to work in a manner that allows full implementation of the wraparound model, including provision of high-quality training, coaching, and supervision.
Theme 6: Accountability	The community has implemented mechanisms to monitor wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall wraparound effort.

Subsequent research has shown that these conditions can be measured and that they are associated with positive implementation on the ground level (Bruns, Leverentz-Brady, & Suter, 2006; Walker & Sanders, 2011). In the "real world" of wraparound implementation, the following are examples of topics that will require careful attention:

- *System structures for governance and management*, including consideration of options such as care management entities[3] and health homes[4];
- Investment in *quality assurance and accountability*[5] structures;
- *Sustainable financing* of high quality Wraparound, including the use of Medicaid and other federal financing mechanisms[6];
- Developing *centers of excellence* for ongoing implementation, quality assurance, policy, financing, and evaluation support;
- Building, enhancing, and/or implementing *workforce development initiatives* outside of the Wraparound practice model, including shifting providers from residential services to quality home- and-community-based services; and
- Implementation of Wraparound in the context of other systems of care efforts, including developing and implementing other *evidence-based and promising practices.*

Conclusion

In the late 1990s and early 2000s, many feared that the exciting innovations in family- and youth-driven, team based "wraparound" care would become a passing fad. Instead, wraparound has become a touchstone for children's mental health, recommended as a strategy in federal guidance documents,[7] and available in nearly every one of the United States. While it is encouraging that wraparound has gone to scale in this way, wraparound applied inappropriately or implemented "in name only" may represent a waste of our increasingly scarce behavioral health dollars.

Though it is no longer radical, wraparound has the potential to be quite powerful. To make the most of their investment in wraparound, however, states and communities must heed the lessons learned from recent research, lest they be doomed to repeat them.

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Exhibit E

ORGANIZATIONAL STRUCTURE

FEBRUARY 16, 2016

Illinois Department of DCFS Children & Family Services

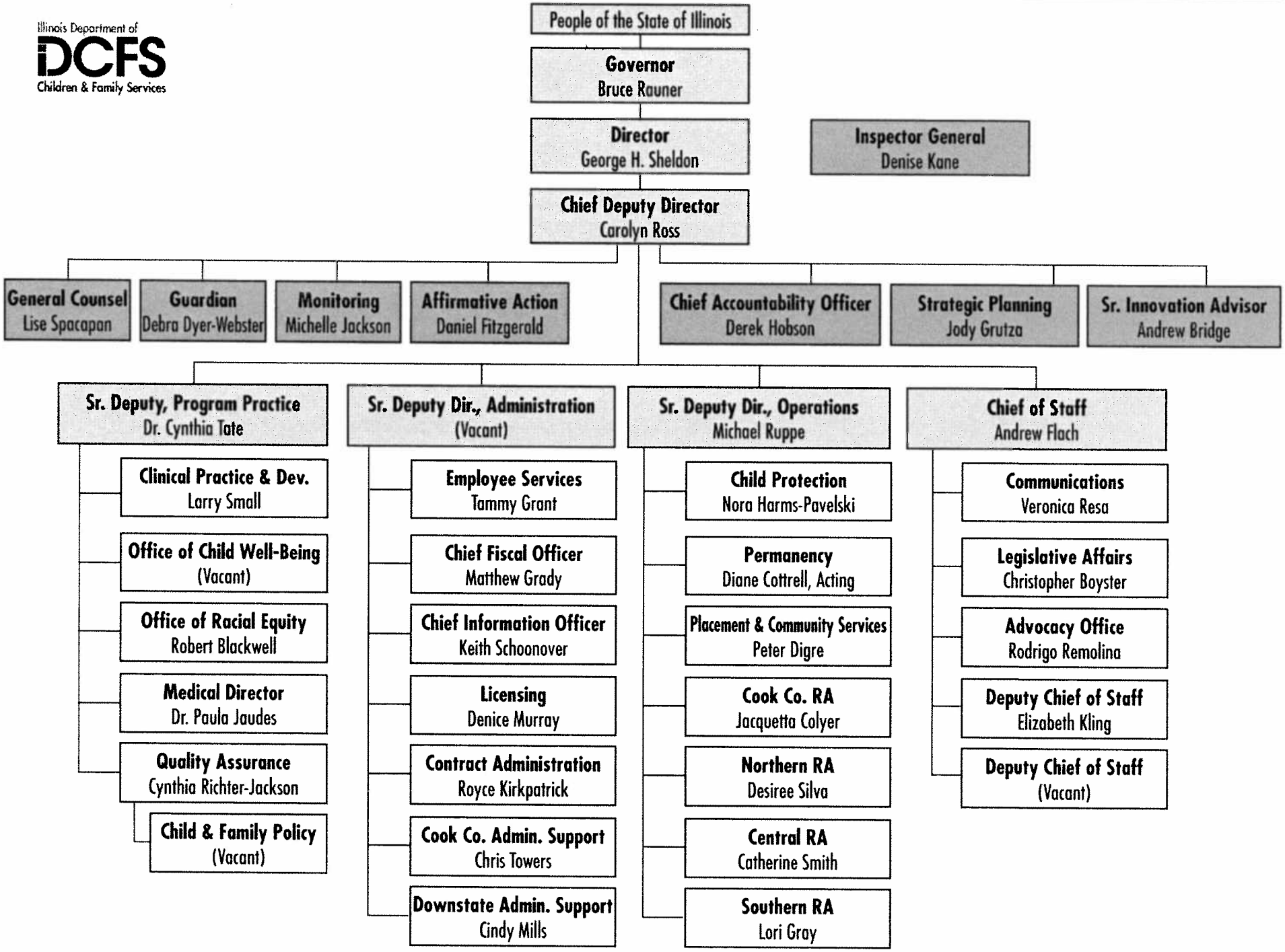

Exhibit F

STATE OF ILLINOIS
CONTRACT
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

CDC: CON Program Name: ICARE Contract #: 5469579016

CONTRACT SIGNATURES

VENDOR NAME: MINDSHARE CONSULTING GROUP

DCFS Name: MINDSHARE CONSULTING GROUP	Address: 3853 NORTHDALE BLVD
Signature:	City, State ZIP: TAMPA, FL 33624
Printed Name: Greg Povolny	Phone: 813-949-3293 x221
Title: Chief Executive Officer	Fax: 813-949-3483
Date: 2-3-16	Email: gpovolny@mindshare-technology.com
Dept. of Human Rights Public Contract #: 5469579016	DUNS #: 826757044

STATE OF ILLINOIS

Agency: IL Department of Children and Family Services	Address: 406 E Monroe St.
Director Signature:	City, State ZIP: Springfield, IL 62701
Printed Name: George H. Sheldon	Phone: (217) 785-3930
Title: Director	Fax: (217) 782-3796
Date:	
Designee Signature: George H Sheldon by William H Wolfe	Date: 2-5-16
Printed Name: William Wolfe	Phone: (217) 785-3930
Designee's Title: Deputy Director	Email: William.Wolfe@illinois.Gov

PROCESSED SPRINGFIELD FEB 10 2016 CENTRAL OFFICE CONTRACTS & GRANTS

If this Contract is in the amount of $250,000 or more in a fiscal year, or order against a master contract in the amount of $250,000 or more in a fiscal year, this Contract shall not be binding and enforceable until it is also approved and signed in writing by the Chief Legal Counsel and the Chief Fiscal Officer of the Department in accordance with 30 ILCS 105/9.02.

DCFS Chief Legal Counsel Signature: See attached	Date:
Printed Name:	
DCFS Chief Financial Officer Signature: See attached	Date:
Printed Name:	

Illinois Department of
DCFS
Children & Family Services

Statement of Work

1. Scope of Services

Services
ICARE will be the interim solution which will provide the Agency with individual dashboards for each level of staff from Caseworker to the Director. This system will be utilized to correct the lack in reporting and data availability that is currently hindering performance until the Enterprise Statewide Platform can be implemented. This will be an Outcome Driven Hosted Business Analytics Tool which is specifically designed for improvements in Child Welfare Practice. The ICARE solution will use embedded metrics to present actionable intelligence to caseworkers and Investigators as well as Administrative Staff. The intent is that this tool will drive practice and ensure timeliness and accuracy of information and instant access to areas of risk that include compliance and out of compliance situations as it relates to State Statutes and Department guidelines. Individual Dashboards will be provided and allow for customization. A summarized view should give an at-a-glance look as well as have drill down capability to the lowest entity. Each staff member should also be given the ability to create and share Ad-Hoc Dashboards as needed. Daily actionable items and real time metrics should always be available. The Mindshare will be required to provide a tool that is easy to use, is outcome driven with indicators, has the ability to set goals with actionable items and see the progress towards that goal. It is expected that the time to market will be 30 days for the initial delivery of key dashboards as agreed upon by the department and the Mindshare. Training should be provided for a period of 90 -180 days. Support hours must be 24/7/365. SLAs will be established as agreed upon by the Department and the Mindshare. The dashboards/reports are associated to the following seven service areas: Foster Care, Home of Relative, Intact, Intake, Investigation, Residential Treatment, and Specialized Foster Care. The following solution requirements should be met by the Mindshare. These solution requirements relate to the deliverables in section 2. The solution must: • use embedded metrics to present actionable intelligence to identified service areas • provide customizable dashboards • provide a summarized at-a-glance view with drill-down capabilities to the lowest entity • provide the ability to create and share Ad-Hoc Dashboards as needed • provide the ability to document and track actionable items • provide metrics on-demand and available at all times • provide the ability to create automated standard federal reports (e.g., AFCARS, NCANDS, NYTD) • provide the ability to share Standard Federal Reporting measures • provide obtainable logic and rules in a readable fashion • provide auditing and statistical mechanisms to determine metrics on usage

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Statement of Work

2. **Deliverables**

Category	Deliverable	Timeframe
Data Collection	Data feed to be established between OITS and Mindshare	3 Days
Preliminary Activities	Hold sessions to gain agreement and understanding for the meaning of the dashboards	7 Days
Preliminary Activities	Provide a process that produces an analysis summary for determining classification type for each identified dashboard/report. Example classification types include the following: • Doable – Business process, system, and data exist to produce the desired dashboard • Development Needed – System development changes doable in the desired timeframe • Business Process Changes Needed – Staff can be taught in the desired timeframe • Data Quality Issues – Data isn't accurate enough to produce meaningful results • Undoable – Data and/or system doesn't exist to produce the desired dashboard	7 Days
Preliminary Activities	Produce a traceability listing for the dashboards/reports in the addendum to the following Seven Service Areas: Foster Care, Home of Relative, Intact, Intake, Investigation, Residential Treatment, and Specialized Foster Care	7 Days
Preliminary Activities	SLAs will be established	7 Days
Development/ Implementation	ICARE Portal with out of box functionality in production Dedicated Hardware, configured and racked Dedicated Domain Name Installed and Accessible Approved and Signed Security Certificate, installed and operational Dedicated Portal, configured and accessible Account profiles for initial and pre-defined users – readied for login and daily use Functional dashboards based on default measure definitions (dashboards as defined in Addendum A and depending on availability supporting data)	30 Days
Development/ Implementation	Establish statewide and regional dashboards, with drill-downs based on role, as defined in Addendum A	30-60 days
Development/ Implementation	Establish role-based user groupings (or otherwise agreed upon during the first week of the engagement) for defining dashboards and reporting levels of abstraction are as follows: Executive, Area Administrator, Supervisor, Team, Worker	60 days
Development/ Implementation	Establish statewide and regional dashboards, with drill-downs based on role, as defined in Addendum B	60-120 Days
Development/ Implementation	Mobile Apps Available	120-180 Days
Support	Helpdesk support to be on-going for length of contract	On-Going

***The Department reserves the right to change priority within the defined scope of work. Deliverables and Timeframes may be adjusted as agreed upon between the Department and the vendor.**

Addendum A

The following list of dashboards/reports is in scope:

1. Executive MyDash to give high level view of dashboards included in this addendum.
2. Median length of stay for children in congregate care
3. Percent of children in congregate care who are under age 12
4. Percentage of children who have clinical assessments completed prior to and during residential care stay
5. Ratio of planned to unplanned exits
6. Percentage of referrals to residential care are clinically appropriate *(assessment indicates high need AND high risk)*
7. Degree of clinical change is achieved during residential care *(as measured by periodic assessment)*
8. Average length of sustained favorable discharge
9. Average wait time to placement in residential care
10. Proportion of providers are using clearly articulated and/or evidence-based intensive treatment approaches
11. Average wait time to placement after residential care
12. Percentage of sibling groups remaining intact
13. Percentage of children transferred to residential care from a specialized foster care placement
14. Median Length of Stay for Children Reunified
15. Percent of Children Entering Out-of-Home Care Reunified within 12 Months
16. Median Length of Stay for Children Adopted
17. Percent of Children in Out-of Home Care for 24 Months or More Who Achieved Permanency
18. Average length of time from commencing a ICPC case till completion
19. Total number of available step-down family placements
20. Total number of available wrap-around service options to prevent placement in residential treatment
21. Total number of youth assessed by case workers for step-down from residential treatment
22. Total number of case workers with youth in residential treatment beyond "medical necessity"
23. Total number of youth in residential treatment for more than 6, 12, and 18 months
24. Average wait time for Hotline
25. Average of the percentage of calls returned
26. Percentage of mandated reporter calls not referred for investigation (MCNRT)
27. Percentage of reports issued by the Hotline resulting in substantiated finding

*DCFS will provide Mindshare with the data from the following additional systems to allow for the completion of the above dashboards.

- Illinois Outcomes
- Psychiatric Hospital Tracking
- ACR

**Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.

Addendum B

Priority Outcomes for the Bureau of Operations

1. Child Safety and Well Being—Data measured by CERAP compliance, mandate compliance, safety plan monitoring, and percentage of SOR's
2. Return Home Achievement of Minors Particularly between the ages of 0 and 6 years
3. Sibling Visitation
4. Parent/Child Visits
5. Court Compliance in Investigations, Permanency, and High Risk Intact/Intact
6. Increase in Percentage of Providers in the Communities in which our clients actually reside
7. Increase of foster homes for children between the ages of 0-2 (hard to place babies and kids being potty trained) and teenagers
8. Increase of amount of foster children that are actually placed within the same community as their home in which they were removed
9. ACR compliance but just as important documentation supporting client input in the service/treatment plan—Client Input = Better Outcomes
10. 30 day completion compliance rate for investigations when ratios of 9:1 are enacted
11. 60 day completion rate/Undetermined Rate of less than 5% for the State and Regions and Overdue Investigative Rates/Percentages
12. Staff Morale needs to be measured ongoing to take affect at 6 month and 12 month intervals. Higher the morale hopefully will lead to better performance measures for our clients
13. Amount of time to open a case once service needs are identified. This includes handoff, transitional visit, and paperwork being processed by CAPU. The less time the better as clients are more engaged in the beginning of an investigation to address the presenting problem etc.
14. Increase the percentages and rates of successful case closing for youth in DCFS care that age out or have independence goals.
15. Body charts being included on 100% of all investigations on allegation 11—Many death cases with bad outcomes do not have a current body chart in the record at the time of the bad outcome
16. Ensuring timely medical compliance for our DCFS wards at 24 hour screenings and three week follow up
17. Increase graduation rates and grade level promotions for our DCFS wards
18. Reduced rates of probation non-compliance and Juvenile Justice violations/incarcerations of our DCFS Wards
19. Percentage of Protective Custodies that DCFS is awarded temporary custodies on – The higher the percentage the better
20. Percentage of intact cases that the remain home goal is achieved

The premise to all of the above is that these objectives and goals are all interrelated and tied together. The better we do in the above areas will lead to better outcomes for our staff, agency, and will greatly benefit most of all our clients. The above also take the premise that it is not just about numbers and being efficient but it needs to be quality driven for the ultimate success of our families that DCFS services.

*Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.

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Statement of Work

Investigations

1. 24 Hour mandate compliance
2. CERAP Compliance
3. Data Entry into SACWIS
4. Compliance on Safety Plan Monitoring
5. Good Faith Attempt Follow up
6. Percentage of investigations completed within 10, 30, and 60 days
7. Percentage of Cases that are Overdue or Undetermined in the Region
8. Protective custodies that are approved by the ASA office and by the Judge
9. Percentage of investigations that become SOR reports while the current sequence is still pending

Child Protection

1. Overdues
2. Missed mandates
3. Completion time frames
4. Investigations at 55 days with no extension
5. Ward Investigations
6. Child care worker Investigations
7. Good faith attempt contacts for child victims with time frames
8. Ceraps with child victims seen and time frame
9. Safety plans and 5 day monitoring
10. Supervision activities and dates
11. Abuse Investigations for victims age 6 and younger
12. Protective custodies taken with date, time, child victims, outcome
13. Facility reports-residential, foster care (including HMR), day care
14. Worker activity over the life of an investigation

Intact/High Risk

1. Weekly Visits and in person contact compliance
2. Cases closed in less than a year
3. Cases closed six months or less
4. Cases open one year or more
5. Initial social history compliance
6. Social History Update Compliance
7. Service Plan Compliance

Intact

1. Geographic location of intact referrals (community, county, field office all acceptable) by month giving a year to date total
2. Disrupted cases
3. Caseload capacity report
4. Case closing
5. Identified case dynamics (This would allow us to identify service needs in what geographic locations and responsiveness of services)

6. Court involved cases
7. Safety plans
8. SORs by agency
9. Cases reopened within 1 year
10. Frequency of contact with family
11. Completion of IA and Service plan –Timeliness

Placement

1. Sibling visit compliance
2. ACR Compliance
3. Court attendance/compliance
4. Parent/child visit compliance
5. Permanency outcome percentages as it relates to Return Home, Adoption, and Guardianship
6. Percentage of older youth that successfully reach independence goal
7. Title IV Eligibility Compliance for federal funds
8. Service Plan Compliance
9. Integrative Assessment Compliance
10. Compliance with Parent/Child visitation with court
11. Child and Family Team Meetings

*Complete and accurate business definitions, supporting data and respective data explanations are pre-requisites for dashboard completion and signoff.