Illinois Department of DCFS Children & Family Services

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Illinois Department of Children & Family Services
Family First Prevention Services Act
Title IV-E Prevention Plan

July 16, 2021

Table of Contents

Section 1: Introduction

The Family First Prevention Services Act (FFPSA) provides an unprecedented opportunity for system transformation as we work toward a vision of an Illinois where children, youth, and families thrive. Illinois will leverage the Family First Prevention Services Act (Family First) to mobilize and broaden the array of evidence-based parenting skills, substance use disorder prevention and treatment, and mental health services, and strengthen and improve the ability to engage families as active partners in identifying and meeting their own needs.

By maximizing the use of existing evidence-based practices and building upon the system's capacity to engage families, the state will not only build a continuum of care that provides comprehensive and coordinated support to families to prevent them from entering the child welfare system, but also to reinforce the family-centered, trauma-informed, and strengths-based approach to engaging families that has been implemented over the last ten years. In partnership with community-based providers, sister agencies, and local community networks, the Illinois Department of Children & Family Services (DCFS) will build cohesive community supports and resources through Family First and its greater prevention strategy to help each child realize his or her potential and safeguard vulnerable families. Together, we aim to reduce the stigma of child welfare involvement through a personalized approach to partnering with families that emphasizes sustaining and preserving family connections. Preventing foster care placements requires that all staff authentically engage and build trust with families *and* have the evidence-based treatment the children and families need.

As a fundamental principle of child well-being, children and families should have access to supports and services to ensure that they can reach their potential. Under this vision, child welfare is defined more broadly than just child protection and the systemic response to indicated abuse or neglect. Child protection data (hotline calls, child protection investigations, and foster care intakes) are lagging indicators of the health of children and families and the ability of our overall human services infrastructure to support people who need assistance to weather life's storms and construct a strong foundation for the future. Solutions aimed at transforming intergenerational cycles of poverty, abuse, and trauma into sustainable patterns of intergenerational well-being must drive children and youth toward achieving the six developmental goals that all young people must meet to thrive as adults who can contribute positively back to their communities. Those goals are to be safe, stable, connected, educated, healthy, and employable, which combine to create wellbeing (Youth Budget Commission, Civil Administrative Code of Illinois, 2018).

DCFS has embraced a prevention strategy that is broader and bolder than Family First. While the DCFS Title IV-E prevention plan, detailed in the following sections, focuses on the array of services that will be available to support Family First prevention-eligible children and caregivers, the Department continues to build a more comprehensive set of family-strengthening supports through a variety of existing and upcoming strategic initiatives, programs, and interventions. Stakeholders involved in the

implementation of Family First are currently working to ensure a successful integration and alignment with DCFS' overall prevention strategy.

Vision for Transformation

Illinois DCFS envisions a transformed child welfare system under Family First and its overall Prevention Strategy, in which:

- Families are the drivers, who identify their own goals and have access to the customized, evidence-based interventions and supports that will help them meet these goals.
- An understanding of the impact of past and present trauma, environments, and experiences inform all interactions with families.
- Cohesive communities have the resources and capacity to support families and take collective responsibility for doing so.
- Streamlined and clear processes, technology, and communication minimize the barriers to families seeking and receiving help
- Front-line staff are prepared with a broad array of tools, information, and knowledge to consistently assist families in accomplishing their goals and navigating complex systems and minimize additional involvement at any stage of their child welfare system involvement.

This transformation aims to:

- Promote longstanding consistent connections among children and adults
- Reduce the stigma around needing, seeking, and receiving help
- Promote equity and eliminate race-based disparities in access to community-based resources and poor outcomes
- Enhance coordination and integration between all state and local service systems
- Enable seamless, prepared transitions between levels of care when needed
- Realize each child's fullest potential and safeguard vulnerable community members

Alignment of the Vision for Transformation with the DCFS Mission

This vision extends the Department's prevention strategy, already underway, to ensure safety, deliver permanency, and promote well-being within its family-centered, trauma-informed, and strengths-based model by enhancing the Department's ability to:

- Protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them;
- Provide for the well-being of children in our care;
- Provide appropriate, permanent families as quickly as possible for those children who cannot safely return home;
- Support early intervention and child abuse prevention activities; and
- Work in partnerships with communities to fulfill this mission

Overview of Jurisdictional Considerations Related to Family First and its Overall Prevention Strategy

System transformation efforts toward increased prevention of child maltreatment and foster care reductions. In the late 1990's, Illinois accomplished historic reductions in the numbers of children removed to foster care using a suite of strategically calibrated policies, fiscal levers, and practices. These innovations began with the subsidized guardianship waiver (see below), the standardization of front-end safety assessment with the Child Endangerment Risk Assessment Protocol (CERAP), and the intensification of preventive services. Recognizing that the child welfare system must constantly evolve to meet the needs of the families it serves, the Department has continued to leverage funding opportunities, research partnerships, and deep collaborations across all three branches of government to examine and refine its approach to identifying and responding to child and family needs. On the heels of this success, in the mid-2000s the Department embarked on a coordinated strategy to incorporate brain science and accumulated knowledge on the impact of trauma to inform the development of a Family-centered, Trauma-informed, Strengths-based (FTS) practice model that would incorporate new knowledge within a coordinated strategy to serve families, promote permanency, and prevent harm to children.

Beginning in 2016, some of these strategies were piloted and evaluated rigorously in the context of "immersion sites," specific counties across the state that would serve to test a set of strategies aimed at improving child and family outcomes. These strategies included enhanced child and family team meetings (CFTMs), the operationalization of the FTS practice model, a new model of supervisory practice (MoSP), quality assurance using the Quality Services Review (QSR), enhanced community-based care coordination and mental health services, and streamlined administrative processes. Immersion sites have allowed the Department to learn not only about the impact of these strategies, but also important lessons about the sequencing, phasing, and layering of interventions for successful installation.

At the same time the Department's primary preventive program, Intact Family Services, continued to evolve through partnerships with private providers and the incorporation of strategies that had positive effects in IV-E Waiver demonstrations. Lessons learned through subsidized guardianship were incorporated in the Extended Family Support Program (EFSP), which supports families in which children are voluntarily placed with relatives. Similarly, the success of the Alcohol and Other Drugs of Abuse (AODA) waiver's recovery coaches was incorporated into Intact Family Recovery, a service offered to a geographic subset of cases incorporating evidence-based recovery coach strategies to support family preservation. Other evidence-based approaches have been incorporated by subgroups of providers, such as Solution-Based Casework (SBC) for engaging families in service planning, retention, and the achievement of family goals.

While the Intact program serves families following a child abuse or neglect investigation, other preventive strategies work upstream to meet the needs of families in communities prior to any child welfare system involvement. One of these strategies, Family Advocacy Centers (FACs), provide local

hubs for the delivery of concrete supports, linkage to community services, and opportunities for peer support among parents in the form of Parent Cafes (Be Strong Families, 2018).

In 2019, the newly elected Governor took an interest in front-end and preventive child welfare practices, commissioning a report to examine the effectiveness of these practices for ensuring child safety and identifying opportunities for improvement in the Intact Family Services program (Weiner & Cull, 2019). In response to the report's recommendations, the Department has identified and is in the process of implementing a set of innovations that will streamline processes, heighten responsiveness and coordination, and enhance the effectiveness of preventive interventions.

Illinois is a model of a successfully "privatized" child welfare system; that is, private provider agencies, incentivized by performance-based contracting and rigorously monitored by the Department, partner to manage 80% of foster care and the majority of preventive cases to provide an array of community-based services. This partnership continually presents opportunities to accelerate innovation and broaden the preventive service array. In the context of Family First, DCFS' partnership with private agencies offers opportunities to engage a broad group of stakeholders as well as to build upon the success of numerous implementations and evaluations of evidence-based approaches.

Shift from Title IV-E Waivers to Family First Implementation. The proposed transformation under Family First will build upon the progress made through existing Waivers; namely, Illinois Birth-to-3 (IB3) and Alcohol and Other Drug Abuse (AODA), which were merged into a single waiver that also included support for the immersion sites as well.

IB3 is particularly relevant, as it provides local evidence of the effectiveness of strategies that target the needs of young children and their parents. IB3 supported the adaptation of evidence-supported, trauma-informed parenting programs to the care and permanency planning for infants, toddlers, and preschoolers who were taken into DCFS' legal custody. The selected interventions, Child-Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP), were adapted to fit the needs of child welfare-involved children and are intended to support parents and caregivers in creating supportive, developmentally appropriate parenting environments. The IB3 evaluation found that children receiving the intervention achieved a rate of reunification or legal guardianship with biological and fictive kin that was 53% higher than children assigned to services as usual. At the close of the observation period, there was an estimated 7.8 percentage point difference between the likelihood of family unification in the IB3 Services group compared to Services as Usual. As a result of these demonstrable improvements in family reunification and other positive outcomes, Illinois will be expanding implementation of CPP and NPP to Intact families and other prevention programs.

Subsidized Guardianship. Illinois began providing options to caregivers of youth in care for subsidized guardianship, beginning with a waiver approved in 1995 and initiated in May 1997. By July 2002, the Subsidized Guardianship demonstration enabled more than 7,300 children to achieve permanency through subsidized guardianship. Based upon a historical comparison group that did not have access

to the subsidized guardianship program, this policy increased permanent placements for children in child welfare by 6.4 percentage points, and increased permanency rates without adversely affecting safety and wellbeing of those children in subsidized guardianship care (Children and Family Research Center, 2014). Illinois plans to build from this history of offering subsidized guardianship, by expanding its Extended Family Support Program (EFSP), and by working to ensure that children in subsidized guardianships at-risk of placement disruption receive evidence-based program support for permanent placement.

Alcohol and Other Drugs (AODA) Program. The AODA waiver supported the implementation and effectiveness evaluation of the use of recovery coaches (substance use workers), in tandem with DCFS caseworkers. This waiver program began in 1999 with a pilot in Cook County with family members with substance-exposed infants (including fetal alcohol syndrome). The initial evaluation findings showed an increased likelihood for family reunification, and shortened time to reunification for the program participants vs. comparison group. The initial evaluation demonstrated the need to tailor services to family members with co-occurring disorders (co-morbid substance abuse with mental health, domestic violence, or housing needs). As a result, in the second waiver extension period (2007), DCFS added special mental health recovery coaches to the Recovery Coach teams, augmented assessment with domestic violence screening tools; and expanded linkages with the DCFS Housing Advocacy office. Due to the importance of the timing of assessment and referral to treatment, DCFS added a mobile assessment component to the Juvenile Court Assessment program to allow parents to be assessed who could not attend the temporary custody hearing. In Cook County, the use of recovery coaches with these additional support services showed positive impact on time to family reunification as well as likelihood of reunification compared to the comparison group.

Based on initial success of the AODA waiver, the use of recovery coaches and supportive services expanded from Cook to Madison and St. Clair counties, during the waiver implementation period (through 9/30/19). Illinois has also begun testing the effectiveness of integrated child welfare and recovery coordinator services in four Illinois counties (Boone, Grundy, Kane, Kankakee, Winnebago, Will) with four agencies partnering with the DCFS Intact Division. Family members with substance use disorders eligible for Intact Family Recovery (IFR) Services are participating in a five-year randomized controlled trial on the effects of this intervention. Between May 2018 and September 2019, about 44 families have been enrolled, with an enrollment goal of 480 families in the study. The IFR program is also currently preparing to launch later this year in 16 counties that make up the central region of the state.

Illinois' Family First prevention plan includes candidate families meeting criteria for Intact Family Services and Intact Family Recovery Services. Illinois proposes to expand evidence-based service delivery to families meeting eligibility criteria for Intact Family Recovery.

Training. Subsequent to a pilot period for training curriculum development, DCFS implemented a Title IV-E Training Waiver in June 2003 that allowed Illinois to expand training services to private child

welfare agency staff, in addition to DCFS agency staff. A total of 130 private agency workers participated in enhanced training services, while 148 private agency workers were in the waitlist control group for enhanced training services. The evaluation did not show intervention effects for recurrence of abuse or neglect reports, likelihood of restrictive placements, reunification and time to reunification, or likelihood of adoption or guardianship. The only intervention effect between groups was shown in shorter time to adoption among children served by staff trained through Enhanced Training services (Children and Family Research Center, 2006). Subsequent to this Training waiver, Illinois has reorganized its training delivery and expanded training delivery to child welfare staff in private agencies. Illinois partnered with the University of Illinois-Springfield to develop, implement, and evaluate a simulation-based training academy for child welfare workers.

Home Visiting Expansion in Child Welfare. To support the development of one coordinated, high-quality system of home visiting programs across the state, the Early Learning Council (ELC) created the Home Visiting Task Force (HVTF) under its auspices that reaches all at-risk children under five years of age. The HVTF consists of approximately 200 members representing state agencies such as DCFS, early childhood and child welfare organizations, as well as providers, researchers, and advocates. The Illinois Department of Human Services' Early Intervention (EI) Program and Illinois State Board of Education (ISBE) are the primary funders of home visiting programs in the state, with leadership and oversight from the Governor's Office of Early Childhood and Development.

Through these partnerships, Illinois has invested heavily in evidence-based home visiting programs to improve the life trajectory of expectant and new families who are at risk for poor health, educational, economic and social outcomes. The most commonly used evidence-based home visiting models in Illinois are Parents as Teachers (PAT), Healthy Families America (HFA), Early Head Start- Home Based, and Baby Talk. In 2017, the Illinois Home Visiting system served 11,491 children and 10,958 Illinois families across 189 local agencies (Illinois Department of Human Services, 2018).

To support pregnant youth and mothers in their care, DCFS launched the Early Childhood Project in 1998 through a collaboration with the Erickson Institute. The statewide project provides developmental screenings and offers consultations and referrals to DHS Early Intervention and other early childhood services for children up to age 5 years old. Please see Appendix A for more information on this partnership.

The Department also supports pregnant and parenting youth through its Teen Parenting Service Network (TPSN). This program offers supportive services to DCFS case management agencies, such as staff training and linkages to community services. In Cook County and the collar counties, the Teen Parenting Service Network offers direct services to clients, including educational mentoring, clinical therapy, and family support services.

Home visiting under Family First seeks to expand the delivery of home visiting services to young pregnant and parenting women in care, aged 13-21, and pregnant and new parents of children aged 0-3

years who are receiving prevention child welfare services, with a priority focus on parents of children less than 6 months old. DCFS will implement evidence-based in-home parenting interventions through existing early childhood home visiting capacity within Illinois.

Other Local Initiatives: Impact of Managed Care, Medicaid changes, and Requirements for Integrated Health Homes. To build a statewide network of Integrated Health Homes (IHHs), the Illinois Department of Healthcare & Family Services (HFS) will establish a process for recruitment and selection of IHHs, in collaboration with Managed Care Organizations (MCOs). Once the IHHs have been selected, HFS will have an External Quality Review Organization and/or other HFS vendors conduct readiness reviews of the IHHs to verify their capacity to serve members prior to receiving services. It is anticipated that this will be an ongoing process, since IHH providers will need to be replaced or added over time as necessary to maintain a sufficient network of IHHs to serve members.

Integrated Health Homes (IHH) for members will reflect current best practice approaches and system of care principles including interagency collaboration; individualized, strengths-based care; cultural competence; child and family involvement; community-based services; and accountability. System of care values and practices establish an organizational framework for providing supports and services for children, youth, and young adults with a serious emotional disturbance and their families/ guardians/caregivers. System of care philosophy encourages collaboration across agencies and promotes the active involvement of families, children, youth, and young adults in the design and implementation of individualized, strength-based Individual Plans of Care.

HFS has also secured approval of an 1115 waiver with pilots of Intensive In-Home, Crisis Stabilization (i.e., crisis "beds") and Respite, which will be available to members if they meet eligibility criteria for these waiver pilot services. HFS will be monitoring the availability of waiver pilot services to ensure that members have access to these services on a statewide basis and will address any access issues if they arise.

Racial Equity Efforts. Established in 2012, the Office of Racial Equity Practice oversees the Department's efforts to reduce and/or eliminate racial disproportionality and improve permanency outcomes for children and families of color in the Illinois child welfare system. To ensure collective impact, the Office supports 3 Regional Transformation Teams (Cook, Central and Southern regions) that meet regularly to analyze Department data, policy and practice through a racial equity lens. The teams reflect collaboration both internally with Department units and externally with private agencies, courts, law enforcement, community-based organizations, university partners, and other entities. Efforts to-date have centered on the Permanency Enhancement Project that began in 2007 by promoting awareness among staff and stakeholders, identifying appropriate interventions, and monitoring outcomes data. More recently, in collaboration with Crossroads Antiracism Organizing and Training, the Office has developed a Race-Informed Practice Model to be integrated into the Department's FTS Core Practice Model. In terms of data performance, the Office is also helping the Department establish protocols for tracking racial equity and disparity at each of the critical decision points. This endeavor

will result in the development of annual "System Performance Reports" related to child welfare outcomes, trends, problem areas, and recommendations focused on promoting racial equity.

A Racial Equity Practice Subcommittee of the Child Welfare Advisory Committee (CWAC) in 2016 was also chartered to embed racial equity principles and values into ongoing trainings, practice and policy. The committee continues to work on its primary objective of establishing a 10-Week web-based Educational campaign, "Informing Our Practice by Race", targeting stakeholders to educate, promote and encourage greater awareness of racial equity and the impact of existing inequities in the Illinois child welfare practice and system. At the local level, recent efforts by the Office of Racial Equity include expanding upon the effectiveness of the regional offices and community stakeholders currently in operation as "Local Action Teams" in their strategic planning and programming efforts to address racial disparities.

Infrastructure Supporting the Implementation and Evaluation of Evidence-based Practices

In response to a 2003 review of the Illinois DCFS documenting ACYF concerns about inadequate efforts to meet children's mental health needs, the Director commissioned a number of strategies including a pilot study of three evidence-based practices within the System of Care program - currently named the Intensive Placement Stabilization (IPS) program (Illinois Department of Children of Children & Family Services, 2004). This pilot served not only to demonstrate evidence for the effectiveness of trauma-informed treatment, but also to familiarize the Department with the implementation of evidence-based practice that included managing fidelity, data collection, group assignment, recruitment, retention, and training. DCFS selected three developmentally appropriate evidence-based practices (EBPs) for implementation with three different age-based populations: Child-Parent Psychotherapy (CPP) for young children (0-5 years old); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for school-aged children (6-12 years old); and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) for adolescents (12-17 years old). While implementation challenges varied by model and location, these EBPs were found to be feasible and effective in reducing symptoms and improving functioning in [foster care] youth, and the models were adapted and sustained for Illinois implementation. Further, the Northwestern study noted that "culturally sensitive adaptations were made to treatment approaches to improve client retention and outcomes" and it found "no racial differences in retention in the program and no differences in outcomes between minority youth exposed to the intervention and other participants."(Weiner, Schneider, & Lyons, 2009). As previously discussed, the IB3 waiver also supported implementation of two EBPs (i.e., Child-Parent Psychotherapy - CPP and Nurturing Parenting Program - NPP), which demonstrated positive impacts on relevant child welfare outcomes for participating families. Lastly, from November 2016 to March 2019, 43 pregnant and parenting youth in care participated in Healthy Families America (HFA) home visiting services.[1] Chapin Hall Center at the University of Chicago conducted an implementation evaluation of this pilot program using program data collected from home visitors and doulas; interviews with home visitors, doulas, supervisors, and young parents; and analysis of child welfare

[1] Although fathers and fathers-to-be were eligible for the pilot, all the pilot participants were female.

administrative data (Dworsky, Gitlow, & Ethier, 2018). Illinois will continue to expand on the utilization of HFA through Family First.

Illinois' approach to selecting evidence-based interventions for its Family First Prevention Plan is to build upon existing state capacity to deliver various EBPs, while also taking into account the needs of the candidacy subgroups as well as the level of evidence established through the Title IV-E Clearinghouse, the California Evidence-Based Clearinghouse (CEBC), and local evaluations. DCFS' experience implementing EBPs with child-welfare involved children, youth, and families provides a foundation of implementation experience for Title IV-E prevention planning and service delivery with children, youth, and families at imminent risk of coming into care. As discussed in Section 3, DCFS is currently further expanding its investments in evidence-based interventions beyond those proposed to be claimed through Family First.

Figure 1: DCFS Overall Prevention Strategy and Proposed FFPSA Plan

Cross-System Infrastructure to Support Prevention Services

Illinois' prevention services approach will rely heavily on inter-agency collaboration to enhance service provision. DCFS continues to participate in ongoing dialogues with its sister human service agencies to coordinate these efforts. Among several ongoing forums for these discussions is the Human Services Partnership Committee. This collaborative convenes leadership from state agencies under the Department of Human Services (DHS) umbrella, the Department of Aging, and the Illinois State Board of Education. (ISBE). DHS agencies represented include: Division of Substance Use Prevention and

Recovery (SUPR), Division of Developmental Disabilities, Division of Family and Community Services (DFCS), Division of Mental Health (DMH), and Division of Rehabilitative Services. Many recipients of DFCS programs such as Temporary Assistance to Needy Families (TANF); Women, Infants, and Children (WIC); and Supplemental Nutrition Assistance Program (SNAP) are involved with child welfare services. DHS funds Healthy Families Illinois, which implements the Healthy Families America program with new and expectant parents. For the purpose of Title IV-E prevention services planning, DCFS will continue to coordinate closely with the Human Service Partnership Committee, particularly as it relates to Healthy Families, to expand the delivery of home visiting services.

As mentioned previously, another important cross-sector and public-private partnership involves the Department's participation in the Early Learning Council (ELC) in serving the 0-5-year-old population. Among the many charges of the ELC is improving the quality of and access to evidence-based home visiting programs for all at-risk families and increasing coordination between home visiting programs at the state and local levels. DCFS will continue to work with the ELC, particularly its Home Visiting Taskforce, to coordinate management, policy, and practice needs for the Family First expansion of home visiting services to a larger segment of at-risk families and pregnant and parenting youth in care.

As described above, Family Advocacy Centers (FACs) also offer an opportunity for prevention through service provision and linkage. Family Advocacy Centers are community-based agencies located across the State of Illinois that partner with many other community and government agencies and have comprehensive networks with their own local areas. They work with families who are involved with the child welfare system and with families who have never been involved. In doing so, they extend the reach of Intact prevention services by accepting referrals for aftercare when Intact and Division of Child Protection (DCP) placement cases close. They also accept caseworker referrals and referrals from investigations whether there was an indicated or unfounded finding.

In FY18, FACs served over 5,643 families including 7,681 children. There are 15 FACs in Cook County, 4 in the Northern Region, 9 in the Central Region and 4 FACs in the Southern Region. Of the 29 total Family Advocacy Centers, 2 were added in FY18 in areas demonstrating the need for services the Northern in Region and Central Region near the Iowa border. Two locations were expanded to include additional geographic areas in the Southern and Central region of the state. New this year is the initiation of DCFS Alumni Drop-In Centers for former foster care youth up to age 30 and support for the Extended Family Support Program providing support for family members who have taken on the role of caretakers for children to prevent their entry into the child welfare system.

FACs each develop their own network of local providers in their community; enhancements to the approach are planned to include a wide range of social services available through different entities including the state, county, and municipal agencies. Mental health, medical care, and education are other areas of consideration. Many agencies have community liaisons through which they enhance their networks. Specifically, FACs have already begun to work with the WIC local area offices to promote co-referrals between the two programs.

At the end of this initial 5-year plan, FACs have a goal to have liaisons in an extended network that includes every local DCFS field office. Establishing and maintaining these local networks will be key to preventing involvement or re-involvement with the Department. Please refer to Appendix B for the Proposed Five-Year Plan for Family Advocacy Centers.

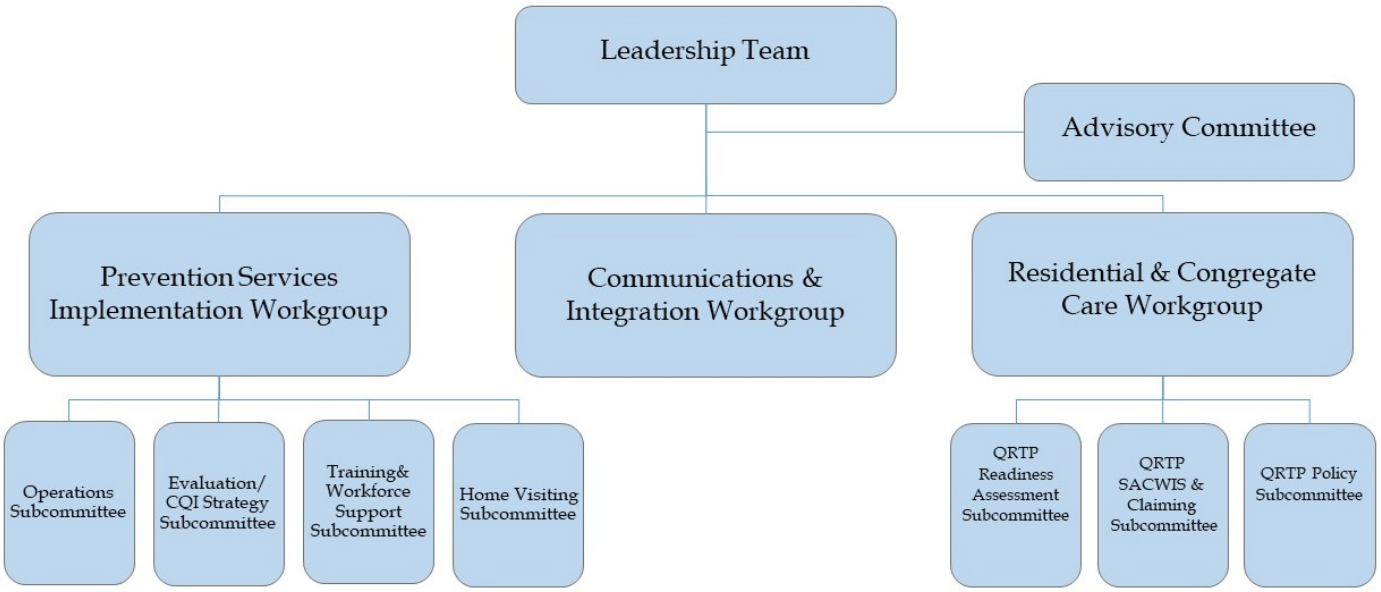
Stakeholder Consultation and Coordination in the Planning Process

Since August 2018, more than 300 stakeholders have participated in Family First committees to learn about the implications of the legislation and contribute to the design of programming in Illinois. The list of participants includes community-based providers, DCFS leadership and staff, researchers, and policy advocates. From August 2018 to March 2019, eight committees worked on planning and design for the implementation of Family First provisions. These groups included: Prevention, Intact Family Services (IFS), Residential & Congregate Care, Licensing, Data & Performance, Financial & Federal Compliance, Legal & Policy, and Technology. During this period, the committees conducted an initial survey of providers in the fall of 2018 to gather baseline information about the provision of evidence-based practices (EBPs), implementation of child and family team meetings (CFTMs), and the delivery of trauma-informed services. In a similar approach, participants conducted analyses of statewide provider capacity from data available in the Service Provider Identification & Exploration Resource – SPIDER online database (please refer to Section 3 for more information). To supplement these findings, in the summer of 2019, DCFS solicited feedback from agency administrators delivering Intact Family Services (IFS) and supervisors of IFS caseworkers to gather in-depth understanding of service coverage and gaps in parenting education, substance abuse treatment, mental health treatment, domestic violence services to support planning and implementation of EBPs for this population.

In the fall of 2019, DCFS expanded the FFPSA governance structure to support ongoing implementation planning progress. As outlined in Figure 2 below, this includes a Leadership team comprised of a group of 7 DCFS executive leaders, as well as strategic advisors from Chapin Hall at the University of Chicago. Reporting directly to the DCFS Director and meeting weekly, this team is responsible for vetting recommendations from the Steering Committee and directing all aspects of FFPSA decision-making and readiness.

Supporting the FFPSA Leadership team is a FFPSA Steering Committee which meets biweekly and consists of over 40 DCFS leadership and staff, public sister agency representatives, community provider executives, university partners, and other stakeholders. This body serves as a forum to share and align the activities of its related workgroups and subgroups, including the Prevention – Operations Workgroup (development of key procedural and policy requirements), the Prevention – Capacity Workgroup (service array selection, procurement, training, and evaluation/CQI), the Residential and Congregate Care Workgroup (QRTP and CCI readiness), and the Communications and Integration Workgroup (stakeholder engagement, communications, and ensuring alignment with the other initiatives previously mentioned). These workgroups, the Steering Committee, and Leadership team will remain in place through launch of FFPSA implementation.

Figure 2: Illinois FFPSA Governance Structure (August 2020)



As part of the planning process, DCFS has ensured that IV-E Prevention Services provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with services provided under Title IV-B Subparts 1 and 2 of the Social Security Act. Title IV-B Subpart 1 funds are primarily used for child welfare caseworker costs. In this capacity, these funds support critical activities essential to caseworker activities with children and families. Title IV-B Subpart 2 funds will continue to be used to support the four Title IV-E prevention services candidate groups to strengthen parents' capacity to safely care for their children and safely reduce the need for foster care. The proportion of Title IV-B Subpart 2 funds allocated to Family Preservation will continue to exceed the minimum proportion requirement of 20 percent, which will enable caseworkers to have additional resources beyond specific prevention EBPs available to support families, such as for a family's concrete needs such as assistance with rent or utilities (Norman Services) or other one-time costs. Title IV-B Subpart 2 Family Support funds will continue to be allocated to support expansion or start-up of additional services for community services that may not yet be available as favorably rated EBPs under the IV-E Clearinghouse. Title IV-B Subpart 2 Adoption Promotion and Support Services funds may be used for post-adoption services outside of the EBP service array that help prevent reentry of children into foster care. Title IV-B Subpart 2 Family Reunification funds may be used to help facilitate return of a child home from foster care, after which the child may be identified as a prevention candidate and receive supportive EBP services under Title IV-E and non-EBP resources under Title IV-B Subpart 2 within the allowable funding period to safely sustain the child at home.

Section 2: Target Population and Eligibility

Overview of Children and Families Likely to Receive Title IV-E Preventive Services

In early 2019, Illinois DCFS conducted a series of analyses to inform its selection of the target population for the FFPSA prevention services. These analyses were focused on understanding the size, distribution, and needs of the populations of children and families who might benefit from evidence-based interventions under Family First. While empirical analyses examined a number of different groups (e.g., children remaining home after substantiated allegations and hotline calls resulting in child welfare service referrals), the Steering Committee ultimately selected three target categories of families (please see Table 1 below). Among these three main populations for Illinois' prevention services, DCFS has estimated the number of children or caregivers served based on fiscal year 2018 (July 1st, 2017 to June 30th, 2018) with the exception of category 2 (based on calendar year 2018).

Table 1: Number of Children or Caregivers (from FY or CY2018 data) for Each Population to be Served by the Illinois Family First Prevention Services Plan

Subpopulation Description and Unit of Analysis	Count
1. Children being served by: a) Intact Family Services, b) Intact Family Recovery Services, and c) the Extended Family Support Program (EFSP) (FY18 data)	
a) Intact Family Services (children)	11,981
b) Intact Family Recovery (children)	1,021
c) Extended Family Support Program (families)[2]	736
2. Children in: a) recently reunified families (within the 6 months), b) adoption families who request services, and c) families who obtained subsidized guardianship or are relatives (Calendar year 2018 data)	
a) Recent Reunifications (children)	2,524
b) Adoptions who request services (children)	2,622
c) Subsidized guardianship or reached permanency with relatives (children)	562
3. Pregnant and Parenting Youth in care and recently aged out (FY18 data)	
a) Pregnant and Parenting Youth in care up to 21 years old (children)	464
b) Pregnant and Parenting Transition Age Youth 18-21 years old who recently opted out of care (TAY)	98
TOTAL	19,151

[2] Child-specific estimates for the Extended Family Support Program were not readily available

1. Children or caregivers being served by: a) Intact Family Services (IFS), b) Intact Family Recovery Services (IFR), and c) the Extended Family Support Program (EFSP).

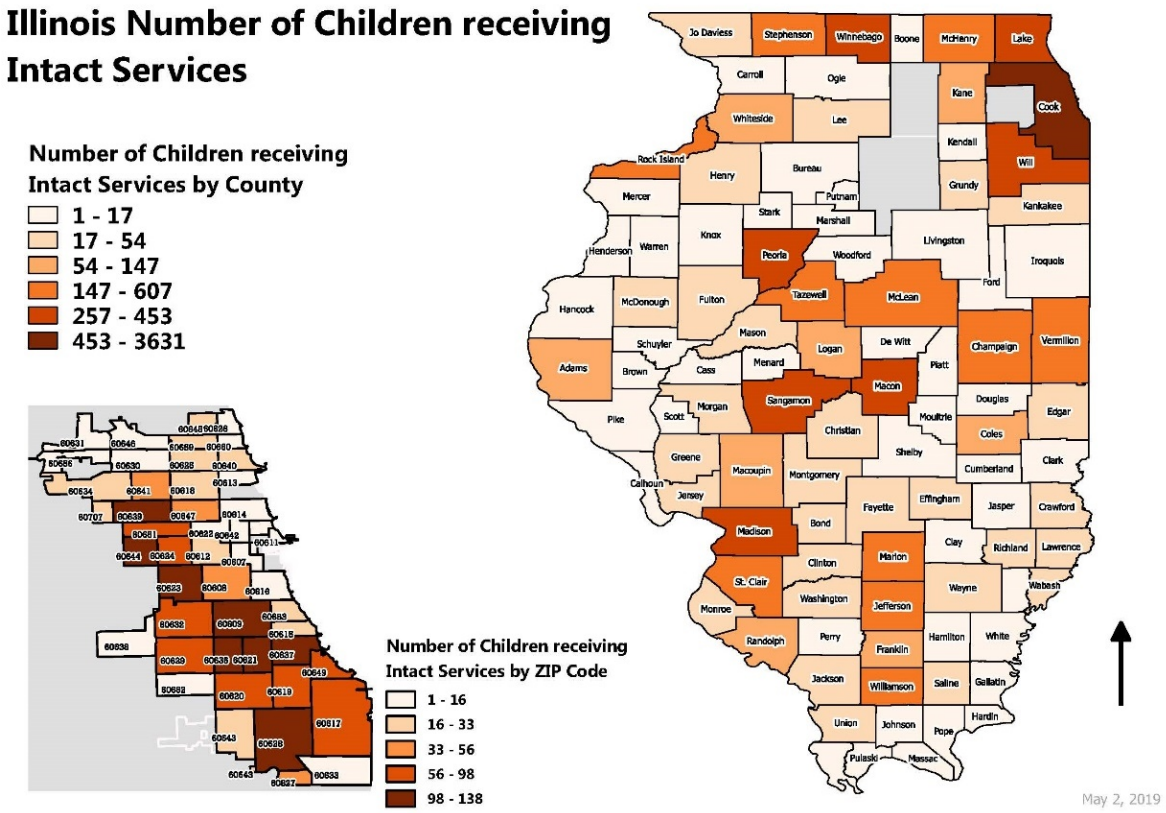
a) Intact Family Services (11,981 children in FY18)

Intact Family Services (IFS) ensures the safety and well-being of children who remain in their parents' homes by providing families with a full array of in-home services. The majority of these cases are indicated (i.e. involve substantiated allegations of abuse or neglect), although cases in which allegations of abuse or neglect are unfounded as a result of investigation may also be referred for and receive IFS (Administration for Children and Families, 2017). It is also relevant to note that approximately 17,000 families experience substantiated harm to children but do not receive Intact services following investigation. In follow-up to a recent Intact report sponsored by the Governor, DCFS is currently undergoing reforms to improve engagement to increase the number of families who accept Intact services as well as improve the practices and resources that support that program.

A recent descriptive analysis of this subgroup using data from the Child Endangerment Risk Assessment Protocol (CERAP; a.k.a. safety assessment), risk assessment (abbreviated version of Child & Adolescent Needs and Strengths - CANS), substance abuse screener, and domestic violence screener indicated that many children whose families receive Intact services experience domestic violence (53%), parental substance abuse (52%), parenting deficits (50%), caregiver mental health service needs (48%), unsafe safety assessments at any time during a case (34%), and a high prior report level history with DCFS (51%). Additional needs included child-related concerns (34%),[3] financial or environmental (30%), and social support (26%) domains. Seven percent (7%) of these children are from Spanish speaking families (7%), 38% are minorities, and the mean child age is 7.5. Maps illustrate the geographic dispersion of the Intact population, which is in part driven by the local availability of services.

[3] Among a broad category of child related needs, the following were included: supports for functioning in the current living situation, developmental/intellectual, and physical needs as well as substance abuse and delinquency.

Figure 3: Intact Service Population



Additional comparative analyses were conducted on children who were removed from their parents' homes while their families were receiving Intact services or within a year of Intact case closure (14%). The results showed that children who were removed came from families who had a higher volume of pronounced needs at the beginning of the Intact case, characterized by problematic substance abuse (67%), deficient parenting skills (61%), domestic violence (60%), impaired caregiver's mental health functioning (57%), child service needs (44%), environmental/financial needs (41%), and low social support (34%). It is likely that these families will need treatment modalities that are intended for complex problems, more intense services, and more types of services than the broader group in Intact services.

b) Intact Family Recovery Support (1,021 children in FY18)

Intact Family Recovery Support (IFR) is a program within Intact Family Services that provides coordinated child welfare and substance abuse treatment supports. IFR services have been provided to families in Cook County since 2000. With a grant from ACF, surrounding counties (Winnebago, Kane, Will, and Boone) have implemented Intact Family Recovery services that are being evaluated through a randomized controlled trial from 2018-2023. DCFS proposes to expand Intact Family Recovery from 2020-2025 in Central and Southern Illinois.

DCFS caseworkers work collaboratively with Alcohol and Other Drug Abuse (AODA) Recovery Coaches or Recovery Coordinators to coordinate and deliver services to the family for up to 18 to 24 months. Various services include but are not limited to case management, psychological and psychiatric assessments, substance use treatment, family therapy, parenting services, early childhood and family life education, transportation, and extended aftercare services.

Among those served in FY18 by Lutheran Social Services of Illinois and Lutheran Children and Family Services in the Cook North, Cook South, and Central regions (n=259), 79% (198) of this group received substance-related treatment, of which 70% (138) successfully completed treatment. Among 56 cases that were not successful completions, 52% (29) were successfully re-engaged in treatment.

Other population needs assessment data that is specific to the FY18 IFR cohort is unavailable, however, a recent preliminary analysis from ACF-sponsored IFR evaluation currently underway has been informative (Pickett, Zawojska, Pass, Patel, Carpenter, & Lundquist, 2019). Using a sample from May 2018 through August of 2019 (n=44 families), the results showed that participants had the following emotional/behavioral needs at intake: depression in the past 30 days (32%), anxiety in the past 30 days (39%), past suicidal ideation (32%), and past suicide attempt (27%). Among participants in the preliminary evaluation, 47.5% required treatment for alcohol, whereas 60% required treatment for drugs. About half (49%) of participants reported an average of 3 prior treatment episodes for alcohol use. About two-thirds (63%) reported an average of 3.6 prior treatment episodes for drug use. In this sample of 44 families, the "typical" IFR client is a 33-year old unemployed Caucasian female with two children under the age of 10. On average, IFR clients in this sample report both alcohol and cannabis use in their lifetime. Since self-report data underestimates usage, substance use in the past 30 days may be higher than reported.

c) Extended Family Support Program (736 families in FY18; *child-specific estimate not yet available*)

Extended Family Support (EFSP) is a kinship navigator program that provides support for short-term services offered to relatives caring for children who have not experienced child abuse or neglect investigations but have been voluntarily placed by their parents. Program staff assist relative caregivers to obtain private guardianship of the children in their care, and referrals come through the DCFS child abuse hotline via the State Central Registry (70%), the Division of Child Protection (27%) and Intact Family Services (3%). Program staff assist relative caregivers to obtain the child-only grant and/or other entitlements from the Department of Human Services (DHS) and enrolling school-age children in the relative caregiver's school district. Supports also include helping the relative caregiver to obtain basic goods and services needed to maintain a stable home for the child. Cash assistance is also available for obtaining guardianship and providing other items needed to care for the child.

Although specific data on the needs of families involved in the EFSP program is limited at this time, general research from the field on kinship placements and kinship care programs may be informative. Despite findings demonstrating that kinship placements are more stable than other types of placements, some data supports continued risk factors for children in these settings (Terling-Watt, 2001). For instance, Taussig & Clyman (2011) found that children who spend more time in kinship care

can experience more adverse outcomes, such as substance abuse, delinquent behavior, and poor academic performance. Kinship caregivers tend to be older and single, to have poor health, to be unemployed, and to live in poverty (Berrick, 1997; Berrick, Barth, & Needell, 1994; Cuddeback, 2004; Dubowitz, Feigelman & Zuravin, 1993; Geen, 2004). They also receive fewer services and less support than do other foster parents (Berrick, Barth, & Needell, 1994; Cuddeback, 2004; Dubowitz, Feigelman & Zuravin, 1993; Geen, 2004; Sakai, Lin, & Flores, 2011). Sakai et al. (2011), for example, found that c ompared to other foster parents, kinship caregivers are less than half as likely to obtain financial assistance and four times less likely to receive respite care or peer-support group services. Lack of resources and supervision from caseworkers can also lead to hardships among kinship families and to less than desirable child outcomes. These risk factors may result in instability within the family (Lorkovich, Piccola, Groza, Brindo, Marks, 2004). Kinship homes are also sometimes rated unsafe due to the connection with the abusing parent (Terling-Watt, 2001; Berrick, 1997). In terms of child welfare outcomes, studies have shown that kinship care programs delay the time and reduces the likelihood of reunification and adoption even though it is considered a more stable placement than other types of placements (Connell, Katz, Saunders, & Tebes, 2006; Courtney, & Wong, 1996; Goerge, 1990; Casanueva, Wilson, Smith, Dolan, Ringeisen, & Horne, 2012). Similarly, a recent systematic review of services for kinship care families demonstrated enhanced well-being and permanency outcomes of children and kinship caregivers, however, the review the rigor of the research designs are low, making it difficult to draw any firm conclusions about the effectiveness of these programs (Lin, 2014).

Given these overall findings, Illinois has opted to include families involved in EFSP as a candidate subgroup for Family First. EFSP has room for expansion under Family First. The Cook County Court probate court judge estimates that only one-fifth of the cases that come before her for guardianship are represented by EFSP. Thousands more relative caregivers do not currently have guardianship of their relative's child but would like to obtain guardianship and support through the program.

2. Permanencies, including recent reunifications (2,524 in CY18)**, recent assigned guardianships** (395 in CY18)**, recent relative permanencies** (167 in CY18), **and post-adoptions and subsidized guardianships in need of services** (2,622 in CY18).

In the calendar year of 2018, 3,084 youth in DCFS care were either reunified (2,524), obtained guardianship (395) or achieved permanency with relatives (165). Recent reunified, guardianship, or achievement of permanency with relative candidates will be defined as those who exited care within 6 months, as this group has the highest re-entry rate.[4]

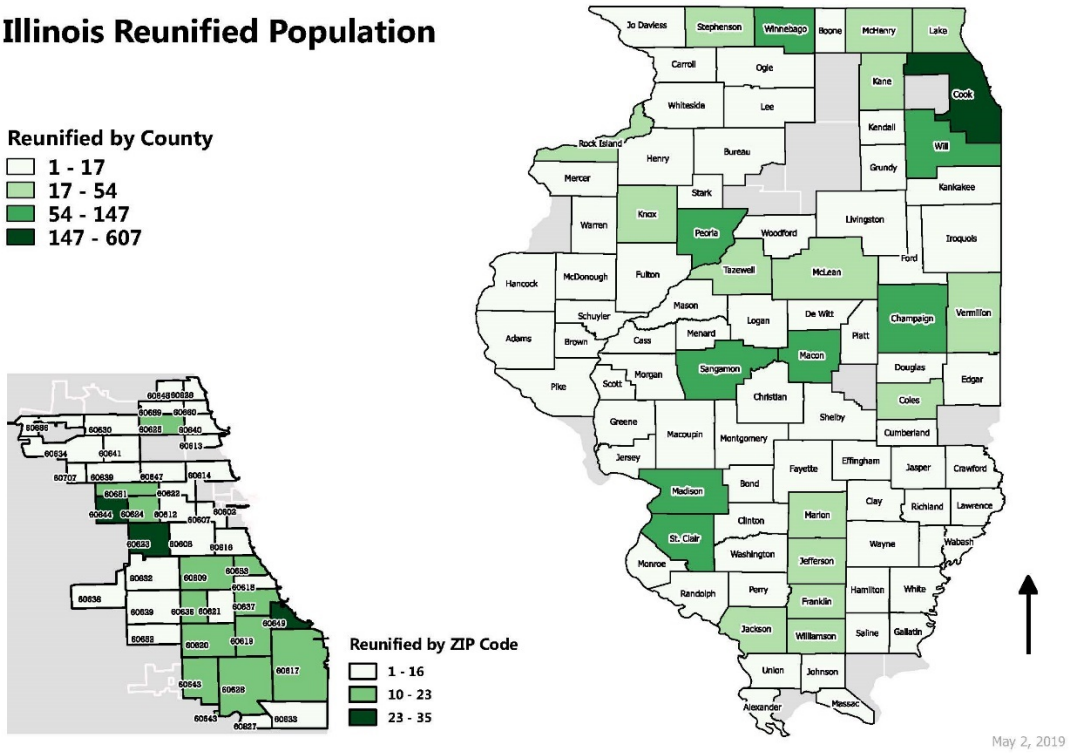
Based on the most recently completed CANS for families in the reunification subgroup, almost 20% of the youth had actionable behavioral or emotional functioning needs.[5] Additionally, approximately 31%

[4] According to 2014-2017 IL foster care entry cohort data examining disruptions following permanencies, there were 11.76% reunification, 1.68% guardianship, and 0.10% adoption related disruptions.
[5] The following CANS items were included in the aggregate number: psychosis, depression, anxiety, attachment difficulties, eating disturbances, oppositional behavior, conduct, anger control, attention deficit/impulse control, affect dysregulation.

of youth had past exposure to family violence and 2% had substance abuse disorder or substance exposure as an infant. Approximately 24% of the caregivers had problematic parenting skills,[6] 20% had mental health concerns deemed as a "serious illness," and 18% had substance-related disorders. Service considerations will need to take into account the needs of minority children (47%), child age (mean = 7.1 years of age), length of stay (27% spent more than 2 years in care) and geography (majority of children reside in the Central and Cook regions).

In 2018, 2,622 with families of adopted children or involving subsidized guardianship called the post-adoption hotline requesting specialized services. Questions about adoption subsidies unrelated to services will not constitute eligibility. In contrast to other subgroups in this category, eligibility for the post-adoption subgroup will not be defined based on the recency of the adoption period.

Figure 4: Recently Reunified Population



[6] The following CANS items were included in the parenting construct: safety (e.g. safety, supervision), knowledge of parenting and child development (e.g. knowledge of child's needs, discipline, effective parenting approach), identification and use of concrete supports in time of need (e.g. parent's knowledge of rights and responsibilities [as a parent]), and ability to nurture social & emotional competence of children (e.g. ability to listen as a parent, empathy with children).

3. Pregnant and Parenting Youth (562 children in FY18)

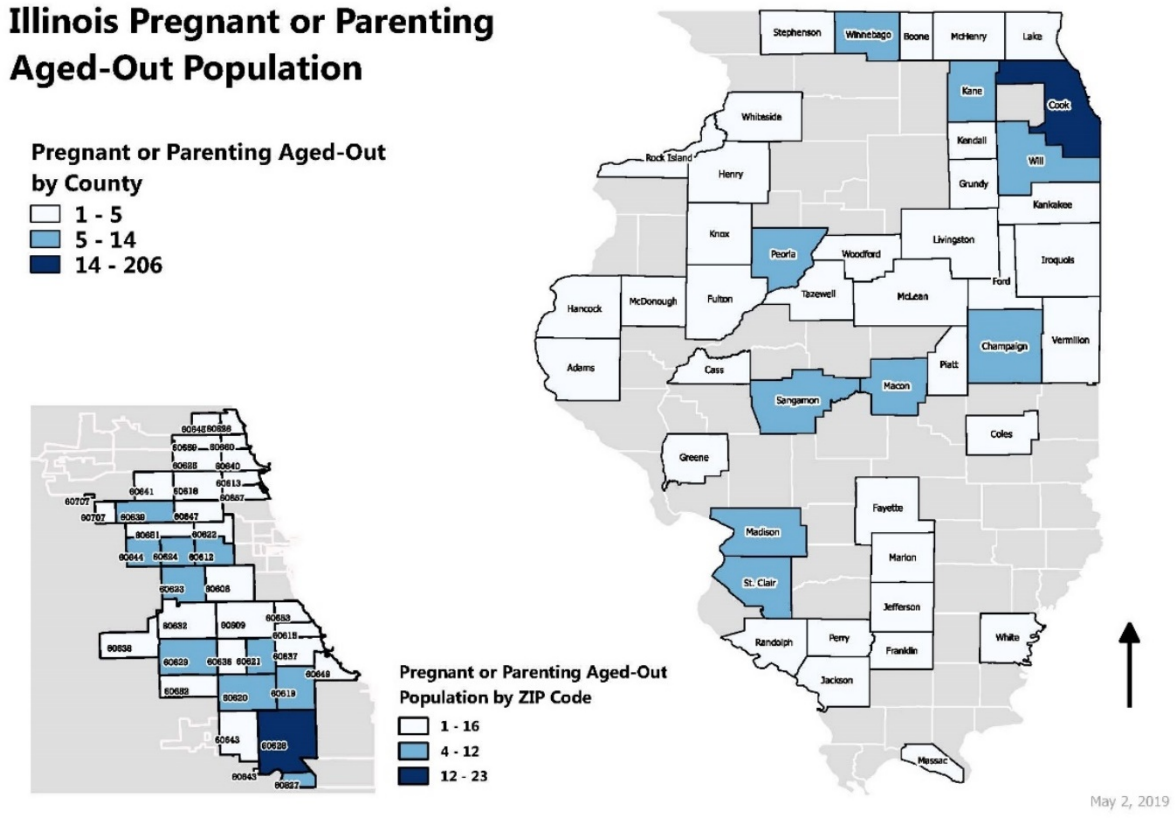
Based on FY18 data, there were 464 youth in DCFS care who are pregnant and/or parenting (PPY). We anticipate between 32 - 58 new youth entering this category annually[7] (either youth currently in care who will become parents or new youth who will enter care and become pregnant or already be a parent). Among the Illinois population of pregnant/parenting youth in care for FY19, approximately 14% have children in DCFS care, but the majority (86%) do not have children in DCFS care (UCAN, 2018). The Teen Parent Service Network (TPSN) provides a variety of supports for pregnant and parenting youth through private agencies, including parenting services, home visiting and doula services, clinical assessment and treatment, (e.g., domestic violence counseling and other therapeutic services), pre-and post-natal care, family planning, risk reduction training, substance abuse psychoeducation, child development evaluation, and education services. TPSN's innovative programs also focus on building self-esteem, leadership development, and preparing youth for independence.

Data analysis revealed that a large number of expecting and parenting youth had pronounced needs that would require intense and specialized services. As determined by a recently completed (within the last year) Child and Adolescent Needs and Strengths (CANS) instrument, 42% of youth had behavioral or emotional functioning needs that reached the clinical level.[8] Almost 22% of youth struggled with parenting while 17% had substance abuse disorders. These analyses are supplemented by data from Medicaid claims examining lifetime reported disorders for a subset of these youth receiving Medicaid services for mental health. This analysis revealed that the majority of youth had much more pronounced needs. For example, mood (affective) and anxiety disorders were present in 78% of youth receiving a Medicaid supported mental health service. Other disorders included the following: mental and behavioral disorders due to psychoactive substance use (61%), adult personality and behavior disorders (46%), pervasive and specific developmental disorders (38%), schizophrenia & other non-mood psychotic disorders (36%), other unspecified mental disorders (21%), behavioral syndromes associated with physiological disturbances and physical factors (8%), and intellectual disabilities (6%).

[7] According to FY2017 entry cohort data, there were 58 youth who entered care as pregnant or parenting while, in FY2018, there were 38 such youth.

[8] The following needs were included in the aggregate number: psychosis, depression, anxiety, attachment difficulties, eating disturbances, oppositional behavior, conduct, anger control, attention deficit/impulse control, affect dysregulation.

Figure 5: Pregnant and Parenting Youth Population



Service considerations will take into account demographic and case related PPY characteristics. In particular, the current pregnant and parenting youth in care varied by gender (74% females and 26% males), minority status (71%), Spanish as preferred language (4%), age (mean 18.6), geography (67% from Cook county), length of stay (57% have been 4 or more years in care), living arrangements (almost 40% reside in transitional or independent living), and permanency goal (92% have independence). Additionally, 36% of youth have been in an unknown location or detention in the last 12 months.

In addition to PPY minors in care, there are 98 former youth in care, aged 18-21, who have a child on their own and may be in need of support services to prevent re-entry to care for themselves or their child. Although DCFS normally serves the majority of PPY cases until 21 years old, these youth have chosen not to remain in care (aged out once 18), or in some instances, have recently exited to permanency (e.g., reunification). The descriptive analysis using the latest (prior to exit) CANS revealed that 43% of former youth had behavioral or emotional health needs, characterized at the clinical level. Approximately, 27% struggled with parenting while 22% reported moderate or severe substance abuse disorder. Additionally, 26% of former youth had past exposure to family violence. See Appendix C for additional data tables on each of the target populations' needs and characteristics.

Section 3: Title IV-E Prevention Services

The array of interventions proposed here is informed by analysis of the needs of the target populations as well as previous experience with the IV-E Waiver and other EBP implementations. Most children, youth, and families that will be served through preventive services will have multiple needs and thus may be better served with interventions that can be flexibly deployed to address a wide variety of psychosocial needs. In acknowledgement of this complexity, Illinois DCFS has been less likely to select interventions that are targeted narrowly to specific conditions and challenges [i.e. a single DSM classification]. The long history of implementing and evaluating EBPs in Illinois has illuminated the challenges that are likely to be encountered in a geographically, racially, and economically diverse system. For example, the pilot evaluation of trauma EBPs (2004-06) outlined in Section 1, demonstrated the feasibility limitations in implementing group interventions (e.g., Structured Psychotherapy for Adolescents Responding to Chronic Stress – SPARCS) within rural communities where substantial travel was required for participation. This finding was considered in our adoption of the Nurturing Parenting Program (NPP) which allows for flexible implementation of home-based and group interventions using the same model.

To ensure a rigorous selection process, the State engaged approximately 30 community providers, DCFS administrators, university partners, and other stakeholders in ongoing work sessions. Several important factors were considered to develop the proposed list of EBPs, including 1) needs of the target populations (Section 2); 2) evidence ratings from the Title IV-E Prevention Services Clearinghouse (IV-E Clearinghouse) and California Evidence-Based Clearinghouse (CEBC); 3) Illinois' existing capacity of providers to deliver relevant, evidence-based programs; 4) cost and feasibility of implementing various evidence-based programs relative to population needs and anticipated cost-benefit expectation associated with program implementation; and 5) DCFS and sister agencies' previous experience in implementing and evaluating these interventions.

To gather data on existing capacity, the Steering Committee reviewed data from Illinois' Service Provider Identification & Exploration Resource (SPIDER). This publicly searchable tool contains resources beyond those contracted for by DCFS; it is meant to assist caseworkers and other professionals in identifying referrals for various types of human services offered to children and families. From this database, DCFS can also derive counts of certified staff by location who are available to deliver evidence-based programs. It should be noted, however, that the SPIDER data is limited and likely does not accurately reflect true counts statewide counts of trained staff or provider locations for some EBPs. Despite its limitations, the SPIDER data has been a helpful tool to gauge general statewide capacity of EBPs to inform the selection process.

Based on the SPIDER counts as of September 2019, there is a range of capacity of certified staff in many of the evidence-based programs proposed for implementation under this Family First Prevention Plan.

The information detailed in Table 2 represents the array of preventive programs that aligns with the needs of children and families involved with or at risk for becoming involved with Illinois' child welfare system. The rows highlighted in blue are the interventions that DCFS plans to claim through Family First at this time, while the other rows represent interventions that are part of the Department's overall prevention strategy that may be considered for inclusion in the IV-E prevention plan in the future.

Table 2: Overview of Illinois' Prevention Services Array

Service Type	Intervention	Target Population (in years)	Length of Service (LOS)	Already in use by DCFS (IUD), to be adopted (TBA), or in use by Sister Agency (IUS) [9]	# of Locations Offered Statewide (according to SPIDER)	IV-E Clearing-house Rating	Funding Source (Family First, Other Federal, or State)
Substance Use Disorders & Mental Health	Multisystemic Therapy (MST)	Youth age 12-17 with serious emotional/behavioral difficulties needs & their families	4-6 months	IUD	22	Well-Supported	Family First, Medicaid
	Seeking Safety	Adolescents with a trauma and/or substance abuse; Caregivers with a trauma and/or substance abuse	3-5 months	TBA	15	Does not currently meet criteria	State, Medicaid
Mental Health	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Children age 3-18; Caregivers of children age 3-18 with trauma or other emotional/behavioral difficulties	3-6 months	IUD	199	Promising	Family First, Medicaid
	Child-Parent Psychotherapy (CPP)	Children age 0-5 who have experienced trauma, and their caregivers	20 to 52 weeks	IUD	73	Promising	Family First
	Wraparound[10]	Children age 4-7 with severe emotional/behavioral difficulties and their families	Varies according to family's needs	IUD	Not listed	Not yet rated	State, Medicaid

[9] TBA: The Department will invest in the scaling up of local resources for training and implementation; IUD: DCFS POS agencies have already adopted these models at their own cost. The Department will incentivize expansion/ and utilization through preferred contract models; IUS: These are home Visiting approaches that are already in use throughout the state. Agencies that provide these services DHS & ISBE could seek IV-E funds through DCFS.

[10] Illinois providers are currently using two different models of Wraparound (High Fidelity Wraparound and a variation of the Wrap Milwaukee model)

Service Type	Intervention	Target Population (in years)	Length of Service (LOS)	Already in use by DCFS (IUD), to be adopted (TBA), or in use by Sister Agency (IUS) [9]	# of Locations Offered Statewide (according to SPIDER)	IV-E Clearing-house Rating	Funding Source (Family First, Other Federal, or State)
Parenting Skills	Healthy Families America (HFA)	Families with children age 0-2	60 months (or until the child is at least 3)	IUS	4	Well-Supported	Family First, MIECHV, State
	Parents as Teachers (PAT)	Families with children age 0-3	60 months	IUS	132	Well-Supported	Family First, MIECHV, State
	Positive Parenting Program (Triple P) – Standard Level 4	Caregivers of children from age 0-12 with moderate to severe emotional/behavioral difficulties	10 weeks[11]	TBA	Not listed	Promising	Family First, State
	Nurturing Parenting Program (NPP)	Families and children age 5-12	15 weeks	TBA	22	Does not currently meet criteria	State
Engagement/ Casework practice	Motivational Interviewing (MI)	Caregivers and youth[12]	2 or more sessions, as needed throughout a case	TBA	118	Well-Supported	Family First, State
	Solution-Based Casework (SBC)	Caregivers and youth	Varies according to duration of the family's case	IUD	3	Not Yet Rated	State

[11] Based on Level 4 standard intervention. Levels 1-3 are typically of shorter duration. For any level, if accommodations are needed (e.g., low literacy clients), the duration may be longer.

[12] Illinois DCFS is currently investing in Motivational Interviewing (MI) as a casework practice and client engagement strategy for all involved families.

Rationale for Family First Intervention Selection

Multisystemic Therapy (MST) is a treatment that offers therapy and other needed services to youth and their families. The treatment targets youth ages 12-17 with substance abuse issues or emotional/behavioral difficulties who are experiencing antisocial and delinquent behaviors. MST includes in-home intensive services at least once per week (up to daily) with clinical services available to youth and their family 24 hours a day. Currently, the intervention is in limited use with Intact families. Illinois now proposes to use MST with youth across the candidacy subgroups who are not Medicaid eligible.

While the SPIDER database suggests that there are 22 locations in which MST is offered and 23 certified staff, we are aware of other state agencies (e.g. Illinois Department of Juvenile Justice, Circuit Court of Cook County) that have additional contracted providers for MST service delivery. DCFS will continue to ensure that contracted providers utilize the manual referenced on the IV-E Prevention Services Clearinghouse (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).

Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapeutic treatment that engages children and parents/caregivers together to treat the effects of trauma. The treatment targets families with children ages 3-18 and specifically uses cognitive-behavioral approaches to reduce symptoms of PTSD, anxiety, and depression in children while improving parent-child communication and attachment. The program consists of eight essential components that teach youth how to cope with past trauma using a trauma narrative that addresses feelings of shame, distorted beliefs about self, and other sequelae of trauma. Parents of target youth also receive therapy to address parental stress related to trauma and to minimize harmful parenting practices.

Illinois proposes to use TF-CBT with non-Medicaid families with histories of traumatic stress across the candidacy subgroups. Illinois has substantial capacity to deliver TF-CBT, with 199 locations offering the treatment and 254 certified staff. DCFS plans to ensure that DCFS' contracted providers will utilize the manual referenced on the IV-E Prevention Services Clearinghouse (Cohen, Mannarino, & Deblinger, 2006).

Child-Parent Psychotherapy (CPP) is an in-home intervention for trauma-exposed children who are 0-5 years old. Typically, the child is seen with his or her primary caregiver; the intervention aims to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other, and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect. DCFS plans to expand the use of CPP based on its earlier implementation during the Illinois Birth-to-

Three (IB3) IV-E Waiver. DCFS will continue to ensure that contracted providers utilize the manual referenced on the IV-E Prevention Services Clearinghouse (Lieberman, Ghosh Ippen, & Van Horn, 2015).

Healthy Families America (HFA) is an intensive, long-term home-visiting program tailored to families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA's services begin in pregnancy and are intended to support new parents through the first 3-5 years. Program participation is optional and relatively intensive (Illinois Department of Human Services, 2017). During pregnancy and for a minimum of six months after the baby is born, weekly home visits are recommended. Home visits are 50-60 minutes in length, on average. Home visitors may meet with families more than 1x per week, depending on nature of the risks, crises, etc. The frequency of home visits decreases over time, depending on the age of the child and needs of the mother and family.

HFA is currently funded through MIECHV as well as through several state programs. DCFS is planning to use IV-E funding to ensure appropriate capacity of these services to support the proposed candidate subgroups. HFA will be targeted to young pregnant and parenting youth in care, aged 13-21, and pregnant women and new parents with target children that are younger than 24 months at enrollment who are receiving Intact Family Services, with a priority focus on parents of children less than 6 months old. In Illinois, there are 31 providers utilizing this approach with capacity in FY19 to serve approximately 1,900 families. The Department plans to work with DHS to expand this capacity to ensure provision to IV-E candidate children. DCFS and DHS will continue to ensure that contracted providers utilize the manual referenced on the IV-E Prevention Services Clearinghouse and available on the HFA website (Healthy Families America, 2018a; Healthy Families America, 2018b).

In Illinois, HFA providers must be accredited HFA affiliates. Most, if not all, use the Signature HFA model. A few providers have also been approved to use the HFA child welfare protocol with families referred by the child welfare system. Services delivered under the HFA child welfare protocol to child welfare system-involved families are the same as the services delivered to other families. The only requirement that is different with the child welfare protocol is that it allows families referred by the child welfare system to be enrolled up before the target child is 24 months old (Healthy Families America, 2018).

All HFA providers in Illinois, including those using the Child Welfare Protocol, are expected to adhere to HFA best practice standards (Healthy Families America, 2017). HFA Best Practice Standard 1-3.B is to begin to serve at least 80% of families prenatally or within the first three months after the target child's birth. This means that up to 20% of families can begin to receive services more than three months after birth. Additionally, the HFA model was originally designed for families with children ages zero to five and staff are trained to serve families with children covering this age range. The minimum length of service delivery for HFA is three years, and families can be served for at least three years as long as the target child is less than 24 months old when the family enrolls.

Parents as Teachers **(PAT)** provides parents with child development knowledge and parenting support and conducts early detection of developmental delays and health issues. Features of the program include: one-on-one home visits, monthly group meetings, developmental screenings, and linkages and connections for families to needed resources. With the aim of preventing child abuse and neglect, and increasing children's school readiness, parent educators conduct the home visits using structured visit plans and guided planning tools. Visits can be conducted in home or at community agencies. Local sister agency sites offer at least 12, hour-long home visits annually with more offered to higher-need families. PAT serves families for at least two years between pregnancy and kindergarten.

Similar to HFA, PAT is primarily currently funded through the Illinois State Board of Education (ISBE). DCFS is planning to use IV-E funding to ensure appropriate capacity of these services to support the proposed candidate subgroups. This intervention will be targeted to young pregnant and parenting women in care, aged 13-21, and pregnant and new parents with target children that are up to 3 years old who are receiving Intact Family Services, with a priority focus on parents of children less than 6 months old. In Illinois, there are 132 locations in which PAT is offered, and 157 staff who are certified to deliver the intervention using the Foundational curriculum (Parents as Teachers National Center, 2016). DCFS and its sister agency (ISBE) will continue to ensure that all contracted providers utilize this curriculum. In addition, ISBE requires all home visiting programs implementing PAT to seek the PAT Quality Endorsement.

Motivational Interviewing (MI) is a client-centered counseling method that aims to develop the client's internal motivation to achieve behavioral change. It is often used in pre-treatment work to help engage and motivate clients for other treatment modalities as it helps clients explore and resolve their ambivalence to change. The evidence base for MI is strong in the areas of addictive and health behaviors for adolescents and adults, and also appears to improve outcomes in other domains when added to other treatment approaches (Hettema, Steele, & Miller, 2005).

DCFS is encouraging the Children's Bureau to take a broader look at MI as a beneficial practice to enhance the effects of other interventions by promoting client engagement and motivation. While its roots are grounded in substance abuse treatment, MI has emerged as a prominent case management tool in the field of child welfare beyond substance abuse. Research and evaluation to date have highlighted MI as an effective clinical application to help engage families and enhance their motivation to participate in services to change the range of behaviors that may contribute to child maltreatment (Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick 2008; Shah, Jeffries, Cheatham, Hasenbein, Creel, Nelson-Gardell, & White-Chapman, 2019; Miller & Rollnick; 2012).

Recognizing the challenges of service utilization and ongoing engagement in previous implementations of EBPs (Illinois Birth to Three Waiver, 2018; Weiner & Cull, 2019), DCFS will invest in MI by training all associated caseworkers that interact with the Family First candidate subgroups. In addition, DCFS has committed to fully funding the training of investigators and other staff roles in this intervention

with the aim to increase the number of families who participate in voluntary services to prevent child removal. By training workers across the Department in MI, we also anticipate enhanced partnering and collaborative decision-making with families to ensure appropriate service matching. MI's client-centered approach is expected to support and sustain family motivation toward progress, so each child and family is able to receive an appropriate dose and level of support and service to successful completion. Based on the individual needs of each candidate child, DCFS plans to employ Motivational Interviewing either as a standalone intervention to advance the goals of the prevention strategy or as an adjunctive intervention to improve the appropriate selection and fulfillment of other evidence-based practices in the child's plan.

Research has demonstrated MI's effectiveness in bringing about a wide range of behavior changes when used as a standalone intervention, including multiple studies suggesting its effectiveness in a child welfare setting. Additional findings bolster MI's effectiveness when paired with other interventions. Please refer to section 6 for a review of MI's effectiveness.

Although evidence-based, MI does not require a Master's degree, thus enabling a broad array of front line staff to be able to provide this service. DCFS plans to utilize the MI manual referenced on the IV-E Prevention Services Clearinghouse to guide implementation (Miller & Rollnick; 2012).

Positive Parenting Program (Triple P) aims to support parents of children experiencing developmental and behavior problems. The intervention provides parents with strategies to encourage self-regulation in children, including the development of a "parenting plan" that identifies parents' strengths and supports new parenting skills development. Triple P helps parents by growing their knowledge of child development, increasing their confidence in their own parenting ability, and teaching strategies for common child-raising stressors.

Triple P is comprised of five intervention levels of increasing intensity. Families can be offered only one level of the intervention, dependent upon the severity of their problems, or they can receive all five levels of the intervention. Among in-home parenting interventions, Illinois will use the standard Level 4 model for parent-focused education to support strengths and reduce risk factors for child development, as well as for children with emotional/behavioral needs across the targeted subgroups. The standard version of Level 4 has been rated as "promising" by the Title IV-E Clearinghouse. Contracted providers in Illinois will be using the manual and supporting curriculum referenced on the IV-E Prevention Services Clearinghouse to guide implementation (Sanders, Markie-Dadds, & Turner, 2013).

Interventions for Future Consideration

The next set of interventions are being considered for future amendments to Illinois' IV-E prevention plan. DCFS is continuing to invest in these programs and evaluate their results to produce evidence

that can support their favorable inclusion in the IV-E Clearinghouse by the Children's Bureau. Until such time, Illinois does not plan to claim Title IV-E reimbursement for these interventions.

Nurturing Parenting Program (NPP) is a curriculum-based psycho-educational and cognitive-behavioral group intervention with home coaching that seeks to modify maladaptive beliefs that contribute to abusive parenting behaviors and to enhance parents' skills in supporting attachments, nurturing, and general parenting (Nurturing Parenting Program, 2015). The program supports families in increasing parents' sense of self-worth, personal empowerment, empathy, bonding, and attachment; improving the use of alternative strategies to harsh and abusive disciplinary practices; increasing parents' knowledge of age-appropriate developmental expectations; and reducing abuse and neglect.

Similar to CPP, Illinois has a history of implementing NPP through its IB3 IV-E Waiver with a foster care population and is now initiating provider contracts to support prevention populations as well. During this expanded implementation, DCFS will commence a formal process and outcomes study to build the evidence for its effectiveness to encourage another systematic review by the IV-E Clearinghouse.

Seeking Safety (SS) is an integrated cognitive behavioral model designed to concurrently address symptoms of post-traumatic stress disorder and substance use through a single trained person with flexibility to treat other high-risk behaviors. Services are provided in various modalities (i.e., individual, group and family) and settings (e.g., outpatient, inpatient, residential, home care, schools). The intervention is provided in gender-specific sessions and targets families with children ages 0–3 and teens who are at-risk of being removed from the home as a direct or indirect result of the teen's or parent's substance use. Children ages 0–3 could be currently living with a relative due to a parent's substance use. Pregnant or parenting youth in foster care or out-of-home placement who are currently experiencing SUD will also be eligible. During this expanded implementation, DCFS will initiate a formal process and outcomes study to build the evidence for effectiveness of SS to encourage another systematic review by the IV-E Clearinghouse.

Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed.

DCFS currently implements Wraparound across several programs that serve youth in congregate care, hospitalization, or are dually-involved. In addition, DCFS is piloting more expansive use of Wraparound as a care coordination practice in the immersion site regions. Each of these Wraparound implementations are currently being evaluated. Existing variation of the specific Wraparound models (e.g., High Fidelity Wraparound, Wraparound Milwaukee adaptation) across these programs and sites will require further planning and alignment as the Department considers scaling up this intervention.

Solution-Based Casework (SBC) is an approach to casework that emphasizes care for the family and prompts the caseworker to help families identify and leverage their strengths to achieve goals (Christensen, Todahl, & Barrett, 1999). SBC is typically used for family problems that range from substance abuse and neglect to stress and work issues. Families observe everyday events and activities that create obstacles in goal achievement are able to clearly identify their needs for preventing difficulties.

The SBC approach is targeted at families with children ages 0-17. The recommended dosage of SBC varies widely based on family needs and is delivered across a range of settings such as adoptive family homes, community agencies, hospitals, and schools. Although the IV-E Clearinghouse recently rated SBC as "Does not currently meet criteria," it maintains a rating of promising by the CEBC. Studies of SBC are mostly retrospective case reviews, scientifically limited by selection bias and non-randomization. However, all studies concluded that SBC is associated with lower recidivism and positive safety, permanency, and well-being outcomes (Antle, Barbee, Christensen, & Martin, 2008; Antle, Christensen, van Zyl, & Barbee, 2012).

Like Motivational Interviewing (MI), the Department will leverage SBC to enhance clinical practice. Currently, SBC is successfully implemented within two large agencies with multiple locations across the state. The Department has plans to incentivize other agencies to implement this casework intervention for purchase of service (POS) private agency workers. However, unlike MI, the Department does not have plans to train 100% of the workforce in this intervention.

Please see Appendix D for a map reflecting the new FY21 contracted provider capacity for CPP, MST, NPP, TF-CBT, Triple P (data reflecting Healthy Families America, Parents as Teachers, Seeking Safety, Motivational Interviewing, Solutions Based Casework, and Wraparound is not available at this time). It should be noted that this map does not reflect existing provider capacity prior to FY21 that may also be utilized.

Trauma-Informed Service Delivery

All of the evidence-based interventions that Illinois plans to implement under Family First will be administered within a trauma-informed framework. In recent years, DCFS has also sought to expand its trauma training programs for these agencies. In 2013, the Department began a Trauma Credentialing program that aimed to research training and certification criteria for evidence-based, trauma-informed

treatments. The program subsequently began gathering proof of training and certification among Illinois mental health treatment providers. In addition to information gathering, a workgroup including DCFS, university partners, and private providers developed a curriculum designed to improve basic knowledge in trauma-informed assessment, treatment planning, cultural competency, self-care/vicarious trauma, and other areas. Future goals include dissemination of information to the field via the Service Provider Identification and Exploration Resource (SPIDER) and aiding referral to properly trained providers. Information concerning the availability of trauma-informed evidence-based practices will also be used to identify service gaps and develop new capacity.

The Department has had a long-standing commitment to a trauma-informed practice and providing training for its caseworkers and investigators (Illinois Department of Children & Family Services, 2007). The Office of Learning and Professional Development has infused trauma-informed training content into the foundation of pre-service and in-service trainings for investigators, DCFS caseworkers, and Purchase of Service (POS) private agency caseworkers. This focus on trauma-informed care was further enriched recently with the launch of the Family-Centered, Trauma-Informed and Strength-Based (FTS) training as part of the rollout of the Department's new core practice model. The FTS is a cornerstone training that provides education about the impact of trauma on the child and family and teaches skills to ensure that worker engagement, advocacy, assessment, and service planning are aligned to these needs.

As Illinois moves forward with its expansion of prevention services in FY20, all service providers will now be contractually required to participate in a trauma-informed care learning community. This training curriculum will be discussed further in Section 7.

The State is committed to expanding the capacity of the Department, its sister agencies, and the wider provider community to deliver services within a trauma-informed approach. Please see Appendix H for assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma informed organizational structure and treatment framework.

Implementation Approach

As discussed previously, the Department, in collaboration with sister agencies, will implement the vision for prevention and support FFPSA implementation by expanding capacity through existing contracted providers to scale up EBPs. To complement existing capacity, the State will also initiate contracts with several new providers across the state. This procurement process is underway and set to be complete by July 2020.

As the Single State Agency for the federal Title IV-E program, DCFS processes all eligible IV-E claiming for reimbursement. DCFS currently maintains a state appropriation for the purpose of allowing the pass through of funds from the Title IV-E program to public entities for eligible services. An Interagency Agreement will need to be developed with each public agency interested in participating in the Title IV-E Prevention claiming. This agreement will outline each entity's responsibility and

liability. Since IV-E operates as an open-ended entitlement grant, claiming requires that qualifying services as outlined in the State's IV-E plan and provided to a qualified individual within the defined prevention candidacy population may be partially reimbursed at approximately 50% (less administrative processing fees).

These agreements will be particularly important for provisioning home visiting services (i.e., Healthy Families America and Parents as Teachers). DCFS will administer these home visiting programs through existing early childhood programming. The DCFS Early Childhood team currently links families to established networks within the Department of Human Services and the Illinois State Board of Education. Prevention casework staff in Intact Family Services (including Intact Family Recovery programs), will be offered the support of the home visiting specialists as a part of the Erikson Institute DCFS Early Childhood Project. Please see Appendix A for more information on this partnership.

DCFS and sister agencies have ongoing discussions to plan and prepare the State's information systems to be able to reliably accommodate the Plan's candidacy tracking, child-level plan development, referral processes, service utilization, and claiming. Executive leadership from the Department's information technology, finance, and contracting offices are represented on the Steering Committee and other supporting workgroups to direct the operationalization of these areas.

After initial implementation of this five-year plan, DCFS will continue to conduct analyses comparing service capacity and the needs of the target subgroups presented. The Steering Committee and its associated workgroups will continue to review data on service availability, gaps, and community readiness to determine geographic areas for service expansion across the state. Throughout the initial five-year plan period, Illinois will expand contracts or issue new RFPs to continually expand service capacity. This phased approach to service expansion will allow time for the opportunity to respond to learnings from the initial implementation period before further scaling up occurs.

To monitor implementation fidelity, DCFS will use its existing infrastructure of continuous quality improvement (CQI) processes, research staff, contract monitoring staff, purveyors, trainers, and relationships with external evaluation and implementation support partners to engage DCFS staff and providers in a standardized quality assurance process. For more on this subject, please refer to Section 6: Evaluation Strategy and Waiver Request Evaluation.

Given that the State's prevention plan relies heavily on cross-system collaboration, DCFS will continue to communicate and coordinate with its sister agencies, the wider provider community, and other stakeholders to ensure the implementation's success. The Department will develop internal resources as well as those contributed through members of the Human Services Partnership Committee, the Early Learning Council and its Home Visiting Taskforce, and other cross-sector bodies to provide training and educational opportunities for various audiences (courts, providers, Family Advocacy Centers, etc.).

Section 4: Child Specific Prevention Plan

The development and monitoring of child-specific prevention plans for the children in the target populations (Intact Family Services; Intact Family Recovery; Extended Family Support program; recent reunifications; youth in post-adoption or guardianship with calls to the post-adoption hotline; and pregnant and parenting youth in care and those who recently opted out of care who are 18-21) will require a tailored approach and multiple process adjustments. Illinois DCFS has worked to identify areas for improvement in serving children and families across its programs through the Program Improvement Plan (PIP) and Child and Family Services Plan, and we intend to build upon these efforts through the delivery of FFPSA prevention services.

Table 3 below provides details on the staff roles by eligible subgroup that are responsible for each phase in the planning process.

Table 3: Responsibility for Eligibility Determination, Assessment, and Prevention Planning

Target Subpopulation	Staff Determining Eligibility and/or Providing Assessment[13]	Staff Responsible for Developing or Updating Prevention Plan
Children and family members referred to **Intact Family Services**	Intact Family Services Worker	Intact Family Services Worker
Children and family members eligible for **Intact Family Recovery** (i.e. substance-exposed infants; children with family members who have substance use disorder)	Intact Family Services Worker and Substance Use Worker	Intact Family Services Worker
Children and family members participating in supports in the **Extended Family Support program** (kinship navigator program)	Extended Family Support Worker	Extended Family Support Worker
Children who have exited care through **reunification** in past 6 months, and may be at-risk of re-entry	Permanency Worker	Permanency Worker
Children who have exited care through **adoption or guardianship** and may be at-risk of re-entry	Post-Adoption Worker	Community Provider, with approval and monitoring by Post-Adoption Worker
Pregnant or parenting youth currently in care or who have exited care through age 21	Permanency Worker or TPSN Specialty Parenting Workers	Permanency Worker

[13] For simplicity, some specialized assessment required to evaluate for certain needs are not represented here. For instance, for Intact and PPY subgroups in need of post-natal or early childhood developmental assessment, the caseworker will rely on the DCFS/Erikson Developmental/Infant Mental Health Specialists.

Eligibility Determination and Assessment for IV-E Prevention Services

To ensure that workers correctly identify children who are at imminent risk for foster care, plan protocols will be developed for each subgroup to help guide staff through the eligibility, assessment, prevention planning, and referral processes. DCFS plans to leverage the current assessment processes for each of the target populations. Some modifications will also be made for certain programs (i.e., Extended Family Support and Post-Adoption) to further enhance the assessment and referral processes.

Several different types of screens and assessments that are performed by investigators or assigned workers at initial intake or ongoing monitoring will inform the eligibility determination process. The core suite of tools to determine eligibility will include the Child Endangerment Risk Assessment Protocol (CERAP) safety assessment and the Child and Adolescent Needs & Strengths (CANS). The CERAP is a household-based assessment focused on the characteristics and behaviors of the caregivers and children living in that household. By completing the CERAP at intake and at subsequent milestones, the worker obtains an objective appraisal of the potential future risk to a child. The CANS is a comprehensive service planning tool that identifies caregivers or child needs and strengths to engaging in services and areas of focus for clinical and non-clinical interventions. It is formally assessed at case opening, closing, and at every 6-months in between.

In some cases, other instruments or forms may also be employed, including: Significant Event Reports, Certificate of Child Health Examinations, Adolescent Alcohol and Other Drug Abuse (AODA) forms, Paramour Assessment Checklists, New Birth Assessments,[14] and Integrated Assessments. The specific criteria within these tools will look to identify the following types of concerns:

- Families with an identified risk of harm
- Families in unsafe living conditions
- Families with complex psychological and/or behavioral needs
- Families experiencing a substance use disorder
- Families with complex medical needs
- Victims of trafficking
- Informal kinship living arrangement

In addition to the at-risk subgroups, pregnant and parenting youth in care or who have recently exited will be uniquely eligible, and thus all will be assessed to support their healthy parenting and any behavioral health needs they may have. The Family First Prevention Capacity Workgroup and other supporting subgroups are currently working to map the specific risk criteria within each instrument or form to further operationalize the assessment process and recommendations for specific interventions.

[14] The New Birth Assessment (NBA) refers to a battery of assessments, including The NBA includes the Child and Adolescent Needs and Strengths Assessment (CANS), the Adolescent-Adult Parenting Inventory (AAPI), the Edinburgh Post Natal Depression Scale (EPDS), the Ages and Stages Questionnaire (ASQ), interviews with the worker and the new parent as well as observation of parent/child interaction and ensures completion of the 6-week post-natal check-up.

Worker populations that will be responsible for completing a prevention plan will be trained in understanding assessment results to inform an eligibility determination as well as appropriate evidence-based interventions.

Prevention Planning

DCFS is currently developing functionality to integrate the prevention planning process into SACWIS and other adjacent information systems. These capabilities will enable workers to review comprehensive assessment results while developing the plan so that they can refer to and draw this information when determining eligibility, developing the prevention strategy, and selecting appropriate services. The enhancements will also ensure that the Family First prevention plan aligns with larger case and service planning efforts. DCFS is currently exploring technological capacity for sister agencies and attached service providers to be allowed access to the prevention plan created with the family to ensure all roles understand the identified service needs to prevent placement.

To initiate a prevention plan, the caseworker and supervisor will make the clinical decision as to whether IV-E prevention services are the appropriate course of action for a child/family based on a review of available assessment criteria. Subsequently, the family or child, in consultation with the caseworker, will identify what service needs the family or child are willing and able to focus on to mitigate the risk of future maltreatment and strengthen parenting capacity to prevent foster care placement. These discussions will take into account and resolve barriers to receiving appropriate and needed services.

Each child will have a documented prevention plan that includes specific goals with measurable action steps, individualized interventions and activities, short achievement dates, and task owners. These plans will be written at a development level the child and family can understand.

Service Referral, Linkage and Monitoring

Linkage to available evidence-based interventions will occur after approval of the service plan with the family and the worker's supervisor. The referral process will be supported in part by leveraging the Service Provider Identification and Exploration Resource (SPIDER), a publicly available, web-based human service provider locator. Evidence-based practices supported by Illinois' FFPSA approved plan will be listed in the database to improve knowledge of availability. For some services types (i.e., home visiting services) with centralized intake processes, workers may have to work through dedicated intermediaries to be able to be referred to a specific provider. Referrals and linkages will be monitored by their respective caseworker. Recurring check-ins with the child and/or family as well as the provider will ensure ongoing engagement, retention, and appropriateness of services. Child and family team meetings (CFTMs) that occur no less than on a quarterly basis (with the exception of families at the point of post-adoption) will be another forum to discuss progress and re-evaluate services.

Section 5: Monitoring Child Safety

During the provision of Family First services, DCFS will ensure that each child receives an accurate assessment of risk on an ongoing basis by leveraging the current assessment processes for each of the target populations. Ongoing monitoring will be accomplished through one or both of the following mechanisms: (1) formal risk assessment through completion of the Child Endangerment Risk Assessment Protocol (CERAP) safety assessment, Home Safety Checklist, Child and Adolescent Needs & Strengths (CANS), or other applicable assessment by an attached worker or clinician on no less than a quarterly basis; or (2) informal risk assessment on an ongoing basis, for example though face-to-face conversations and observations of the family dynamics and/or the home while considering information from other sources, such as school and medical staff, therapists, etc.
Each unique program serving these subgroups implements different levels of familial contact based upon the risk and family's level of need. During all family and child contact, caseworkers or attached clinicians are continuously assessing new safety issues and unaddressed risk factors, progress toward reducing ongoing safety issues or risk factors, progress toward meeting case objectives and service receipt, and barriers to progress in improving child safety or reducing risk factors upon review of service. Data from Intact offers some insight on how often workers detect risk concerns in the in-home population. Using CERAP, workers detected changes in safety that prompt CERAP administrations in 8-10% of cases in FY19, particularly for safety threats regarding the mental health and/or substance abuse issues of a paramour who may come and go from the home (Fuller, Wakita, Chiu, Nieto, & Lee, 2019).

Please refer to the Table 4 for the list of staff roles responsible for assessing risk as well as the associated tools and timeframes for administering.

Table 4: Responsibility for Risk and Safety Monitoring and Supporting Protocols

Target Subpopulation	Staff Responsible for Monitoring Risk and Safety	Monitoring Tools/Protocols and Timeframes for Administering Them
Children and family members referred to **Intact Family Services**	Intact Family Services Worker	CERAP, Home Safety Checklist: no less than every 90 days[15] CANS, SACWIS Risk Assessment: no less than every 180 days
Children and family members eligible for **Intact Family Recovery** (i.e. substance-exposed infants; children with family members who have substance use disorder)	Intact Family Services Worker and Substance Use Worker	CERAP, Home Safety Checklist: no less than every 90 days[16] CANS, SACWIS Risk Assessment: no less than every 180 days
Children and family members participating in supports in the **Extended Family Support program**	Extended Family Support Worker	CERAP: no less than every 90 days
Children who have exited care through **reunification** in past 6 months, and may be at-risk of re-entry	Permanency Worker	CERAP, Home Safety Checklist: no less than every 90 days CANS, SACWIS Risk Assessment: no less than every 180 days
Children who have exited care through **adoption or guardianship** and may be at-risk of re-entry	Community Provider, Statewide Program Monitor	Informal safety assessments performed by the provider every 90 days and submitted to the Post-Adoption Unit for review and monitoring
Pregnant or parenting youth currently in care or who have exited care through age 21	Permanency Worker and TPSN Specialty Parenting Workers	CERAP, Home Safety Checklist: no less than every 90 days CANS, SACWIS Risk Assessment: no less than every 180 days

Section 6: Evaluation Strategy and Waiver Request

Theory of Change

DCFS' vision statement for Family First aims for "communities strengthening families to ensure every child is safe, healthy and productive at home and in school." DCFS used a series of "so that" chains as recommended by the Annie E. Casey Foundation to articulate a theory of change clarifying the relationship between planned activities and outcomes and that is consistent with this vision (Annie E. Casey Foundation, 2004). Specifically, DCFS hopes to leverage FFPSA funding to:

[15] For higher risk levels, Intact Family Recovery cases receive more frequent levels of face-to-face contact and administration of the CERAP.
[16] For higher risk levels, Intact Family Recovery cases receive more frequent levels of face-to-face contact and administration of the CERAP.

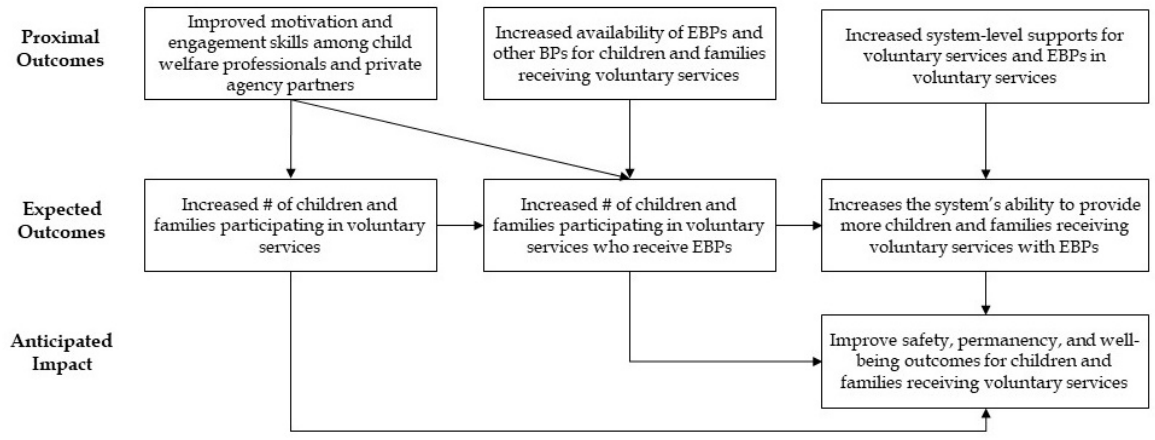
- Improve motivation and engagement skills among child welfare professionals in DCFS and its network of private providers *so that*
- More families with children at-risk for entering care participate in voluntary services *so that*
- More families with children at-risk for entering care can benefit from evidence-based and other best practices.

- Increase the array of evidence-based and other best practices available to families with children participating in voluntary services *so that*
- More families with children at-risk for entering care can benefit from evidence-based and other best practices *so that*
- Every child at-risk for entering care can be safe, healthy and productive at home and in school.

- Increase system-level supports for family-focused, trauma-informed, and strengths-based care *so that the*
- Families with children participating in voluntary services are better served by the child welfare system *so that*
- Safety, permanency and well-being outcomes for children and families improve.

Figure 6 depicts the hypothesized causal relationship between activities, expected outcomes, and anticipated impact underlying DCFS' theory of change.

Figure 6: Theory of Change



Evaluation Waiver Request for Well-Supported Interventions

The requirement for a formal evaluation may be waived if the intervention has been rated by the Title IV-E Clearinghouse as well-supported, there is compelling evidence in support of the effectiveness of the intervention, and CQI requirements are met. DCFS is requesting an evaluation waiver for four

interventions that were rated well-supported by the Title IV-E Clearinghouse: Motivational Interviewing (MI), Healthy Families America (HFA), Parents as Teachers (PAT), and Multisystemic Therapy (MST). There is compelling evidence in support of the effectiveness of each intervention. CQI plans are aligned to the extent possible across interventions and include activities to monitor fidelity to the models and use the results of that monitoring to improve practice and measure the outcomes that are achieved.

Motivational Interviewing (MI) was rated well-supported by the Title IV-E Clearinghouse. Compelling evidence in support of MI's effectiveness comes from existing literature demonstrating that (a) MI is an effective treatment or adjunctive treatment for a wide range of health behaviors and conditions in diverse patient populations, (b) existing child welfare-specific curated literature reviews, and (c) existing child welfare-specific literature reviews published after those curated reviews were last updated.

(a) In regards to compelling evidence in support of MI as an effective treatment or adjunctive treatment for a wide range of health behaviors and conditions in diverse patient populations, the primary literature is so large that reviewing it is beyond the scope of preparing the prevention plan document. However, existing systematic reviews provide compelling evidence that MI is an effective treatment or adjunctive treatment for a wide range of health behaviors/conditions in diverse patient populations. Cochrane Reviews are widely regarded as the most rigorous literature reviews. A keyword search in the Cochrane Database of Systematic Reviews for "motivational interviewing" shows that MI was the focus of or an adjunctive treatment included in more than 30 Cochrane Reviews including 5,833 trials of interventions for a number of health behaviors and conditions in diverse patient populations (Cochrane Database of Systematic Review, 2020). These reviews include reviews of MI's effectiveness as a treatment or adjunctive treatment for substance use disorders (Foxcroft et al., 2016; Smedslund et al., 2011), smoking cessation (Lindson et al., 2019), and improving outcomes for youth living with HIV (Mguagbaw et al., 2012), among many others. Non-Cochrane reviews of the evidence in support of MI as an effective treatment or adjunctive treatment for a wide range of health behaviors and conditions in diverse patient populations. These reviews include evidence in support of MI's effectiveness as a treatment or adjunctive treatment for alcohol use (Tanner-Smith & Lipsey, 2015; Vasilaki et al., 2006), smoking (Heckman et al., 2010; Lindson-Hawley et al., 2015), oral health maintenance (Kay et al., 2018), Type II diabetes management (Song et al., 2014), and weight loss (Suire et al., 2020), among many others. Taken together, evidence from existing reviews demonstrates compelling evidence in support of the effectiveness of MI for many different health behaviors and conditions in diverse patient populations.

(b) Existing curated sources of information about MI's effectiveness within child welfare more specifically, the Title IV-E Clearinghouse and the California Evidence-based Clearinghouse, have both rated MI as well-supported. The Title IV-E Clearinghouse rated MI as a well-supported substance use intervention. Its review of MI identified 206 studies, of which 75 were eligible for review (13 were rated High quality, 8 were rated Moderate quality, 9 were rated

Low quality, and 45 were reviewed for risk of harm only). Fifteen studies including 109 findings were included in its Adult well-being: Parent/caregiver substance use outcome review. Of the 109 findings, 16 showed Favorable effects, 91 showed No Effect, and 2 showed Unfavorable effects. The CEBC rated MI as a well-supported adult substance abuse treatment and as a well-supported motivation and engagement program. The CEBC review cites several meta-analyses on the effects of MI (Burke et al., 2003; Hettema et al., 2005; Vasilaki et al., 2006; and Lundahl et al., 2010).

Lundahl et al. (2010) is the most recent of these existing reviews. In this review, the authors specifically examined evidence in support of MI for three outcomes related to client motivation and found that MI has a small but statistically significant effect on client engagement and intention to change, but no effect on client confidence/ability to change (Table 5).

Table 5: MI for Client Motivation Outcomes (adapted from Lundahl et al., 2010)

Variable	k	Effect Size	CI	Z Value / p Value
Engagement	34	0.26	0.15/0.37	4.78/0.001
Strong comparison	14	0.12	0.00/0.25	1.94/0.053, ns
Weak comparison	20	0.35	0.21/0.50	4.80/0.000
Intention to change	23	0.24	0.13/0.34	4.35/0.001
Strong comparison	6	0.23	-0.09/0.55	1.40/0.161, ns
Weak comparison	17	0.24	0.13/0.35	4.15/0.000
Confidence/ability	11	0.18	-0.06/0.42	1.44/0.149, ns
Strong comparison	2	0.33	-0.08/0.74	1.50/0.114, ns
Weak comparison	9	0.15	-0.13/0.43	1.07/0.286, ns

(c) Since information in the Title IV-E and CEBC curations were last updated, more recent reviews have also been published. The most recent appears to be the review published by Hall et al. (2020). Nineteen studies met criteria for inclusion in the review. Of those 19 studies, 8 studies provided information about the acquisition of MI by child welfare employees or social work students through training and education and 11 studies examined the effectiveness of MI on child welfare outcomes.

Regarding the 8 studies of the acquisition of MI by child welfare employees or trainees, the authors conclude that trainees generally described MI favorably (Maxwell et al, 2012; Scourfield et al., 2012; Snyder et al., 2012) and that some studies showed training increased worker empathy (Forrester et al., 2008) and self-efficacy (Forrester et al., 2008). Recurring training, training with ongoing coaching, and training with booster sessions was more likely to result in

skill acquisition than a one-off training (Pecunkonis et al., 2016). This has implications for Illinois' training plan.

Regarding the 11 effectiveness studies, 3 of the 5 studies examining MI as a stand-alone treatment (Carroll et al., 2001; Forrester et al., 2008; and Forrester et al., 2012) and all 6 of the studies examining MI adjunctive to other treatments (Chaffin et al., 2009; Chaffin et al., 2011; Schaefer et al., 2013; Runyon et al., 2009; and Porter and Howe, 2008) reported results in favor of MI.

Three of the 5 studies examining MI as a stand-alone treatment reported results in favor of MI (Carroll et al., 2001; Forrester et al., 2008; and Forrester et al., 2012) Carroll et al. (2001) examined substance use treatment uptake among a sample of parents in child welfare who had been referred for substance use evaluations. Participants randomly assigned to receive the MI-informed evaluation were significantly more likely to attend a subsequent treatment session than those randomized to receive a standard evaluation. Forrester et al. (2008) compared outcomes for families referred to and receiving an intensive family preservation program based on MI and solution-focused principles to those of families who were referred but did not receive the program due to limited program capacity. Although the two groups were equally likely to enter out-of-home care, those who received the MI-informed treatment had shorter lengths of stay, lower costs, and were more likely to remain with their parents at case closure. Forrester et al. (2012) conducted a second evaluation of the same intensive family preservation program and found that program participants were less likely to enter out-of-home care.

All 6 of the studies evaluating MI adjunctive to other treatments reported results in favor of MI (Chaffin et al., 2009; Chaffin et al., 2011; Schaefer et al., 2013; Runyon et al., 2009; and Porter and Howe, 2008). It is important to note that the Schaefer et al. (2013) study used two different research designs for two different outcomes and the 1 paper was therefore counted as 2 studies. Two studies examined MI adjunctive to Parent-Child Interaction Therapy (Chaffin et al., 2009; Chaffin et al., 2011), 2 studies examined MI adjunctive to MST (these two studies are included in one publication by Schaeffer et al., 2013 that presented results based on two different research designs for each of two different outcomes, thus it is counted as 2 different studies even though it is only 1 publication), 1 study examined MI adjunctive to Combined Parent-Child Cognitive-Behavioral Therapy (Runyon et al., 2009), and 1 study examined MI adjunctive to the Parents Raising Safe Kids program (Porter and Howe, 2008).

Importantly, these studies provide compelling support for MI in child welfare generally and for Illinois' specific plan to use MI adjunctive to other EBPs more specifically. Schaeffer et al. (2013) provides direct support for Illinois' plan to use MI adjunctive to MST. Other studies provide indirect support for Illinois' plan to use MI adjunctive to interventions with some of the same treatment elements. For example, the Parents Raising Safe Kids program includes home visits that share characteristics with HFA and PAT (Porter and Howe, 2008), PCIT includes similar treatment elements as CPP (Chaffin et al., 2009; Chaffin et al., 2011), and Combined Parent-

Child Cognitive-Behavioral Therapy includes similar treatment elements to CPP and TF-CBT (Runyon et al., 2009).

Healthy Families America (HFA) was rated "well-supported" by the Title IV-E Prevention Services Clearinghouse because two studies found favorable effects on child safety (Duggan et al., 2004; Mitchell-Herzfeld et al., 2005), two found favorable effects on children's behavioral and emotional functioning (Caldera et al., 2007; Duggan et al., 2005), one found favorable effects on children's cognitive functioning (Caldera et al., 2007), one found favorable effects on positive parenting practices (DuMont et al., 2008), three found favorable effects on parent/caregiver mental or emotional health (Duggan et al., 2004; Duggan et al., 2007; McFarlane et al., 2013), and one found favorable effects on family functioning (Bair-Merritt et al., 2010). The CEBC determined that HFA is well-supported by research evidence as a home visiting programs for child well-being. The Home Visiting Evidence of Effectiveness (HomVEE) review, which was funded by the U.S. Department of Health and Human Services, identified HFA as meeting the criteria established by HHS for an "evidence-based early childhood home visiting service delivery model." Five moderate to high quality impact studies were found to favorable effects oncome Positive Parenting Practices (Duggan et al., 1999; LeCroy & Krysik, 2011; Caldera et al., 2007; Duggan et al., 2007; Green et al., 2014) and six were found to have favorable effects on Reductions In Child Maltreatment (Duggan et al., 2004; Duggan et al., 2007; Dumont et al., 2008; Dumont et al., 2010; Green et al., 2017; Landsverk et al., 2002).

Additionally, in September 2018, Healthy Families America rolled out an optional child welfare protocol. Programs that choose to implement the protocol can enroll families referred by the child welfare system up until the target child is 24 months old rather than 3 months old (Healthy Families America, 2018). HFA created the protocol so that fewer high-risk families would be ineligible for intensive home visiting services due to their target child's age. Services delivered under the child welfare protocol to child welfare system-involved families are identical to the services delivered to other families. The only difference is that families referred by the child welfare system can be enrolled up until the target child is 24 months old.

Enrolling families up until the target child is 2 years old is not a deviation from standard practice. HFA Best Practice Standard 1-3.B is to begin to serve at least 80% of families prenatally or within the first three months after birth. This means that HFA providers can begin to service up to 20% of families more than three months after the target child's birth and still meet Best Practice Standard 1.3B. Although no evaluation of HFA to date has focused exclusively on families enrolled under the child welfare protocol, Easterbrooks and colleagues reported that the mean age of the target child at enrollment in their evaluation of Healthy Families Massachusetts was 2.83 months old, with a standard deviation of 3.51 (Easterbrooks, Kotake & Fauth, 2019). This means that a good number of families were enrolled when the target child was older than 3 months. Additionally, the HFA model was originally designed for families with children ages zero to five, and staff are trained to serve families with children covering this age range. The minimum length of service delivery for HFA is three years, and families can be served for at least three years as long as the target child is less than 24 months old

when the family enrolls.

Under Family First, the Department seeks to expand the delivery of home visiting services to pregnant and parenting youth currently or formerly in care and to families receiving placement prevention services in which the mother is pregnant or at least one child is 0 to 23.9 months old (with priority given to families in which at least one child is under age 6 months). Expanding the delivery of home visiting evidence-based home visiting services to these groups will help the Department meet their needs for trauma-informed, strengths-based, and family-centered services that are designed to promote positive parent-child relationships and healthy attachment. Additionally, if the Department is limited to enrolling families in HFA prenatally or up until the target is 3 months old, very few families receiving placement prevention services will be eligible for this evidence-based intervention which has been shown to reduce the recurrence of maltreatment reports and increase the length of time between initial and subsequent reports of maltreatment among child welfare system-involved families (Easterbrooks et al., 2019). For HFA to be relevant to families with open-child welfare cases, the Department must be able to enroll these families until the target child is age 24 months.

Multisystemic Therapy (MST) was rated "well-supported" as a Mental Health Program and as a Substance Abuse Program by the Title IV-E Prevention Services Clearinghouse. MST "aims to promote pro-social behavior and reduce criminal activity, mental health symptomatology, out-of-home placements, and illicit substance use." Using personalized strategies to address the identified drivers of problematic behaviors, MST is available 24/7 and delivered for an average of three to five months, enabling timely crisis management and allowing families to choose times that work best for them. The target population for MST is youth, ages 12 to 17, and for the families of youth who are (1) at risk for or engaging in delinquent activity or substance misuse, (2) experiencing mental health issues, and (3) at risk for out-of-home placement.

According to the IV-E Clearinghouse, 10 studies in 33 publications were rated high (7 studies in 27 publications) or moderate (3 studies in 6 publications) on research design and execution.

- 2 studies represented in 2 publications reported favorable findings on at least one child permanency outcome (Henggeler et al., 2006; Vidal et al., 2017);

- 4 studies represented in 13 publications reported statistically significant favorable findings for at least one child well-being behavioral and emotional need outcome (Asscher et al., 2013; Asscher et al., 2014; Dekovic et al., 2012; Manders et al., 2013; Asscher et al., 2018; Jansen et al., 2013; Vermeulen et al., 2017; Weiss et al., 2013; Weiss et al., 2015; Fonagy et al., 2018; Fonagy et al., 2013; Ogden et al., 2006; Ogden et al., 2009; Ogden & Halliday-Boykins, 2004);

- 2 studies represented in 3 publications reported statistically significant favorable findings for at least one child well-being substance use outcome (Fonagy et al., 2013; Fonagy et al., 2018; Henggeler et al., 2006); and

- 6 studies represented in 24 publications reported statistically significant favorable findings for at least one child well-being delinquency outcome (Henggeler et al., 1997; Scherer et al., 1994; Asscher et al., 2013; Asscher et al., 2014; Dekovic et al., 2012; Manders et al., 2013; Asscher et al., 2018; Jansen et al., 2013; Vermeulen et al., 2017; Borduin et al., 1995; Henggeler et al., 1991; Sawyer & Borduin, 2011; Schaeffer & Borduin, 2005; Wagner et al., 2014; Johnides et al., 2017; Klietz et al., 2010; Dopp et al., 2014; Dopp et al., 2017; Borduin et al., 1990; Mann et al., 1990; Butler et al., 2011; Cary et al., 2013; Vidal et al., 2017; Henggeler et al., 1992; Henggeler et al., 1993).

Taken together, this body of evidence justifies implementing MST as an intervention to reduce out-of-home placement, improve behavioral and emotional functioning and reduce substance use among 12-17-year-olds in the target population. DCFS plans to contract with one private provider to deliver MST to 243 12-17 years old in the target population DCFS will require the provider to use *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), the MST version reviewed by the IV-E Clearinghouse.

CQI Strategy for Well-Supported Interventions

The CQI Strategy that will meet the continuous fidelity monitoring requirements under Family First is based on the Model for Improvement, a widely used framework for CQI that consists of three fundamental questions and the Plan-Do-Study-Act (PDSA) Cycle (Figure 7, adapted from Langley et al., 2009). This CQI model will be used for the CQI plans for the two home visiting interventions (HFA and PAT) and for MST. All CQI work will use a racial equity lens to inform program design and ensure related issues are addressed as part of the CQI process.

Figure 7: Overview, Model for Improvement

CQI Teams. Across IV-E waiver projects and other major projects over the last 10 years, the DCFS Office of Research and Child Well-Being has developed collaborative CQI processes that engages program staff, implementation support staff, and evaluators in sharing quantitative data and lessons learned from the field, and generating ideas about how to address critical implementation challenges (e.g., referral and linkage to services, knowledge transfer, staff turnover), improve data collection/tracking, inform data analyses, improve service quality and outcomes. These long-standing DCFS CQI practices and processes will be continued and expanded for the EBIs in the FFPSA CQI and Evaluation plans. Monthly CQI reports will generated for each project (EBI) to inform and guide the discussions and pertinent data will be shared with stakeholders as appropriate. The senior DCFS leadership, the managers of the implementation support efforts, and all of the lead evaluators have extensive experience in working with the CQI team.

Dr. Kimberly Mann, DCFS Deputy Director for Research and Child Well-Being, will lead the CQI teams for all four well-supported interventions (i.e., HFA, PAT and MST) and will meet monthly with a subgroup of members from the respective CQI teams, including Dr. Amy Dworsky (HFA, PAT) and Dr. Richard Epstein (MI, MST), Research Fellows at Chapin Hall. Regular meetings of the full CQI teams for all four interventions will be held bi-monthly. However, the frequency of those meetings will be intervention-specific (as described below).

In addition to Dr. Mann, the CQI team for HFA and PAT will include Ms. Pfeffer Eisin, DCFS Early Childhood Project Director, representatives from the Illinois Governor's Office of Early Childhood Development; Regionally-based DCFS Early Childhood Project Home Visiting Specialists; representatives from DCFS Intact Families Services, representatives from the Illinois State Board of Education (ISBE); representatives from the Illinois Department of Human Services (IDHS);

representatives from Illinois Purchase of Service (POS) Intact Service Providers, representatives from the DCFS Teen Parenting Services Network (TPSN); and Dr. Amy Dworsky, Research Fellow at Chapin Hall. The Illinois Pregnant and Parenting Youth in Care (IPPYC) Home Visiting Project Director will also participate. This team will be responsible for identifying areas in need of improvement, selecting and implementing CQI activities designed to achieve the improvements needed, and monitoring the results of those activities. These teams will also be responsible for providing feedback on client outcomes, experiences and barriers experienced to identified stakeholders including provider agencies, Sister Agencies, and the Illinois Home Visiting Task Force.

The full HFA and PAT CQI team will convene bi-monthly. Between those bi-monthly meetings, Dr. Amy Dworsky will meet monthly with a subgroup of the CQI team and additional meetings will be held as needed. During the bi-monthly meetings, Dr. Amy Dworsky, Research Fellow at Chapin Hall, will share a data dashboard that will be used to monitor key performance indicators for Intact families and pregnant or parenting youth currently or formerly in care. The dashboard will be produced using data on referrals, enrollment and service receipt that will be provided to Chapin Hall by the Early Childhood Project Home Visiting Specialists and the IPPYC Project Director and data on outcomes reported by HFA and PAT providers to the Illinois State Board of Education (ISBE) and the Illinois Department of Human Services (DHS). Dr. Dworsky will also share data being collected by the Chapin Hall evaluation team from families receiving Intact services, pregnant or parenting youth currently or formerly in care, home visitors, home visiting specialists, and Intact services caseworkers. These data will be used to identify areas in need of improvement, inform the selection of CQI activities designed to achieve the improvements needed, and monitor the results of those activities. Additional meetings will be held as needed between the bi-monthly meetings with a subgroups of the CQI team.

In addition to Dr. Mann, the CQI team will include the Director of Evidence-Based interventions, the FFPSA program manager and the 4 regionally based FFPSA Implementation Specialists. Under the Direction of the Deputy Director of the DCFS Office of Research and Child Well-Being, this position supports the implementation of the state's adopted evidence-based interventions through the Family First Prevention Services Act [FFPSA]. Implementation specialists will be assigned to each of the 4-DCFS regions and provide implementation support, including CQI to the provider agencies that utilize evidence-based interventions adopted by DCFS to enhance the service array for children and families served by the Department. In addition, the specialists will work with agencies that serve the target population identified under the FFPSA to enhance referral pathways and general knowledge of the adopted interventions. They are also responsible for providing feedback on client outcomes, experiences and potential barriers to access for EBI services.

Additional CQI team members for MI and MST will include DCFS representatives responsible for each of the candidacy sub-populations, representatives from the DCFS Teen Parenting Services Network (TPSN), representatives from Illinois Purchase of Service (POS) Intact Service Providers, and Dr. Richard Epstein. The CQI team for MI will also include DCFS representatives responsible for investigations and the DCFS training division [Office of Learning and Professional Development]. This team will be responsible for identifying areas in need of improvement, selecting and implementing CQI

activities designed to achieve the improvements needed, and monitoring the results of those activities. During those meetings, Dr. Richard Epstein, Research Fellow at Chapin Hall, will share information that can be used to monitor key performance indicators. The information will include information about change over time in the proportion of child welfare staff who have completed MI and MST training, MI and MST fidelity assessments, and proximal and distal outcomes. These data will be used to identify areas in need of improvement, inform the selection of CQI activities, and monitor the results of those activities.

Additional meetings will be convened as needed with appropriately comprised subgroups of the CQI team. The full MI team will convene bi-monthly. Between those bi-monthly meetings, Dr. Richard Epstein will meet monthly with a subgroup of the CQI team and additional meetings will be held as needed. The full MST team will convene bi-monthly. Between those bi-monthly meetings, Dr. Richard Epstein will meet monthly with a subgroup of the CQI team and additional meetings will be held as needed.

***Research Questions*.** The CQI processes for HFA, PAT, MI, and MST will address a common set of research questions about the respective interventions.

- Are DCFS-involved children/families being referred to evidence-based practice (EBPs)?
    - What are the characteristics of referred children/families?
    - Are the characteristics of referred children/families consistent with the EBP's eligibility criteria and with any DCFS eligibility criteria (e.g., candidate population, age, documented needs, provider location)?
- Are referred children/families actually receiving services?
    - What are the characteristics of children/families receiving services and how do they differ from the characteristics of referred children/families not receiving services?
    - What is the time from referral to the initiation of services and how does that vary by region or child/family characteristics?
- Were the services delivered with fidelity to the model?
    - What is the dosage of services received and is this consistent with the EBP model?
    - What is the length of time that children/families receive services and is this consistent with the EBP model?
- How engaged are children/families in services?
    - What child/family, caseworker/caseworker agency, or EBP provider characteristics are associated with increased engagement?
    - What implementation/system strategies are used to try to increase engagement following a referral and which appear to be most effective?
- Are children/families successfully completing services?
    - What are reasons services are being terminated and how does that vary by region or child/family characteristics?

- How and to what extent do EBP providers coordinate and communicate with key partners (e.g., caseworkers) across the life of the case?
    - How does the level of coordination vary by provider, region, or referral source (casework agency)?

Data Sources. To address these questions, the CQI teams for all four interventions will rely on a common set of data sources including:

- DCFS administrative data on the children and families referred to or receiving services and their child welfare system involvement (e.g., child maltreatment investigations; foster care entries and exits).
- DCFS billing records
- Administrative records from other state agencies (i.e., DHS) linked to DCFS administrative data
- Data collected by provider agencies and staff on services provided to children and families
- Survey/interview data about experiences with the interventions collected from implementing provider agencies and staff; DCFS/POS caseworkers and leadership, and children and families.

Human Subjects Considerations. The CQI plans for all three interventions involve research with human subjects. Approval for this research will be sought from both the University of Chicago's School of Social Service Administration- Chapin Hall Institutional Review Board and the Illinois Department of Children and Family Services Institutional Review Board. The issue of informed consent will be addressed as outlined in Table 5.

Table 5: Plan for Informed Consent by Data Source

Data Source	Plan for Informed Consent
DCFS administrative data	Waiver of informed consent
DCFS billing records	Waiver of informed consent
Administrative records from other state agencies	Waiver of informed consent
Data collected by provider agencies and staff	Waiver of informed consent but permission to share data with Chapin Hall
Survey/interview data	Informed consent/assent obtained by Chapin Hall prior to data collection

In addition to these common elements, the CQI plans for the four well-supported interventions include elements that are intervention-specific. These elements are described in detail below.

HFA- and PAT-Specific Elements. Two target populations will be eligible for HFA and PAT and the referral process for each target population and each program is distinct.

For HFA:

- **Intact families in which the mother is pregnant or a child in the family is not yet 24 months old, with a particularly focus on families with children less than six months of age.** Intact family caseworkers will refer eligible families to the Erikson DCFS Early Childhood Project. The project's Home Visiting Specialists will engage with families and refer those that consent to an HFA provider that serves the catchment area in which the family lives. Once a family is referred to either HFA, the Home Visiting Specialists will follow up with the HFA provider to which the family was referred regularly to ascertain whether the family enrolls in the program and to monitor engagement in services post-enrollment.
- **Youth currently or formerly in care who are pregnant or the parent of a child that is not yet 24 months old.** The DCFS Teen Parenting Services Network (TPSN), which oversees the provision of services to pregnant and parenting youth in DCFS care throughout Illinois, will refer eligible youth to the Illinois Pregnant and Parenting Youth in Care Home Visiting (IPPYC-HV) Coordinator. The Coordinator will then refer those youth to an HFA provider that serves the catchment area in which the youth lives. Once a referral is made, the Coordinator will follow up with the HFA provider to which the youth was referred to ascertain whether the youth enrolls in the program and to monitor engagement in services post-enrollment.

For PAT

- **Intact families in which the mother is pregnant or a child in the family is not yet three years old, with a particularly focus on families with children less than six months of age.** Intact family caseworkers will refer eligible families to the Erikson DCFS Early Childhood Project. The project's Home Visiting Specialists will engage with families and refer those that consent to an HFA or PAT provider that serves the catchment area in which the family lives. Once a family is referred to either HFA or PAT, the Home Visiting Specialists will follow up with the HFA or PAT provider to which the family was referred regularly to ascertain whether the family enrolls in the program and to monitor engagement in services post-enrollment.
- **Youth currently or formerly in care who are pregnant or the parent of a child who is not yet three years old.** The DCFS Teen Parenting Services Network (TPSN), which oversees the provision of services to pregnant and parenting youth in DCFS care throughout Illinois, will refer eligible youth to the Illinois Pregnant and Parenting Youth in Care Home Visiting (IPPYC-HV) Coordinator. The Coordinator will then refer those youth to an HFA or PAT provider that serves the catchment area in which the youth lives. Once a referral is made, the Coordinator will follow up with the HFA or PAT provider to which the youth was referred to ascertain whether the youth enrolls in the program and to monitor engagement in services post-enrollment.

Despite these two different referral processes, the CQI activities for the two populations will largely be the same. Additionally, although HFA and PAT are distinct interventions, the same set of CQI activities will be used to monitor fidelity to the models and use the results of that monitoring to improve practices and to measure the outcomes that are achieved.

During the first year of implementation, the CQI team will focus primarily on questions related to process and implementation.

- Are families receiving Intact services and pregnant and parenting youth currently or formerly in care being referred to HFA and PAT programs?
- Are families receiving Intact services and pregnant and parenting youth currently or formerly in care enrolling in HFA and PAT programs once they are referred?
- Is enrollment of families receiving Intact services and pregnant and parenting youth currently or formerly in care in HFA and PAT programs occurring in a timely manner?
- Are families receiving Intact services and pregnant and parenting youth currently or formerly in care that enroll in HFA and PAT programs engaged in services?
- Are families receiving Intact services and pregnant and parenting youth currently or formerly in care receiving services with fidelity to / that are consistent with the HFA and PAT models?
- What is the level of coordination between HFA and PAT programs, the DCFS Early Childhood Project Home Visiting Specialists, and the DCFS/POS Intact Families Services caseworkers?

The justification for focusing on process and implementation during the first year is threefold. First, one of the lessons learned from the home visiting pilot for pregnant and parenting youth in care is that families can easily "fall through the cracks" if referrals, enrollment and service receipt are not carefully monitored. The pilot team implemented a CQI process to perform this monitoring function. Second, neither HFA nor PAT can reduce the occurrence of (subsequent) child maltreatment or prevent entries into foster care if families are not referred to, enrolled in and receiving services. And third, it will take time to observe any movement on either proximal or distal outcomes.

Beginning at the end of the first year and then continuing thereafter, the CQI team will expand its focus to include both proximal and distal outcomes (Table 6 below). We selected the proximal and distal outcomes for each of the interventions based on (1) the respective goals of each intervention according to the Home Visiting Evidence of Effectiveness; (2) evidence from prior evaluations of each intervention related to other outcomes of particular interest to the Department (e.g., receipt of prenatal care); and (3) a consideration of what we can reasonably expect to be able to measure using data collected from or reported by HFA and PAT providers. We have also included placement prevention as an outcome for both interventions because it is a primary goal of the Family First legislation and because both interventions have been found to reduce child maltreatment, a precursor to placement.

By the end of the first year, we expect that implementation will have stabilized and that a sufficient amount of data will be available to begin to assess outcomes. The question we will address include:

- Are proximal parent outcomes being achieved among families receiving Intact services and pregnant and parenting youth currently or formerly in care?
- Are proximal child outcome being achieved among families receiving Intact services and pregnant and parenting youth currently or formerly in care?

- Are proximal system-level outcomes being achieved?
- Are distal parent outcomes being achieved among families receiving Intact services and pregnant and parenting youth currently or formerly in care?
- Are distal child outcome being achieved among families receiving Intact services and pregnant and parenting youth currently or formerly in care?
- Are distal system-level outcomes being achieved?

Table 6: Overview of CQI Outcomes for HFA and PAT

Category		PAT	HFA
Proximal Outcomes			
Parent outcomes	Pregnant women receive timely prenatal care		X
	Mothers are screened for maternal depression and referred for treatment if appropriate	X	
	Parents are more knowledgeable about child development and child safety (including safe sleep)	X	
	Parents engage in more positive interactions with their children[1]		X
	Parents demonstrate more positive parenting and child rearing attitudes[1]	X	X
	Parents are better able to cope with parenting stress[1]		X
	Parents have access to primary healthcare and other needed services		X
Child outcomes	Children are immunized	X	
	Children receive well-child checks	X	X
	Children receive developmental screenings	X	X
	Children with developmental delays are referred for services	X	X
System outcomes	HFA/PAT providers receive the training and support needed to serve DCFS-involved families	X	X
	Policies for sharing information between HFA/PAT providers and the child welfare system are established	X	X
Distal Outcomes			
Parent outcomes			
Intact families	Parents are not reinvestigated for child maltreatment[2]	X	X
	Parents do not have a subsequent indicated allegation[2]	X	X
PPY in care	Parents are not investigated for child maltreatment[2]	X	X
	Parents do not have an indicated allegation[2]	X	X
Child outcomes	Children remain at home with their parents	X	X
System outcomes	Increased coordination between the child welfare and home visiting systems in Illinois	X	X

[1]Eligible target parent well-being outcomes via Title IV-E Clearinghouse
[2]Eligible target safety outcome via Title IV-E Clearinghouse
[3]Eligible target permanency outcome via Title IV-E Clearinghouse
[4]Eligible target child well-being outcomes via Title IV-E Clearinghouse

Addressing these questions will require data from a variety of sources.

- DCFS administrative data will be used to measure the occurrence of child abuse and neglect investigations, foster care entries and other child welfare outcomes.

- Data on referrals and enrollment will be collected from the HV Specialists (in the case of Intact families) and the IPPYC-HV Coordinator (in the case of pregnant and parenting youth) using REDCap (Research Electronic Data Capture), a secure, HIPPA-compliant application maintained by the University of Chicago. These data will include (1) the number and characteristics of families/youth offered an HFA/PAT program referral; (2) the number and characteristics of families/youth referred to an HFA/PAT program; (3) the HFA/PAT programs to which families/youth are referred; (4) the number and characteristics of families/youth enrolled in an HFA/PAT program; and (5) the HFA/PAT programs in which families/youth are enrolled.
- Data on family/youth engagement in home visiting services will be collected from the HV Specialists (in the case of Intact families), the IPPYC-HV Coordinator (in the case of pregnant and parenting youth), or the HFA/PAT providers using REDCap. These data will include (1) the dates of completed home visits; (2) the dates of missed home visits; (3) the reasons home visits are missed; and (4) consultations between HFA/PAT providers and child welfare professionals
- DCFS billing records, which will contain information about the dates on which home visiting services are provided to DCFS-involved families, may also be used to measure service receipt.
- Data reported by HFA/PAT providers to the Illinois State Board of Education (ISBE), the Illinois Department of Human Services (DHS) and the Governor's Office of Early Childhood Development (GOECD) through web-based data systems (e.g., Visit Tracker, Ounce Net, and Penelope) and the ISBE Student Information System (SIS) may be used to measures some outcomes of interest. Because different funding sources have different reporting requirements and use different reporting systems, there is considerable variation across home visiting programs in what data they reported. However, most providers do report a set of common elements. Those include: (1) pregnancy status at intake, (2) prenatal care; (3) birth outcomes; (4) breast feeding; (5) well-child visits; (6) child immunizations; (7) developmental screenings; and (8) post-partum depression screenings.
- Survey and/or interview data will be collected from DCFS-involved families by the Chapin Hall evaluation team to understand how families experience the services they receive from HFA and PAT providers, to assess whether those services are meeting their needs, and to measure their satisfaction with those services.
- Survey and/or interview data will be collected from home visitors and home visiting supervisors from HFA and PAT programs by Chapin Hall to learn about any differences between serving families referred by DCFS and serving other families, any barriers to enrolling, engaging or serving DCFS-involved families, any additional training or other supports that are needed to serve DCFS-involved families, and any experiences they have had with the DCFS Early Childhood Project Home Visiting Specialists or with DCFS/POS Intact Families Services caseworkers.
- Survey and/or interview data will be collected from Early Childhood Project HV Specialists, DCFS and POS Intact Families Services caseworkers, and DCFS and POS Intact Families Services supervisors by Chapin Hall to learn about their experiences with (1) the referral process, including any barriers to engaging with or referring families identified by the Early Childhood Project; and (2) the HFA and PAT programs to which DCFS-involved families are being referred.

The full HFA/PAT CQI team will have bimonthly meetings to review data, identify areas in need of improvement and discuss ongoing CQI activities. Those meetings will include representatives from the DCFS Early Childhood Project, DCFS Intact Families Services, Purchase of Service (POS) Intact Service Providers, the DCFS Teen Parenting Services Network (TPSN), the Illinois State Board of Education (ISBE), and the Illinois Department of Human Services (IDHS) as well as the Illinois Pregnant and Parenting Youth in Care (IPPYC) Home Visiting Project Director.

During those meetings, Dr. Amy Dworsky, Research Fellow at Chapin Hall, will share a data dashboard that will be used to monitor key performance indicators for Intact families and pregnant or parenting youth currently or formerly in care. The dashboard will be produced by the Chapin Hall HFA/PAT CQI team using data on referrals, enrollment and service receipt that will be provided to Chapin Hall by the Early Childhood Project Home Visiting Specialists and the IPPYC Project Director and data on outcomes reported by HFA and PAT providers to the Illinois State Board of Education (ISBE) and the Illinois Department of Human Services (DHS). Dr. Dworsky will also share data being collected by the Chapin Hall evaluation team from families receiving Intact services, pregnant or parenting youth currently or formerly in care, home visitors, home visiting specialists, and Intact services caseworkers. These data will be used to identify areas in need of improvement, inform the selection of CQI activities designed to achieve the improvements needed, and monitor the results of those activities. Smaller groups of CQI team members will meet between those bimonthly meetings to address specific issues that arise. Fidelity to the model will be assessed by examining whether the HFA/PAT providers are meeting performance standards (e.g., % of families with the required number of visits) for the Intact families and pregnant and parenting youth in care that they are serving.

Although DCFS does not have contracts with any of the state's HFA or PAT providers that can be leveraged to require their cooperation with data collection efforts, our CQI plan includes a number of data collection activities that will allow us to meet the continuous monitoring requirements for HFA and PAT. First, referrals and enrollments will be tracked using Excel spreadsheets by the Early Childhood Project Home Visiting Specialists (for Intact family cases) and the IPPYC Project Director (for pregnant and parenting youth in care). Second, data on the provision of home visiting services will be collected from HFA and PAT providers by the Early Childhood Project Home Visiting Specialists and the IPPYC Project Director using REDCap, a data collection platform maintained by the University of Chicago and used by Chapin Hall. Third, Chapin Hall will enter into data sharing agreements with the Illinois State Board of Education (ISBE) and the Illinois Department of Human Services (DHS). Those agreements will covert sharing of data on outcomes reported by HFA and PAT providers to ISBE and DHS through web-based data systems.

The Early Childhood Project Home Visiting Specialists will seek permission from the families and the IPPYC Project Director will seek permission from the youth in care to share they are collecting with Chapin Hall.

MI-Specific Elements. All children and families of children in any of the target population sub-groups will be eligible for MI. Unlike the other EBPs in the FFPSA prevention services array, MI will be used

by investigators (prior to the completion of the FFPSA Prevention Plan) to encourage children and families to accept voluntary services and by caseworkers to encourage children and families to participate in voluntary services, including in the other EBPs in the service array.

As with HFA and PAT, the CQI team for MI will focus on questions related to process and implementation during the first year of implementation. However, these questions differ because it is the caseworkers who will be using MI.

- Does the FFPSA prevention plan for children and families in the target population refer to MI all children and families who are identified as having a need for MI as a cross-cutting motivation and engagement strategy?
- Are children and families in the target population receiving MI once a need for MI is identified in their prevention plan?
- Is receipt of MI occurring in a timely manner?
- Is service engagement consistent with the MI model?
- Relative to historical data on retention of families receiving preventive services, do rates of referral and engagement increase following the implementation of MI (including rates of participation in voluntary candidate populations such as Intact Family Services, as well as rates of referral to and engagement in EBPs)?

There is considerable information about MI implementation in the public domain (c.f., Miller & Rollnick, 2012). DCFS expects that all caseworkers will adhere to any MI-specific measurement requirements. The CQI plan will use any measures required by MI for the secondary purpose of fidelity monitoring. Fidelity will also be assessed by examining whether the caseworkers are meeting MI performance standards as represented in administrative data, including case notes.

The justification for focusing on process and implementation during the first year is threefold. First, because caseworkers will be providing MI for all members of the target populations as a cross-cutting motivation and engagement strategy, training all caseworkers to use MI in practice with fidelity to the model will be a significant undertaking. CQI activity will be necessary to help the Department monitor the implementation. Second, based on prior DCFS' experiences implementing other caseworker interventions, variation in uptake and in practice across caseworkers seems inevitable. The CQI team plans to implement processes to help the Department monitor this variation. This is important because MI cannot increase the likelihood that children and families will participate in voluntary services, including the other EBPs, if children and families do not accept and participate in voluntary services. Finally, it will take time for a sufficient number of children and families to participate in MI and for movement on either proximal or distal outcomes to be observed.

Beginning at the end of the first year and then continuing thereafter, the CQI team will expand its focus to include both proximal and distal outcomes (Table 7 below). By this point, we expect early

implementation issues to have been resolved and sufficient data will be available to begin to assess outcomes. The questions we will address include:

- Are proximal parent-level outcomes being achieved among families in the target population receiving MI?
- Are proximal child-level outcomes being achieved among families in the target population receiving MI?
- Are proximal system-level outcomes being achieved?
- Are distal parent outcomes being achieved among families in the target population receiving MI?
- Are distal youth outcome being achieved among children in families in the target population receiving MI?
- Are distal system-level outcomes being achieved?

Table 7: Overview of CQI Outcomes for MI

Proximal Outcomes	Distal Outcomes
Parent Outcomes	
• Parents demonstrate more participation in voluntary services, including EBPs • Parents are satisfied with how they are engaged by workers and the services they receive	• No subsequent investigations for child maltreatment[1] • No subsequent indicated allegations[1]
Child Outcomes	
• Children demonstrate more participation in voluntary services, including EBPs	• Children remain at home with their families[2]
System Outcomes	
• Caseworkers receive the training and support needed to serve DCFS-involved families • Caseworkers are communicating with DCFS and POS agency caseworkers and other service providers	• Coordination and communication between child welfare staff and providers of EBPs to children and families involved with DCFS in Illinois has increased

[1]Eligible target safety outcome via Title IV-E Clearinghouse

[2]Eligible target permanency outcome via Title IV-E Clearinghouse

Addressing these questions will require data from a variety of sources.

- DCFS administrative data will be used to measure the occurrence of child abuse and neglect investigations, foster care entries and other child welfare outcomes. They will also be used to measure the number of children and families who were eligible for and who actually received MI
- Data on the number of children and families who were eligible for MI will be collected from the administrative data
- Survey and/or interview data will be collected from DCFS-involved families by the CQI team to understand how families experience the MI services they receive from caseworkers, to assess whether those services are meeting their needs, and to measure their satisfaction with those services.

- Survey and/or interview data will be collected from caseworkers and supervisors by Chapin Hall to learn about any differences between families referred to different locations, any barriers to enrolling, engaging or serving DCFS-involved families, and any additional training or other supports that are needed to serve DCFS-involved families.
- Data collected by caseworkers in the course of providing MI with fidelity. This information will likely include results from a MI adherence tool to be administered by supervisors as required by the contracted MI trainer for ongoing fidelity monitoring.

MST-Specific Elements. Children who are (a) in one of the target population sub-groups and (b) between 12 and 17 years old, (c) have an eligible mental health and/or substance use diagnoses, and (d) exhibit antisocial or delinquent behavior that puts them at risk for involvement or further involvement in the juvenile justice system or for out of home placement will be eligible for MST referral. Only some eligible children will actually be referred and only some referred children will be treated.

As with HFA, PAT, and MI the CQI team for MST will focus primarily on questions related to process and implementation during the first year of implementation.

- Are children and families in the target population being referred to MST?
- Are children and families in the target population enrolling in MST once they are referred?
- Is enrollment occurring in a timely manner?
- Are children and families in the target population engaging in services?
- Is service engagement consistent with the MST model?
- What is the level of coordination between the MST provider (and its locations) and the relevant DCFS staff?

There is considerable information about MST's quality assurance program in the public domain (MST Services, Inc, 2020). DCFS expects that all MST provider locations will adhere to the measurement requirements. The CQI plan will use the measures required by MST for the secondary purpose of fidelity monitoring. Fidelity will be assessed by examining whether the MST provider locations are meeting MST performance standards (e.g., % of families with the required number of visits).

The justification for focusing on process and implementation during the first year is threefold. First, even though there is only one MST provider, that provider has multiple locations. Some of the provider's capacity to provide MST already exists and some will be new. Working with DCFS to provide this service to this target population under this funding mechanism will be new for all provider locations and for DCFS. Thus, DCFS anticipates that there will be early implementation issues that must be resolved. Second, DCFS' experience implementing EBPs is that children and families can easily "fall through the cracks," especially early in an implementation, if referrals, enrollment and service receipt are not carefully monitored. The CQI team plans to implement a CQI process to perform this monitoring function. This is important because MST cannot reduce the occurrence of (subsequent) child maltreatment or prevent entries into foster care if children and families are not referred to,

enrolled in and receiving services. Finally, it will take time for a sufficient number of children and families to participate in MST and for movement on either proximal or distal outcomes to be observed.

Beginning at the end of the first year and then continuing thereafter, the CQI team will expand its focus to include both proximal and distal outcomes (Table 8 below). By this point, we expect early implementation issues to have stabilized and that a sufficient amount of data will be available to begin to assess outcomes. The question we will address include:

- Are proximal parent outcomes being achieved among families in the target population receiving MST?
- Are proximal youth outcome being achieved among children in families in the target population receiving MST?
- Are proximal system-level outcomes being achieved?
- Are distal parent outcomes being achieved among families in the target population receiving MST?
- Are distal youth outcome being achieved among children in families in the target population receiving MST?
- Are distal system-level outcomes being achieved?

Table 8: Overview of CQI Outcomes for MST

Proximal Outcomes	Distal Outcomes
Parent Outcomes	
• Parents demonstrate more positive parenting practices[1] • Parents report improved mental or emotional health[1] Parents report improved family functioning[1]	• No subsequent investigations for child maltreatment[3] • No subsequent indicated allegations[3]
Child Outcomes	
• Children demonstrate improved mental or emotional health[2] • Children demonstrate reduced substance use[2] • Children demonstrate reduced delinquency[2]	• Children remain at home with their families[4]
System Outcomes	
• MST programs receive the training and support needed to serve DCFS-involved families • MST providers are communicating with DCFS and POS agency caseworkers and other service providers	• Coordination and communication between child welfare staff and providers of mental health services to children and families involved with DCFS in Illinois has increased

[1]Eligible target parent well-being outcomes via Title IV-E Clearinghouse
[2]Eligible target child well-being outcomes via Title IV-E Clearinghouse
[3]Eligible target safety outcome via Title IV-E Clearinghouse
[4]Eligible target permanency outcome via Title IV-E Clearinghouse

Addressing these questions will require data from a variety of sources.

- DCFS administrative data will be used to measure the occurrence of child abuse and neglect investigations, foster care entries and other child welfare outcomes.

- Data on the number of children and families who were eligible for MST referral will be collected from the administrative data
- Data on the number of children and families who were eligible for MST referral who were actually referred and/or enrolled will be collected from the MST provider using REDCap (Research Electronic Data Capture), a secure, HIPPA-compliant application maintained by the University of Chicago (Harris et al., 2009; Harris et al., 2019). These data will include (1 and 2) the number and characteristics of families/youth referred/enrolled; (3 and 4) the MST program location to which families/youth are referred/enrolled.
- Data on family/youth engagement in MST will be collected from the MST program also using REDCap. These data will include (1) the dates of completed sessions; (2) the dates of missed sessions; (3) the reasons sessions are missed; (4) consultations between MST providers and child welfare professionals; and (5) consultations between MST providers and other consultants
- DCFS billing records, which will contain information about the dates on which MST services are provided to DCFS-involved families, may also be used to measure service receipt.
- Survey and/or interview data will be collected from DCFS-involved families by the CQI team to understand how families experience the services they receive from the MST provider, to assess whether those services are meeting their needs, and to measure their satisfaction with those services.
- Survey and/or interview data will be collected from MST therapists and supervisors by Chapin Hall to learn about any differences between families referred to different locations, any barriers to enrolling, engaging or serving DCFS-involved families, and any additional training or other supports that are needed to serve DCFS-involved families.
- Data collected by MST providers in the course of providing MST with fidelity. Information may include fidelity surveys required by the model purveyor (i.e., MST Therapist Adherence Measure-Revised - TAM-R) and other child- and family-level information contained within the provider's records.

CQI Plan Limitations. The primary limitations of the CQI plan include uncertainties about the quality of data on referrals, enrollment and service receipt that will be available. Because MI is being implemented by caseworkers whereas the other EBPs are being implemented by private agency staff, some data quality issues will be specific to MI. Two additional limitations are unique to the two home visiting interventions. One is that DCFS does not have contracts with any of the HFA or PAT providers that can be leveraged to require their cooperation with data collection efforts. This could make it difficult to obtain timely data on engagement in home visiting services. The second is the variation in the outcomes that different HFA and PAT providers are required to report to their funders, which could complicate efforts to measure outcomes.

Evaluation Strategy - Integrated Evaluation Framework

Overview. Illinois has chosen to implement three interventions rated "promising" by the Title IV-E Prevention Services Clearinghouse as part of its Family First prevention plan: Child Parent

Psychotherapy (CPP), Triple P, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In this subsection, we present an integrated framework for evaluating all three interventions. In the following subsections, we will then describe each of those interventions' specific evaluation considerations, including the aims of therapy, the population served, the modality and theoretical underpinnings, planned dosage, evidence supporting its effectiveness, key aspects of implementation, fidelity processes, key individualized outcomes, and targeting. Additional information is provided on the history of using CPP in child welfare in Illinois given over 15 years of experience.

Any evaluation of CPP, Triple P, and TF-CBT must take several key sources of complexity stemming from the state's broader FFPSA plan into account. First, the state's FFPSA plan includes several distinct candidate populations and 5 different interventions including the four interventions for which CQI plans have been proposed (i.e., HFA, PAT, MI and MST) and the three interventions that will require evaluations and CQI plans (i.e., CPP, Triple P, and TF-CBT). Second, the candidate populations are broadly defined, most of the interventions are potentially relevant to multiple candidate populations, and families will not be randomly assigned to one (and only one) intervention. Third, to meet the Title IV-E Clearinghouse standards for inclusion, then the comparison group for the evaluations of CPP and TF-CBT must receive treatment as usual (TAU) and therefore cannot include children and families receiving any of the other interventions that the state is implementing as part of its FFPSA plan.

To deal with these complexities, we propose an integrated evaluation framework for examining treatment effects across interventions and candidate populations using a rigorous quasi-experimental design (QED). Core elements of this integrated evaluation framework include:

- Articulating an overarching evaluation question using the PICO (population, intervention, comparison, outcomes) framework that is consistent with the Illinois FFPSA Theory of Change
- Identifying Intention to Treat (ITT) treatment groups for CPP, Triple P, and TF-CBT using referral data for all the interventions in the FFPSA plan
- Describing a plan for identifying a pool of children and families that don't receive any of the interventions from which matched *treatment as usual* (TAU) comparison groups can be drawn
- Using propensity score matching and weighting strategies to create matched TAU groups
- Using Child and Adolescent Needs and Strengths (CANS) data and administrative data to examine outcomes over time—the administrative data examine safety, permanency and well-being outcomes over time for both treatment and comparison groups
- Using the research questions listed in the CQI plan as the core process evaluation questions
- Understanding the reach (i.e., penetration) of CPP, Triple P, and TF-CBT (individually and collectively) for each candidate population.

In describing our evaluation plans for CPP, Triple P, and TF-CBT, we highlight key differences in outcomes for different candidate populations and provide additional intervention-specific details. Note that our description of the plan and some of the graphics focus on families receiving Intact Family Services. This is the largest candidate population and many of the intervention are likely to be

provided primarily with this group. As a result, the power to detect treatment effects is likely to be greatest for this population. Furthermore, the CANS data are most likely to be available for this population.

Candidate Populations. Illinois has identified several candidate populations that will be served by CPP, Triple P, TF-CBT and other FFPSA interventions (Table 9). These candidate populations are described and the reasons for choosing each are articulated in Section 2. These populations vary in terms of their size, where they are situated in the *life of the case* (e.g., pre and post placement, prior to formal involvement in child welfare services, in care vs. out of care), and parent/caregiver characteristics that have implications for the number of children in different age groups within each.

Table 9: Target Populations

Candidates	N*	Initial Context	Parent/Caregiver
Intact Family Services (IFS)	11,981 children	Post-investigation, formal services, medium to high risk	Parent(s)
Intact Family Recovery (IFR)	1,021 children	Post-investigation, substance abuse identified, formal services, medium to high risk, often substance exposed infants	Parent(s)
Extended Family Support (EFSP)	736 families	Post-investigation, no formal child welfare involvement	Relatives & fictive kin
Post-reunification (in last 6 months)	2,524 children	Post-permanency event	Parent(s)
Post-adoption request services	2,622 children	Post-permanency event	Non-relatives, relatives, and fictive kin
Subsidized guardianship or permanency with relatives	562 children	Post-permanency event	Non-relatives, relatives, and fictive kin
Pregnant and parenting youth in care	464 youth	Youth in care, young children	Pregnant and parenting youth
Pregnant and parenting youth age 18-21 who recently opted out of care	98 youth	Youth out of care, young children	Pregnant and parenting youth

* Based on FY18 or CY18 data

From an evaluation design perspective, several differences in the candidate populations are particularly relevant. First, larger candidate populations (e.g., Intact Family Services) will likely allow for larger treatment and matched comparison groups, thereby enhancing statistical power to detect between-group differences in outcomes. Conversely, detecting between-group differences will be much more difficult with the smaller candidate populations (e.g., pregnant and parenting youth who opted out of care). Second, the services and supports normally provided (i.e., *treatment as usual*) may vary

from candidate population to candidate population due in part to differences in their respective needs (e.g., the needs of pregnant and parenting youth are different from the needs of recently reunified children). Relatedly, the plan for caseworkers to use MI with all members of all candidate populations as a cross-cutting motivation and engagement strategy means that MI becomes part of usual services moving forward. Third, the risks to safety and permanency may be different for different candidate populations. Fourth, the availability of well-being/functioning data also varies by candidate population. Administrative data that can be used to measure change in well-being over time are available for some candidate populations, including Intact Family Services and Intact Family Recovery cases, but not others (e.g., post permanency cases).

The candidate populations are *target* populations only in a broad sense, that is, for the FPPSA plan as a whole. Targeting for specific EBPs is more nuanced. To illustrate, CPP and TF-CBT are potentially relevant to many children and families in all candidate populations. More specific targeting efforts are being developed for each EBP, along with plans differential assessments based on the age of children, the nature of service needs, and client motivation to participate in these voluntary services.

PICO Questions and Intent to Treat Evaluation. The Population, Intervention, Comparison, and Outcome (PICO) Tool is a framework used to articulate the essential components of research questions that a study will address (e.g., Huang, Lin, & Demner-Fushman, 2006). The overarching research question that frames Illinois' evaluation plan is:

> Will children and families in the identified candidate populations (**P**) referred to an EBP as part of their prevention services plan (**I**) in comparison to a group of similar children and families who receive treatment as usual (**C**) experience better safety, permanency, and well-being outcomes (**O**)?

We define our intervention condition as children and families *referred* to an EBP to more closely approximate an intent to treat (ITT) analysis. ITT analyses in randomized clinical trials (RCTs) are the gold standard because they analyze data for all individuals who are randomized to one of the conditions, not just those who actually receive the treatment. Analyzing all individual randomized to one of the conditions means that ITT analyses are better able to maintain the baseline equivalence between the intervention and comparison conditions (Fisher et al., 1990). In this way, our quasi-experimental evaluations of CPP, Triple P, and TF-CBT will more closely approximate and ITT analysis in an RCT than it otherwise might.

Although this plan to define our intervention conditions on children and families *referred* is a strength of our evaluation plan, implementation realities might mean that the difference between the number of youth who are referred to the EBPs and who actually receive the EBPs is larger than it is under other circumstance. This possibility must be examined. For this reason, our process study focuses on implementation support efforts to improve referral and linkage processes, management of waiting lists, engagement skills, and other factors that can affect engagement and retention. We also plan an

outcome sub-study to examine the effect of the treatment on the treated as a type of sensitivity analysis (see Outcome Sub-study section below).

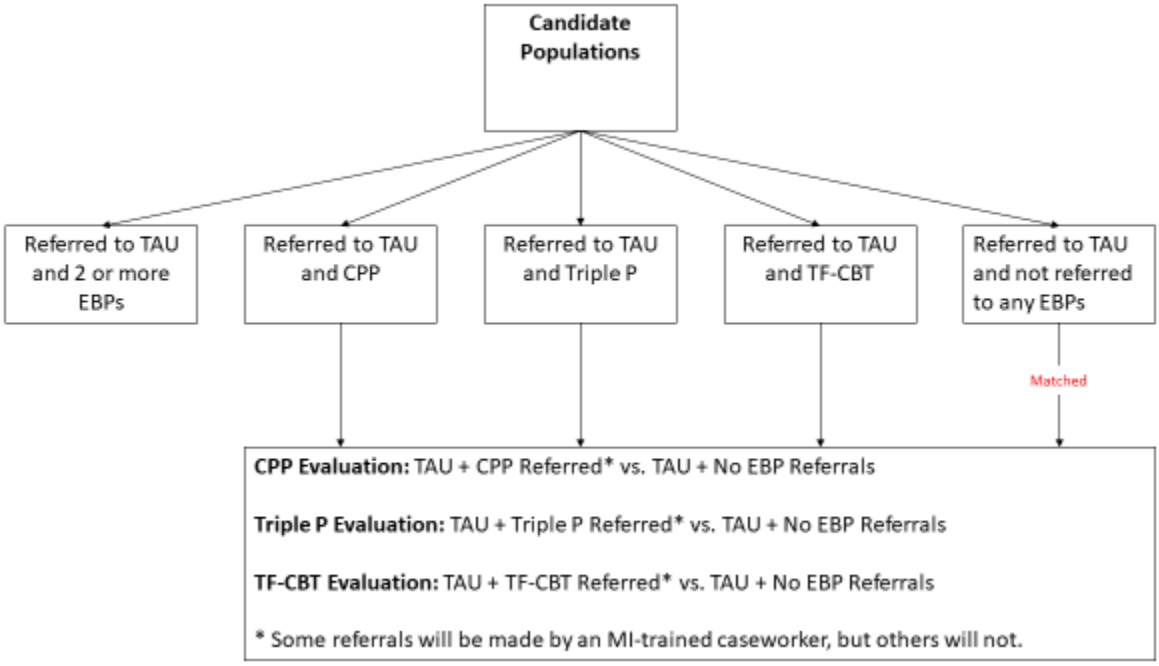
It is important to note that we will also restrict the children and families included in our intervention condition to children and families that are referred to only one of the EBPs in order to provide a more accurate estimate of the unique effects of each EBP over and above TAU and to increase the likelihood that our evaluation meet the standard to be included in subsequent reviews of evidence in support of these interventions by the IV-E Clearinghouse. Families referred to more than one FFPSA intervention will not be prohibited from receiving other interventions or any of the services and supports available as part of TAU.

Comparison Intervention (Treatment as Usual). The IV-E Clearinghouse notes that comparison interventions must be "no or minimal intervention" or "treatment as usual" and the treatment as usual services must be clearly described as the usual or typical services available for that population. Accordingly, the *treatment as usual* comparison groups will be drawn from the candidate population pool of children and families have not been referred to any of the interventions identified in the Illinois FFPSA plan. The types of services and supports included in TAU will vary by candidate population and geographic location. To the extent possible, this variation will be taken into account in creating matched comparison groups. Evaluators will review existing program plans and analyze available data to better understand what constitutes *treatment as usual* for the candidate populations. This will provide valuable context for the ITT evaluation and help evaluators prepare for statistical matching.

It is important to note that *treatment as usual* will be changing in Illinois. A primary example of this is the system-wide plan to implement Motivational Interviewing (MI) at multiple levels of practice and administration, and as a cross-cutting motivation and engagement strategy by caseworkers for all members of all of the candidate populations. Implementation of MI is likely to vary across the state and the CQI teams over time. Evaluators will track relevant indicators (e.g., number and percent of staff trained at different points in time) in order to adjust for the possible effects of MI on outcomes in the ITT evaluation.

Figure 8 provides a high-level illustration of the flow of cases from candidacy to distinct treatment groups for CPP, Triple P, and TF-CBT, respectively. The figure shows that cases with 2 or more FFPSA referrals will be excluded from the evaluation. The figure also shows that a pool of cases with no referrals to FFPSA interventions will exist from which matched comparison groups can be drawn. Finally, the figure notes that EBP referrals will be made by caseworkers who have and have not completed MI training when they make each referral. Each of the evaluations will leverage this naturally-occurring variability to provide information that can be used to estimate the added value of MI to each of the EBPs.

Figure 8: Generic Depiction of Flow from Candidacy to Matched, ITT analyses



Process Study. In general, the purpose of a process study is to describe the contextual factors that affect implementation, the intervention, the implementation, and/or the mechanisms by which outcomes are achieved. The process studies included in the evaluations of CPP, Triple P, and TF-CBT will incorporate insights from implementation science (Proctor et al., 2011) by tracking referrals and services utilization, monitoring fidelity appraisal, and collecting information on barriers to and facilitators of implementation. Given the statewide initiation or expansion of multiple EBPs across multiple candidate populations, tracking implementation efforts and learning about implementation successes and challenges from key stakeholders will be critically important, especially during the first year or two of implementation, for quality improvement purposes and for laying the groundwork for the outcomes evaluation.

As noted earlier, the process study shares the CQI approach and orientation articulated in the CQI section of the plan. It will be important to provide a picture of the characteristics (e.g., demographics, location), service experiences (referrals and participation in each EBP) and outcomes for each candidate population. The evaluators will provide stakeholders with quarterly updates using tables and charts based on simple descriptive analyses including penetration/reach of EBPs and outcomes within and across candidate populations: by EBP participation, DCFS region, and key demographics (child age, race/ethnicity, and gender). The purposes of these analyses are to provide DCFS with broad perspective on FFPSA implementation and outcomes, to inform CQI efforts for each EBP, and to provide essential context for the ITT evaluation.

Similar to the CQI plans proposed for the well-supported interventions that qualify for evaluation waivers, the process studies for CPP, Triple P and TF-CBT will focus on answering implementation questions such as:

- Are eligible children and families being referred to EBPs?
- Are referred children and families actually receiving services?
- Were the services delivered with fidelity to the model?
- How engaged are children/families in services?
- Are children/families are successfully completing services?
- How much coordination occurs between EBP providers and other key partners (e.g., case managers)?

Gathering and periodically reviewing systematically collected data to address these questions will inform CQI efforts by targeting key points in referral, linkage, and service processes where the quantity or quality of implementation need to be examined and addressed. Analyzing likely sources of variation in participation indicators and implementation quality within and across EBPs (e.g., provider, location, referral sources, child age, race/ethnicity, and gender) will further help target problem solving efforts and the allocation of DCFS implementation support resources.

Multiple data sources will be needed to address these questions.

- DCFS administrative data and data collected from providers will be used to track children and families referred to and receiving EBPs. Provider data will be collected via Research Electronic Data Capture (REDCap), a secure, HIPPA-compliant application.
- Data on child and family participation / engagement in EBPs will be collected from providers via REDCap. These data will include the dates of completed sessions, missed sessions, reasons for missed sessions, and other information necessary to examine fidelity to EBP models.
- DCFS billing records may also be used, where applicable, to measure service receipt.
- Survey and/or interview data will be collected from children and families by evaluators to understand how children and families experience the services they receive, to assess whether those services are meeting their needs, and to measure their satisfaction with those services.
- Survey and/or interview data will be collected from EBP providers by evaluators to learn about any barriers to EBP enrollment and participation, any additional training or other supports that are needed, and any other relevant experiences.
- Survey and/or interview data will be collected from relevant DCFS and POS supervisors and caseworkers by evaluators to learn about their experiences with the referral process, including any barriers to engaging with referred children and families and EBP providers.

Outcome Study. In general, the purpose of an outcome study is to describe an intervention's effectiveness. The outcome studies included in the evaluations of CPP, Triple P, and TF-CBT will focus

on answering questions related to the effectiveness of each of these interventions in comparison to TAU for members of the candidate populations. It includes a primary study and several sub-studies.

Primary Outcomes Study. The primary outcomes study is the intention to treat (ITT) analysis with a quasi-experimental design to answer the PICO question. This analysis is at the core of the evaluation plan because it is aimed at estimating the effects of each EBP on safety, permanency, and well-being outcomes. The treatment group for the ITT analysis includes children and families referred to CPP, Triple P, or TF-CBT and not to any of the other planned interventions. EBP referrals, which will be documented at the case level in the prevention services plan in the state's SACWIS system, will be made based on four types of considerations:

- Child or family meets criteria for a candidate population
- Age of the child
- Clinical information about child and family needs (e.g., CANS data), family interest/motivation, and prioritizing of needs and services in case planning processes (e.g., Child and Family Team meetings)
- Availability of services

Illinois believes that a randomization protocol is unfeasible. Thus, we will use a quasi-experimental design to support any causal inferences about treatment effects. The evaluators will create matched comparison groups from the pool of children and families not referred to any of the planned interventions (e.g., receive usual services). However, we do not want to specify the matching approach we will use. Rather, we plan to explore multiple matching strategies (e.g., propensity score matching, exact matching) and select the most appropriate one based on the data. We also do not want to predetermine which matching algorithms (e.g., nearest neighbor matching, caliper and radius, kernel and local, and weighting) we will use. This is due to the fact that we simply do not know how many children and families will be in the intervention group and TAU pool, and/or whether each candidate population will need to be considered separately. It is our hope that we will be able to use covariates to identify cases from the comparison group pool that are similar to each of the EBP intervention cases. It is essential to include all observable variables that predict both referral and outcomes to account for selection effects (Huhr & Wulczyn, 2019). Data elements that will be examined as potential predictors of referral to an EBP for the matching analyses include (1) candidate population; (2) demographics (e.g., age and race/ethnicity of the child and the primary caregiver, geographic location); and (3) baseline CANS scores (domains and individual items) when available.

Because the sizes of the CPP, Triple P, and TF-CBT treatment groups will be modest, especially initially, it will be important to identify a small number of covariates to minimize the need to drop treatment group cases from the analyses because a matched case cannot be identified. Other potential strategies for increasing statistical power if needed include using one to many matching (creating larger comparison groups), using *nearest neighbor* matching with replacement (comparison group case

can match to more than one treatment group case, and weighting strategies such as the inverse probability of treatment and entropy balancing.

Bivariate and multivariate analyses of outcomes will include the model appropriate to the data structure. For example, in using censored data, we will examine whether proportional hazards or discrete time hazard models are more appropriate. These models are likely relevant for safety and permanency outcomes. Difference in difference analyses may also be needed to estimate treatment effects and control for observable historical variation in outcomes at the level of the referral source (e.g., casework agencies) or geographical unit (e.g., county, DCFS region), especially for well-being outcomes. We plan to conduct analyses within and across candidate populations, but it is not yet clear whether multivariate models will or should include multiple candidate populations.

As shown in the Table 10 below, the evaluations will examine indicators of safety, permanency, and well-being using existing administrative data. These indicators are aligned with the outcomes required for a study to be included in a Title IV-E Clearinghouse literature review. Because all the candidate populations include families in which children are living with parents or guardians, the safety and permanency outcomes are essentially the same—subsequent maltreatment or placement. However, because the candidate populations vary in terms of the *life of the case* (e.g., pre or post foster care), the permanency outcomes for post-reunification, post-adoption, and subsidized guardianship cases also include *re-entries* into care.

Under safety outcomes, we include a composite indicator for children who have either been the subject of an investigation or placed in foster care. This indicator reflects the fact that many children are placed (e.g., when Intact Family Services *disrupt*) without an immediately precipitating maltreatment report and it is reasonable to assume that safety considerations contributed to the need for placement. This indicator has the added benefit of producing higher base rates, thereby increasing the potential to detect treatment effects.

Child and Adolescent Needs and Strengths (CANS; Lyons, 2009) data will be used to measure child and parent/caregiver well-being outcomes. DCFS has used the CANS as its functional assessment for many years and it is the only administrative data source available for most of the candidate populations. Although some of the EBPs require primary collection of well-being data for children and families who receive the promising interventions, these data would not be available for matched controls because they are not required for the larger population of children and families in the candidate populations. A systematic review of child well-being assessments used with child welfare populations (Rosenbalm et al, 2016) identified the CANS as a commonly used assessment with acceptable or good levels of reliability, evidence of multiple types of validity, rigorous training and user support information. The review also found that implementation required ongoing support to ensure fidelity and that the CANS may not be sensitive to change over periods of less than 3 months. The evaluation team will engage in analyses to determine the specific domains and items that will be used for each EBP.

Table 10: Outcomes, Indicators and Data Sources

Outcome category	Indicators	Data sources
Safety	• Maltreatment reports (child and family level) at 6, 12, and 18 months after candidacy established • Indicated maltreatment reports (child and family) at 6, 12, and 18 months after candidacy established • Maltreatment reports OR placement (initial placement or re-entry) at 6, 12, and 18 months after candidacy established	Administrative data on maltreatment investigations and child living arrangements in foster care
Permanency	• Foster care placement (initial or re-entry) at 6, 12, and 18 months after candidacy established • Foster care status at 6, 12, and 18 months after candidacy established	Administrative data on maltreatment investigations and child living arrangements in foster care
Child well-being	• Indicators of emotional and behavioral functioning from CANS domains and items relevant to each EBP • Collected 30 days after candidacy, every 6 months while the case is *open,* and at case closing	Administrative data collected via CANS completed by caseworkers
Parent or caregiver well-being	• CANS domains and items on Caregiver Needs and Strengths related to safety, knowledge of parenting and child development, relevant to each EBP of adult well-being • Collected 30 days after candidacy, every 6 months while the case is *open*, and at case closing	Administrative data collected via CANS completed by caseworkers

To increase our ability to detect the effects of EBPs, we will individualize the measurement and of outcomes for each EBP in two ways. First, for the ITT evaluation, we will focus some of the outcome analyses on specific CANS items and subdomains that are most relevant to target populations and intervention strategies of each EBP. While the specific items and subdomains have yet to be finalized, a simple EBP specific example would be that CPP outcomes will include child level CANS items collected only for young children—these data will not be relevant to most Triple P and TF-CBT cases.

Outcome Sub-studies. The outcome sub-studies include estimating the effect of the treatment on the treated (sensitivity analyses), bivariate and multivariate analyses to identify factors associated with each outcome within the treatment and comparison groups separately and together (exploratory analyses), and bivariate and multivariate analyses (e.g., hazard models, ANCOVA) of the effects of baseline well-being and change in well-being over time on safety and permanency outcomes, controlling for any treatment effects and other co-variates (exploratory analyses).

The "effects of treatment on the treated" sub-study will be conducted to provide a less conservative estimate of treatment effect than that the estimate derived from the primary ITT analysis. It is a sensitivity analysis. The research question for the effects of treatment on the treated sub-study is whether children and families in the identified candidate populations (P) who actually receive an EBP

as part of their prevention services plan (I) in comparison to a group of similar children and families who receive treatment as usual (c) experience better safety, permanency and well-being outcomes (O)? Where it is feasible for providers to reliably collect the pretest and posttest data for treatment group cases (only), we will examine change over time using outcome measures that the purveyor recommends in order to provide program-specific outcome measures for treatment group participants. This is not proposed for matched comparison cases because matching will be done retrospectively and it is not feasible to engage in primary data collection with the entire population of potential comparison cases. For example, for Triple P, the purveyor has identified the Strengths and Difficulties Questionnaire (SDQ, Goodman et al, 1998) to measure child functioning outcomes (emotional symptoms, conduct problems, hyperactivity, peer relationships, prosocial behaviors, and the impact of difficulties on various aspects of functioning), and the Parenting Scale (Arnold et al, 1993), to measure dimensions of parent functioning (overreactivity, hostility, laxness). The SDQ may also be used for TF-CBT cases. Two standardized measures will be used to examine change over time in CPP, the Infant/Toddler Symptom Checklist (ITSC, Degangi, 1995) and the Devereux Early Childhood Assessment (DECA, LeBuffe & Naglieri, 1999). Data from these standardized measures will also enable us to examine the relationship of these baseline and change scores to CANS ratings and subsequent maltreatment and placement prevention outcomes.

The "predictors of outcomes" sub-study will examine predictors of each outcome in multivariate models without the complication of using some variables for propensity score matchings. These analyses can be conducted within the full sample of ITT treatment group cases and for treatment group cases in which some dosage of service was actually provided. These analyses will help us determine the characteristics of the cases that benefitted most and least from the intervention and examine issues of dosage more closely. These analyses are more exploratory. The research question for the predictors of outcomes sub-study is: What factors predict whether children and families in the identified candidate populations (**P**) referred to an EBP as part of their prevention services plan (**I**) in comparison to a group of similar children and families who receive treatment as usual (**C**) experience better safety, permanency, and well-being outcomes (**O**)?

The "effects of well-being on other outcomes" sub-study will examine the assumption, implicit in FFPSA and child welfare broadly, that improvements in well-being outcomes will be associated with improvements in safety and permanency outcomes. Examining this assumption is important because the Title IV-E Prevention Services Clearinghouse reviews of CPP, Triple P, and TF-CBT did not find evidence of improved safety or permanency outcomes despite evidence of improved well-being outcomes. Hence, well-being outcomes could improve without improvements in safety or permanency. The reverse could also occur; safety or permanency outcomes could improve without improvements in well-being. Further empirical and theoretical work on the relationships among these outcomes will, we believe, be beneficial to the field. It is also exploratory in nature. The research question for the effects of well-being on other outcomes sub-study is: Do changes in well-being mediate or moderate the whether children and families in the identified candidate populations (P) referred to an EBP as part of their

prevention services plan (I) in comparison to a group of similar children and families who receive treatment as usual (C) experience better safety and permanency outcomes (O)?

The "racial equity" sub-study will examine potential disproportionality in EBP referral, acceptance, completion, and/or effectiveness. Examinations of disproportionality will need to consider variation in demographic characteristics of the population across geographic areas of the state. It is also exploratory. The research question for the racial equity sub-study is: Whether there are different rates of referral, acceptance, completion and/or effectiveness of EBPs for children and families in the identified candidate populations?

Continuous Quality Improvement (CQI). Continuous monitoring will be aligned with the process and outcome studies. Process study outcomes for continuous monitoring will include: 1. Are eligible children and families being referred to EBPs? 2. Are referred children and families actually receiving services? and 3. Were the services delivered with fidelity to the model? The overall outcomes from Table 10 (above) and the intervention-specific proximal and distal outcomes from Tables 11-13 (below) will be used for continuous monitoring as they become available. Consistent with the CQI plan for well-supported interventions, the evaluators will meet bi-monthly with the full implementation team and monthly subgroup meetings.

Child-Parent Psychotherapy (CPP)-Specific Evaluation Considerations. CPP is a relationship-based therapy model that serves children birth through age 5 years and their parents/caregivers (Lieberman, 2004). CPP aims to restore normal developmental functioning in the wake of domestic violence and trauma by supporting family strengths and relationships, helping families heal and grow after stressful experiences, and respecting family and cultural values. CPP therapy sessions are typically delivered weekly over the course of 20 to 32 weeks or more, depending on clinical need. Each session is 60 to 90 minutes and is delivered at home or in an outpatient clinic. Child-Parent Psychotherapy was rated as a "promising" parenting intervention by the Title IV-E Prevention Services Clearinghouse because at least one study achieved a rating of moderate or high on study design and execution and demonstrated a favorable effect on a target outcome—primarily in the area of child well-being (Cicchetti, Toth, & Rogosch, 1999; Lieberman, Van Horn, & Ghosh Ippen, 2005). One study also found improvement in adult mental health outcomes related to PTSD (Lieberman et al, 2005).

CPP in Child Welfare in Illinois. As a national leader in infant mental health, Illinois has built the capacity of mental health professionals to provide CPP to alleviate the effects of trauma in early childhood. In 2004, one of the model's developers, Patricia Van Horn, along with other certified CPP trainers, trained therapists in several child welfare agencies. CPP was implemented as part of a broader System of Care intervention for children in foster care and their parent or foster caregiver with culturally sensitive adaptations aimed at increasing the effectiveness of services. The most relevant adaptations involved working with foster parents when parents weren't available, working with both foster parent and the biological parent to facilitate reunification, and offering the option of in-home services.

In FY14, DCFS began implementation of the Illinois Birth through Three (IB3) IV-E waiver project and evaluation. This project targeted children age birth through three who entered foster care in Cook County. Child Parent Psychotherapy was one of the primary clinical services offered through IB3. In July 2017, DCFS and the Cook County Juvenile Court partnered to start a Safe Babies Court in Cook County, serving the IB3 target population. CPP is the primary trauma therapy recommended by Zero to Three for Safe Babies Courts around the country, and over half of the children in the Cook County project have a parent or foster parent participating with one or more children in CPP. While no evaluations of these projects have focused on CPP-specific outcomes, we have learned a great deal about the challenges associated with implementing CPP, including:

- High rates of therapist turnover, which inhibit continuity of care and the building of trust that is essential for this relational intervention
- Caseworkers and parents sometimes not understanding aspects of CPP (e.g., effects of trauma on very young children; play as a form of therapy
- Therapists sometimes struggling to balance confidentiality with the need to share information about client progress
- Some parents not being able or *ready* to benefit from CPP given its intensive focus on the child's traumatic experiences and reactions to it
- Provider agencies giving therapists only a few CPP cases at a time rather than "all CPP" caseloads in order to avoid burnout (given the intensity of CPP treatment)

FFPSA Plans to Expand CPP Capacity. The Illinois FFPSA plan expands the existing CPP treatment caseload capacity of 104 families by 183 families, for a total capacity of 287. The CPP expansion focuses on serving various populations of Intact families, which marks a significant change from for the prior focus on families with children in foster care. The contracts for the new providers assume 36 sessions (usually weekly) per case. Given that the standard length of Intact Family Services (the largest candidate population) is 6-9months and extensions of that timeframe can be requested, Intact Family Services cases receiving CPP will be able to receive extensions.

Some contracted agencies have already been providing CPP, while others are new. In addition, newly contracted CPP services will start in some cases before the Department has finalized the IT component of prevention services plans. Thus, these cases will not be included in the ITT evaluation sample.

New therapists will be trained through a CPP learning collaborative process with selected nationally certified CPP trainers (Child Parent Psychotherapy, 2020). The collaborative is co-sponsored by the Irving B. Harris Foundation and the Erikson Institute. Provider staff and supervisors participate as part of an agency team with the agency committing to support participation in the initial and ongoing training. Some provider agencies are starting CPP while others are expanding their existing capacity. Some CPP therapists already serving foster care cases may begin to serve Intact families, which would expand CPP treatment capacity for FFPSA candidate populations.

CPP Fidelity. The Erikson Institute learning collaborative will also monitor and support fidelity of implementation during the 18-month training period. When possible, providers maintain consultation with certified trainers post- learning collaborative for ongoing fidelity support.

Three CPP fidelity packets guide providers through the intervention and support reflection during each phase of treatment. Each of the phase-based fidelity packets include a registration form, contact log, intervention fidelity form, and phase-specific instructions and procedures. The contact log is completed after each session and helps the therapist document each phone call or scheduled session including when the contact occurred, where, with whom, duration, and the session number. The purpose of the foundational phase is to assess the family, including the child's and caregiver's trauma history and mental health before the CPP core intervention phase begins. The therapist collects information about the target child, his or her siblings, and caregivers using the client registration form. After completing the contact log for the session, the therapist completes an assessment and engagement form with each caregiver involved in treatment that captures caregivers' assessment of the child's symptoms, caregivers' acknowledgment of traumatic events and their impact on the child, and caregivers' expectations about treatment.

After completing the assessment, the therapist meets with the caregiver alone to discuss what they have learned, discuss the rationale for treatment and the appropriateness of CPP for the target child, and plan next steps. Next, the therapist completes the intervention fidelity form, which is designed to help the therapist conceptualize the core intervention phase. The form consists of six sections: reflective practice fidelity, emotional process fidelity, dyadic-relational fidelity, trauma framework fidelity, and procedural fidelity. Each section requires the therapist to rate several potential sources of challenge (e.g., family is difficult to engage) using a scale that ranges from "no" to "significant" and to rate their own practice capacity and challenges (e.g., awareness of personal and/or cultural biases) using a scale that ranges from "requires development" to "acquired." Then, the therapist uses the case conceptualization and content fidelity form to rate how well the therapist's interventions addressed a list of CPP objectives (0=not at all a focus; 1 = minor; 2 = moderate; 3 = significant), how much focus the therapist placed on each objective (e.g., "under", "appropriate," or "over"), and how much progress the family made toward each objective (0= primary target; 1 = emerging; 2 = present but unstable; 3 = established). The foundational phase is completed and reviewed with a supervisor before the core intervention phase begins.

During the core intervention phase, the therapist uses a procedural fidelity form to introduce the child to CPP and completes the contact log to track how the child responds to treatment. The procedural fidelity form includes a checklist of activities that the therapist completes with the child (e.g., explained the reason for treatment to child). After every 12 CPP sessions (for most agencies), the therapist uses the Intervention Fidelity form again to re-conceptualize the case until termination begins and the case conceptualization and content fidelity form to rate how well the therapist's interventions addressed each objective.

During the termination phase, the therapist uses the contact log to track participation and completes the closing form and documents when termination occurred, who initiated termination, the type of termination, the change in functioning, prognosis, and reasons for closing. Next, the therapist uses the procedural fidelity form to complete a list of activities (e.g., processed the goodbye). At the end of treatment, the therapist uses the intervention fidelity form to reflect on intervention fidelity and the case conceptualization and content fidelity form to rate how well the therapist's intervention addressed each objective.

In addition to the treatment fidelity packets, CPP providers can monitor supervisors/consultants who support the therapists learning CPP using the consultation fidelity and supervision fidelity packets.

Targeting for CPP. CPP targets children birth through 5 years old who have been exposed to some form of trauma or adversity such as maltreatment (including emotional abuse), which is measured by the CANS, or domestic violence. Before a referral to CPP is made, consideration will need to be given to whether the parent has at least some interest in CPP after it has been described. Consideration will also need to be given to the child's level of risk for subsequent maltreatment or placement. Effects on safety and permanency are unlikely to be detected if only children with the highest functioning parents or families receiving extended family support, which tend to have low base rates of subsequent maltreatment and placement, are referred.

CPP specific outcomes and research questions. The primary research question for the outcome evaluation of CPP is:

> Among children and families from the identified candidate populations **(P)**, do those who are referred to CPP as part of their prevention services plan **(I)** in comparison to a group of similar children and families who receive treatment as usual **(C)** experience better safety, permanency, and well-being outcomes **(O)**?

The distinction between children and families who are eligible to receive CPP and children and families referred to CPP is important. Eligibility is determined by child age and by child and family clinical appropriateness. Whether or not an eligible child and family is actually referred also depends upon whether or not they are located close enough to where CPP will be offered and whether or not they will accept the referral.

Table 11 below includes outcome measures at the parent, child, and system levels that are specific to CPP. Note that, t the system level, the caseworker plays a key role as a broker of engagement in EBPs throughout the life of the case. Supporting sustained parent engagement in clinical services is especially important for EBPs like CPP that require treatment over longer periods of time.

Table 11: CPP Evaluation Outcomes

Proximal Outcomes	Distal Outcomes
Parent Outcomes	
• Adult well-being: Positive parenting practices.[1] CANS will be used to measure change over time in parenting practices. • Adult well-being: Parent/caregiver mental or emotional health.[1] CANS will be used to measure change over time in parent/caregiver mental or emotional health.	• No subsequent investigations for child maltreatment[2] • No subsequent indicated allegations[2]
Child Outcomes	
• Children demonstrate improved behavioral and emotional functioning.[4] CANS will be used to measure change over time in trauma symptoms, internalizing behaviors and externalizing behaviors.	• Children remain at home with their families[3]
System Outcomes	
• CPP providers receive the training and support needed to serve DCFS-involved families. • CPP providers are communicating with DCFS and POS agency caseworkers and other service providers. • Providers receive the training and support needed to serve DCFS-involved families	• Increased communication and coordination between child welfare staff and EBP providers in Illinois

[1]Eligible target parent well-being outcomes via Title IV-E Clearinghouse
[2]Eligible target safety outcome via Title IV-E Clearinghouse
[3]Eligible target permanency outcome via Title IV-E Clearinghouse
[4]Eligible target child well-being outcomes via Title IV-E Clearinghouse

Planned outcome sub-studies were described in the Integrated Evaluation Framework section above. The first of those sub-studies examines the difference between the number of children and families referred to CPP and the number of children who actually received CPP, and to examine the sensitivity of study results by estimating the effect of the treatment on the treated. This sub-study will also examine the reasons why some families will fail to proceed from referral to treatment completion. The second of those sub-studies was designed to examine predictors of treatment outcome. Level of participation in CPP, what we might call dosage, is an important predictor to examine. Given the requirements for parental participation in CPP, these analyses may provide information important to future implementation efforts. The third sub-study is designed to examine the impact of well-being on other study outcomes. Given that CPP has been shown in some studies to impact adult mental health and child well-being, it will also be important to examine these relationships in the CPP evaluation. The final sub-study is designed to examine racial equity issues. Specific to CPP, we will examine questions related to potential equity issues in terms of referral to CPP, completion of CPP, and differential outcomes of participating in CPP.

The primary process and implementation questions designed to describe the status of the CPP implementation are described above in the Integrated Evaluation Framework section. The process

evaluation will examine the historical challenges of implementing CPP in Illinois discussed earlier. Process/implementation questions specific to the implementation of CPP include, but are not limited to, questions such as:

- What proportion of CPP therapists are newly trained through Family First vs. previously trained and certified?
- What percentage of participants in the CPP learning collaborative complete the full 18 month training?
- What are the demographic characteristics of CPP therapists?
- At each provider agency, how do the number of available CPP clinicians (trained and in-training) and caseload capacity change over time?
- How successful are the provider agencies at maintaining their supply of CPP clinicians?
- What are the most common reasons why referred children and families don't participate?
- What are the most common reasons why some participating children and families fail to complete treatment?

Positive Parenting Program (Triple-P)-Specific Evaluation Considerations. The Positive Parenting Program (Triple P) is a parenting intervention for caregivers with children who exhibit developmental, behavioral, or emotional problems. The program aims to equip parents with the parenting skills and competence to be able to manage their children's behavior and promote self-regulation. The level 4 standard version of Triple P (in-person, one-on-one sessions), which will be used in Illinois, was rated as a "promising" mental health program by the Title IV-E Prevention Services Clearinghouse. This version of Triple P had at least one study that achieved a rating of moderate or high on study design and execution and demonstrated favorable effects on the outcomes of child well-being--behavioral and emotional functioning, positive parenting practices, and adult well-being. None of the Triple P studies measured child safety or permanency outcomes.

Among the 7 studies reviewed by the Clearinghouse that examined child well-being, there were favorable outcomes on 4 of 16 indicators, including parent reports of ADHD symptoms (Leung et al, 2003) and conduct and behavior problems (Khademi et al, 2019). The overall effect size across studies was .19 (low). Study findings were more positive for positive parenting practices, with 6 studies showing favorable findings on 11 of 14 indicators. Favorable outcomes included increased parenting sense of competence and improved discipline practices (e.g., Leung et al, 2003; Khademi et al, 2019), including decreased overreactivity (Leung, Fan, & Sanders, 2013). The overall effect size for positive parenting practices was .36, close to a *medium* effect size. There was also some modest evidence of treatment effects on adult mental health outcomes.

The standard version of Triple P covers children from birth to 12 years old. Services are typically delivered over a 10-week period with each weekly session lasting about one hour. In Illinois, sessions will take place in the family's home, and the length of the program will be adjusted as needed for each child and family. However, families are expected to complete between 8 and 10 sessions. Triple P

requires that providers have a post high school degree in a related field, and that requirement is sometimes relaxed. That is, masters level training and clinical licensure are not required.

Eleven agencies across Illinois have been contracted to provide Triple to 325 children and their parents per year. While some contracted providers have been providing Triple P, most have not. Similarly, DCFS program staff and evaluators have had little prior exposure to Triple P.

Fidelity. Topics covered in the Triple P training include applying parenting strategies, identifying risk and protective factors in families, assessing child and family functioning, and making referrals. The first cohort of providers was trained approved Triple P trainers in October 2020. All service providers are given a facilitator's manual in the standard level 4 training course (Sanders, Markie-Dadds, & Turner, 2013), which includes step-by-step guidelines for successful delivery of Triple P. Additionally, there are three fidelity tools provided by the Triple P Implementation Framework that providers use to support implementation: Accreditation of Practitioners, Session Checklists, and Peer Support Networks. The Accreditation of practitioners form is typically completed during the provider training course and establishes a baseline competence of all practitioners and their ability to implement the program as intended. The session checklists are included in the training protocol and in the Triple P Manual. The checklists are optional and can be used by practitioners as either self-assessments or as part of a formal quality assurance protocol. Practitioners will participate in peer support networks and receive feedback from other trained Triple P providers on their cases.

Targeting. Triple P will target families who meet the criteria of one of the target population subgroups and who have children and youth (birth through 12 years old) with behavioral problems. The evaluation team will use the Child and Adolescent Needs and Strengths (CANS 2.0) to assess child behavior and parenting outcomes.

Triple P specific outcomes and research questions. The primary research question for the outcome evaluation of Triple P is:

> Among children and families from the identified candidate populations **(P)**, do those who are referred to Triple P as part of their prevention services plan **(I)** in comparison to a group of similar children and families who receive treatment as usual (**C)** experience better safety, permanency, and well-being outcomes (**O)**?

The distinction between children and families who are eligible to receive Triple P and children and families referred to Triple P is important. Eligibility is determined by child age and by child and family clinical appropriateness. Whether or not an eligible child and family is actually referred also depends upon whether or not they are located close enough to where Triple P will be offered and whether or not they will accept the referral. Table 12 below includes outcome measures at the parent, child, and system levels for Triple P.

Table 12: Triple P Evaluation Outcomes

Proximal Outcomes	Distal Outcomes
Parent Outcomes	
• Adult well-being: Positive parenting practices.[1] CANS will be used to measure change over time in parenting practices. • Adult well-being: Parent/caregiver mental or emotional health.[1] CANS will be used to measure change over time in parent/caregiver mental or emotional health.	• No subsequent investigations for child maltreatment[2] • No subsequent indicated allegations[2]
Child Outcomes	
• Children demonstrate improved behavioral and emotional functioning.[4] CANS will be used to measure change over time in trauma symptoms, internalizing behaviors and externalizing behaviors.	• Children remain at home with their families[3]
System Outcomes	
• Triple P providers receive the training and support needed to serve DCFS-involved families. • Triple P providers are communicating with DCFS and POS agency caseworkers and other service providers. • Providers receive the training and support needed to serve DCFS-involved families	• Increased communication and coordination between child welfare staff and EBP providers in Illinois

[1]Eligible target parent well-being outcomes via Title IV-E Clearinghouse
[2]Eligible target safety outcome via Title IV-E Clearinghouse
[3]Eligible target permanency outcome via Title IV-E Clearinghouse
[4]Eligible target child well-being outcomes via Title IV-E Clearinghouse

Planned outcome sub-studies were described in the Integrated Evaluation Framework section above. The first of those sub-studies examines the difference between the number of children and families referred to Triple P and the number of children who actually received Triple P, and to examine the sensitivity of study results by estimating the effect of the treatment on the treated. This sub-study will also examine the reasons why some families will fail to proceed from referral to treatment completion. The second of those sub-studies was designed to examine predictors of treatment outcome. Level of participation in Triple P, what we might call dosage, is an important predictor to examine. Given the requirements for parental participation in TF-CBT, these analyses may provide information important to future implementation efforts. The third sub-study is designed to examine the impact of well-being on other study outcomes. Given that Triple P has been shown in some studies to impact parenting practices, adult mental health, and child well-being, it will also be important to examine these relationships in the Triple P evaluation. The final sub-study is designed to examine racial equity issues. Specific to Triple P, we will examine questions related to potential equity issues in terms of referral to Triple P, completion of Triple P, and differential outcomes of participating in Triple P.

The primary process and implementation questions designed to describe the status of the Triple P implementation are described above in the Integrated Evaluation Framework section above.

Process/implementation questions specific to the implementation of Triple P include, but are not limited to, questions such as:

- How long does it take for provider agencies to reach full staffing capacity for Triple P?
- What are the characteristics (e.g., existing staff vs. not, level of education, race/ethnicity) of Triple P practitioners?
- How long does it take for a clinician to become Triple P certified at each agency?
- At each provider agency, how do the number of available Triple P clinicians (trained and in-training) and caseload capacity change over time?
- How successful are the provider agencies at maintaining their supply of Triple P clinicians?
- What are the most common reasons why referred children and families don't participate?
- What are the most common reasons why some participating children and families fail to complete treatment?

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)-Specific Evaluation Considerations. TF-CBT is a short-term psychotherapy for children ages 3 to 18 experiencing emotional and behavioral difficulties secondary to traumatic life experiences and their parents/caregivers. The goals of TF-CBT include reducing post-traumatic stress disorder, depression and anxiety symptoms and disruptive behavior problems and increasing parenting support and skills, parent-child communication, and adaptive functioning.

The Title IV-E Clearinghouse rated TF-CBT as "promising" because at least one study of moderate or high rigor demonstrated a favorable effect on at least one target outcome. Favorable outcome domains for TF-CBT included child social functioning, child behavioral and emotional functioning, caregiver mental or emotional health, and positive parenting practices. Other reviews have resulted in more favorable ratings. TF-CBT is designated a Model Program by SAMHSA's National Child Traumatic Stress Network and has received a well-supported Effective Practice designation by the California Evidence-Based Clearinghouse (CEBC).

FFPSA Plans to Expand TF-CBT Capacity. TF-CBT was part of a pilot project in Illinois from 2004-2006. Our current estimate of existing TF-CBT capacity in Illinois is taken from the Service Provider Identification & Exploration Resource (SPIDER) database. A search for mental health treatment programs with the keyword "TF-CBT" in SPIDER shows that TF-CBT is currently offered by private providers of service to children and families involved with DCFS at approximately 20 locations throughout the state. DCFS plans to contract for TF-CBT under FFPSA with 7 providers for a total annual capacity of 232 children and families. Three of these providers are also on the list of 20 providers identified by SPIDER, meaning that a rough estimate of "new capacity" under FFPSA is ~170 children and families annually.

Fidelity. Clinician fidelity to the TF-CBT model will be measured using several implementation tracking tools and as required of providers by the model purveyor to achieve and maintain certification. Session-level TF-CBT fidelity is generally measured using the Brief Practice Checklist. Other details about will be determined as the larger TF-CBT implementation team, including the recently selected provider agencies, come together to engage in more specific planning activities. We expect to use tools used in the subset of prior TF-CBT evaluations that met criteria for the Title IV-E Clearinghouse's evidence review.

Targeting. DCFS is still developing screening/triage methods, but several aspects of "targeting" of children and families in the candidate populations to TF-CBT are already clear. First, although TF-CBT is appropriate for children ages of 3 to 18 years old, the candidate populations are unlikely to include children over age 17. Second, TF-CBT is only appropriate for children who have experienced significant trauma and are experiencing significant symptoms as a result of that experience. Third, because TF-CBT is a psychotherapy that involves the child and his or her parents/caregivers, it is only appropriate for children whose parents/caregivers can and will participate.

TF-CBT specific research questions and outcomes. The primary research question for the outcome evaluation of TF-CBT is:

> Among children and families from the identified candidate populations **(P)**, do those who are referred to TF-CBT as part of their prevention services plan **(I)** in comparison to a group of similar children and families who receive treatment as usual **(C)** experience better safety, permanency, and well-being outcomes **(O)**?

The distinction between children and families who are eligible to receive TF-CBT and children and families referred to TF-CBT is important. Eligibility is determined by child age and by child and family clinical appropriateness. Whether or not an eligible child and family is actually referred also depends upon whether or not they are located close enough to where TF-CBT will be offered and whether or not they will accept the referral. Table 13 includes TF-CBT specific outcome measures at the parent, child, and system levels.

Table 13: TF-CBT Evaluation Outcomes

Proximal Outcomes	Distal Outcomes
Parent Outcomes	
• Adult well-being: Positive parenting practices.[1] CANS will be used to measure change over time in parenting practices. • Adult well-being: Parent/caregiver mental or emotional health.[1] CANS will be used to measure change over time in parent/caregiver mental or emotional health.	• No subsequent investigations for child maltreatment[2] • No subsequent indicated allegations[2]
Child Outcomes	
• Children demonstrate improved behavioral and emotional functioning.[4] CANS will be used to measure change over time in trauma symptoms, internalizing behaviors and externalizing behaviors.	• Children remain at home with their families[3]
System Outcomes	
• TF-CBT providers receive the training and support needed to serve DCFS-involved families. • TF-CBT providers are communicating with DCFS and POS agency caseworkers and other service providers. • Providers receive the training and support needed to serve DCFS-involved families	• Increased communication and coordination between child welfare staff and EBP providers in Illinois

[1]Eligible target parent well-being outcomes via Title IV-E Clearinghouse
[2]Eligible target safety outcome via Title IV-E Clearinghouse
[3]Eligible target permanency outcome via Title IV-E Clearinghouse
[4]Eligible target child well-being outcomes via Title IV-E Clearinghouse

Planned outcome sub-studies were described in the Integrated Evaluation Framework section above. The first of those sub-studies was designed to examine the difference between the number of children and families referred to TF-CBT and the number of children who actually received TF-CBT, and to examine the sensitivity of study results by estimating the effect of the treatment on the treated. This sub-study must also examine the reasons why some families will fail to proceed from referral to treatment completion. The second of those sub-studies was designed to examine predictors of treatment outcome. Level of participation in TF-CBT, what we might call dosage, is an important predictor to examine. Given the requirements for parental participation in TF-CBT, these analyses may provide information important to future implementation efforts. The third sub-study examines the impact of well-being on other study outcomes. Given that TF-CBT has been shown to impact both parent and child well-being, it will also be important to examine these relationships in the TF-CBT evaluation. The final sub-study is designed to examine racial equity issues. Specific to TF-CBT, we will examine questions related to potential equity issues in terms of referral to TF-CBT, completion of TF-CBT, and differential outcomes of participating in TF-CBT.

The primary process and implementation questions designed to describe the status of the TF-CBT implementation are described above in the Integrated Evaluation Framework section above.

Process/implementation questions specific to the implementation of TF-CBT include, but are not limited to, questions such as:

- How long does it take for a clinician to become TF-CBT certified at each agency?
- How does the number of TF-CBT certified clinicians at each agency change over time?
- How successful are the TF-CBT providers at maintaining their supply of TF-CBT certified clinicians?
- What are the most common reasons why referred children and families don't participate?
- What are the most common reasons why some participating children and families fail to complete treatment?

Human Subjects Considerations. Human subjects considerations for the evaluations are largely similar to those discussed above for the CQI plans. The evaluation of both CPP, Triple P, and TF-CBT will involve research with human subjects. Approval for this research will be sought from both the University of Chicago's School of Social Service Administration- Chapin Hall Institutional Review Board (in the case of the Chapin Hall evaluator for TF-CBT), the University of North Carolina at Chapel Hill Institutional Review Board (in the case of the UNC evaluator for CPP and Triple P), and the Illinois Department of Children and Family Services Institutional Review Board (in both cases). The issue of informed consent will be addressed as outlined in Table 14. The human subjects considerations for each of the three evaluations are all very similar.

Table 14: Plan for Informed Consent by Data Source

Data Source	Plan for Informed Consent
DCFS administrative data	Waiver of informed consent
DCFS billing records	Waiver of informed consent
Administrative records from other state agencies	Waiver of informed consent
Data collected by provider agencies and staff	Waiver of informed consent but permission to share data with Chapin Hall
Survey/interview data	Informed consent/assent obtained by Chapin Hall prior to data collection

Limitations. In general, we believe the evaluation plan described above is strong and adheres to the standards outlined by the Title IV-E Clearinghouse. The primary limitation is that we do not propose to use an experimental study design. Randomized controlled trials (RCTs) are the gold standard, but in this case the complexities involved with the multiple interventions included in the state's FFPSA plan precluded assigning children and families to receive them via randomization. Although we plan

to statistically control for factors that we are able to measure, lack of random assignment means that we will not be able to rule out the potential for unmeasured confounding. Unmeasured confounding is always a concern in quasi-experimental studies. We plan to include as many measured covariates as possible in our multivariable models, but standard statistical rules of thumb suggest the number of covariates that can be included in statistical models is limited by the number of observed events (Harrell et al., 1996).

Another strategy we plan to use to overcome the lack of random assignment and to deal with the issue of equivalence between the children and families in our intervention and comparison conditions is by "matching" using propensity scores or other statistical approaches, but we are hesitant to propose a specific matching method at this stage because we simply do not yet know what methods will and will not be feasible. For example, implementation realities may mean that there may be no "propensity" to model and/or that the size of the pool of cases in the intervention and comparison conditions preclude certain matching options and/or any effort to match. This is especially true because Illinois' plan includes multiple EBPs and multiple candidate populations, some of which will make up groups that are quite small. The complexity of multiple candidate populations and referral sources may complicate matching efforts. Multiple candidate populations across multiple interventions will complicate eligibility determinations, referrals, service receipt, and – from a narrower evaluation perspective – matching efforts. To address this complexity, we describe the "pool" of children and families eligible to be matched above. Matching efforts may ultimately require separate analyses for each candidate population for each EBP, which would dramatically reduce statistical power to identify treatment effects.

That we propose an ITT analysis focused on referrals is a strength of our evaluation plan. But, it is a strength that could quickly become a limitation because the flow of cases from referral to service receipt is currently unclear. Implementation efforts are, of course, not yet underway. Much will be learned during the early stages of implementation and the evaluation plans may need to be revised as a result. For example, it may be that the initial triage process may result in a far greater number of children and families being referred to the EBPs than are actually treated. This would bias evaluation results towards the null. We attempt to examine this possibility by including a plan to estimate the effects of treatment on the treated in a sub-study.

Regarding well-being outcomes, one limitation of our design is that it relies upon measures that exist in Illinois' existing administrative data. The purveyors of the EBPs Illinois is implementing recommend the use of specific measures. From their perspective, it is a limitation that our ITT analyses will not use the measures they have fine-tuned their interventions to show change on. In some cases, the purveyors will require Illinois to collect data with those measures, but those data will only exist for children and families who are treated with the specific EBPs. To address this limitation, we propose exploratory sub-studies that will examine these measures as they exist for the treated. Each of the model purveyors has their own list of preferred measures. Thus, this limitation is both general to all and specific to each EBP. Finally, the specific measure that exists in Illinois administrative data is the

Child and Adolescent Needs and Strengths (CANS). The CANS includes a large number of items that can be used to create measures of some but not all relevant constructs. That we will not have a measure of all relevant constructs in a significant limitation. For example, parenting attitudes are not measured directly. Although the CANS contains a lot of information about a caregiver's needs and strengths, some of which are related to parenting behaviors, it is not a standard parent self-report measure of parenting attitudes. Again, because of the models has been shown to be effective using slightly different measures, this limitation is again general to all and specific to each EBP. Another limitation of the CANS is that its ratings are made based on all available information. Although this might make the CANS an ideal measure in certain situations, in this context it is a potential limitation because different information will be available to make ratings for cases referred to EBPs (e.g., children in the intervention conditions) than will be available to make ratings for cases not referred to EBPs (e.g., children in the comparison conditions). Cases referred to EBPs will be working with the EBP providers who will be engaging in assessment that is more detailed than that completed by the providers of usual services. This has the potential to lead to information bias.

Section 7: Workforce Training and Support

To be successful, Illinois must further strengthen the relationships between providers, DCFS, sister agencies, EBP purveyors, trainers, and university partners to accommodate the expansion and scaling up of service provision and to ensure ongoing support and enhancement of a competent and skilled workforce of both child welfare and service provider staff.

All interventions that were included in Illinois's plan have been selected due to their high level of research evidence, as well as accessibility and local support within the state. Each have their own unique staff qualifications and training requirements specific to the intervention's service delivery model. DCFS, in collaboration with its sister agencies, expects all providers of EBPs working with DCFS families as part of this five-year plan to uphold the staffing and training requirements specified by each EBP model. DCFS will hold all EBP service providers accountable to implementing each intervention with fidelity, including requirements of staff training, staff qualifications, and monitoring and reporting as directed by the EBP purveyors and contractual agreements. DCFS will seek opportunities to collaborate with the Department of Human Services (DHS) and other public agencies to integrate existing or create new contracts with training entities.

Child Welfare Workforce Trainings

To prepare the child welfare workforce, the DCFS Office of Learning and Professional Development (OLPD) will design and facilitate curricula to train direct service workers on general knowledge and enhanced practices through pre-service and in-service modules that will cover:

- Family First vision and overview;
- Engagement;
- Trauma-informed practice;
- Identification of eligible cases and assessment for appropriate service interventions
- Prevention plan development and documentation;
- Referral processes;
- Ongoing assessment of risk;
- Oversight and evaluation of the continuing appropriateness of services;
- Supervision;
- Data collection, reporting, and continuous quality improvement

Family First Overview. The first module in this new curriculum will be designed as an overview to assist the field in their understanding of the Family First vision, legislation and guidance, its alignment with DCFS' umbrella prevention strategy, and the expected changes to existing preventive casework practice and operations.

Training to Enhance Engagement. As previously discussed, all caseworker and investigator workers will be trained in Motivational Interviewing (MI). This training is intended to not only enhance engagement and casework practice for families involved in preventive populations but also those involved with foster care. The Department is currently under discussions with external trainers to assist with implementing this practice.

Training to Ensure Trauma-Informed Care. As mentioned in Section 3, the Department has had a long-standing commitment to a trauma-informed practice (Illinois Department of Children & Family Services, 2007). The Office of Learning and Professional Development has infused trauma-informed training components into the foundation of pre-service and in-service trainings for DCFS investigators, DCFS caseworkers, and Purchase of Service (POS) private agency caseworkers. This focus on trauma-informed care was further enriched recently with the launch of the Family Centered, Trauma Informed and Strength Based (FTS) training as part of the rollout of the Department's new core practice model. The FTS is a cornerstone training that provides education about the impact of trauma on the child and family and teaches skills to ensure that worker engagement, advocacy, assessment, and service planning are aligned to these needs. FTS serves as the guide for the caseworker's linkage and coordination with all working on behalf of the child and family—from family-centered support, specialty clinical treatment, social, health and educational services, and community providers. These practice principles grow out of established child welfare assumptions, and in turn, are integral to the

federal Child and Family Service Outcomes. Together, Illinois's Core Practice Model and the federal Child and Family Service Outcomes provide the context for all casework intervention identifying usable strength and providing specialized clinical interventions, social and emotional support, and concrete services aimed at meeting the child, youth, and family's needs. A pillar of trauma-informed care includes the use of trauma informed assessments using the Child and Adolescent Needs and Strengths (CANS) tool. The CANS is now used by therapists, caseworkers and residential staff to guide trauma-informed decision making, case planning, and treatment planning.

DCFS will also build upon the existing infrastructure of trauma-informed trainings to enhance the curricula and create new training opportunities for external EBP service providers. Ensuring trauma-informed care by providers offering IV-E funded prevention services is now a requirement for all contracts through participation in a clinical learning community and will be discussed in the next section.

Training to Identify Candidates; Assess and Develop Prevention Plans. Current pre-service and in-service training will be enhanced to include information on identifying candidates for prevention services based on imminent risk criteria and appropriateness of services through existing assessment tools (e.g., CERAP, CANS, etc.) as well as developing child-specific plans as outlined in Section 4 of this plan. The Foundations pre-service training for all direct service workers includes specific content related to service planning. Content on service planning is referenced as well throughout the Child Welfare Employee Licensure Study Guide that new hires review. Staff are trained to utilize a family centered approach to assess and identify needs and plan for correlating interventions to address those needs.

Beginning with immersion site regions, workers are being trained and coached in an enhanced model of the existing child and family team meeting (CFTM) process that utilizes an FTS approach to work with families to collaboratively identify their needs and strengths and begin to select services to effectively meet those needs. As the enhanced CFTM model continues to expand, OLPD can adapt to training and coaching workers in this model as a foundational support for Family First service planning. Staff will continue to receive training on the case planning process to ensure families are receiving and making progress on their goals and objectives supported by evidence-based treatment programs.

Training to Refer and Link Families with Appropriate Interventions. In preparing for Family First, current DCFS staff will receive training designed to educate staff on the evidence-based services along with the referral process to each service to ensure families have access to the services outlined in Section 3. OLPD will support Division of Clinical Services through incorporating the purpose and benefit for utilizing each EBP intervention into pre-service and in-services trainings. The Department will also make further investment into the development of service navigator/locator platforms such as SPIDER as well as staff use of these tools to support the referral process.

To further enhance cross-system collaboration for home visiting and early intervention services in particular, the Ounce of Prevention, the Governor's Office of Early Childhood Development (OECD), and the Department of Children and Family Services (DCFS) will continue to partner in providing regionally-based trainings. These trainings provide staff with skills to overcome barriers to early intervention and home visiting for families involved in the child welfare system and effectively collaborate with vital cross-sector service partners. These trainings already involve most of the worker populations serving the targeted subgroups, including Intact caseworkers and supervisors, Placement caseworkers and supervisors, Teen Parent Service Network (TPSN) caseworkers and supervisors, in addition to Home Visitors and supervisors, Child and Family Connections (CFC) staff, and Early Intervention (EI) therapists.

Training to Conduct Risk and Safety Assessments. The Office of Learning and Professional Development provides both pre-service and in-service training for child welfare staff that provides training and guidance in completing and utilizing different assessment tools. As part of the pre-service for new hires, the Foundations Curriculum includes a unit on assessments. This Foundations unit includes training assessments and underlying conditions. It includes training on the purpose and application of assessment tools, such as: Child Endangerment Risk Assessment Protocol (CERAP) safety assessment, Home Safety Checklist, Paramour Assessment Checklist, among others. The Foundations curriculum also includes specific training on the Child and Adolescent Needs and Strengths (CANS), as well as further training on working with families impacted by Domestic Violence. In-Service training provides separate standalone trainings on the CERAP and assessment tools, the CANS training, and a standalone training on Services to DCFS Clients Experiencing Domestic Violence. As additional assessment process, procedures, and protocols are created, additional learning opportunities will be developed to support the required knowledge and skill required to complete them.

Oversight and Monitoring of the Continuing Appropriateness of the Services. Once a family is connected to an intervention in the community, both DCFS staff, its sister agency staff, and EBP providers will be responsible for evaluating the ongoing appropriateness of the referral, assessing ongoing safety and risk, and determining if modification to a child's prevention plan are needed to support child and caregiver well-being. Through ongoing child and family team meetings (CFTM), assessment tools, service plan review, and fidelity reporting from university partners and purveyors, staff will be taught in trainings to continually review and assess the effectiveness of interventions as it relates to assessed outcomes demonstrated by the family.

Training for Supervisors. As an extension of the new Model of Supervisory Practice (MoSP), supervisors from the programs that oversee candidate subgroup families will be trained to discuss potential candidates and preventative services during all cases consultations and all phases of assessment. Specifically, the curriculum will address understanding and guidance on (1) identification of candidates (2) overview of the new preventive service array, (3) appropriate assessment to generate service recommendations, (4) prevention plan development and documentation, and (5) ensuring ongoing monitoring of service provision and risk monitoring.

Training on Data Collection to Support Federal Reporting, Continuous Quality Improvement, and Formal Evaluation. Workers, supervisors, and providers will be trained on protocols to support the data collection for required child-level reporting as well as continuous quality improvement plans and formal evaluation plans. Participants will be provided an overview of what the prevention plan is currently measuring by reviewing the theory of change and the process, capacity, and quality indicators and outcomes in the logic model. Training will also include expectations on data quality management and participation in improvement cycles through recurring meetings in the future.

Direct Service Provider Trainings

DCFS is also planning to develop the infrastructure to support a clinical learning series for contracted agencies. For each model that is selected, post-training support will be provided that is unique to the identified EBP by the model purveyors as well as a set of uniform curricula. Ultimately, this supportive structure will provide clinicians *across all models* with the following:

- Support the implementation of trauma-informed care;
- Peer/ cross agency support to share lessons learned across models and strategies to incorporate this work into the broader child welfare system;
- Support for the clinical complexity of the cases which may require clinicians to consider solutions beyond those within the domain of the model, while maintaining fidelity;
- Support for care coordination given the other services received by the child/ family.

One method may involve leveraging providers with considerable experience with certain interventions. For instance, based on the recent implementation of the Nurturing Parenting Program (NPP) and Child-Parent Psychotherapy (CPP) through the Illinois Birth-to-Three (IB3) IV-E Waiver, there would be an opportunity to utilize these providers to help facilitate the implementation process and learning series for other providers in the early adoption phase.

The Department's efforts to implement trauma-informed care through a learning collaborative approach dates back to 2008, when the Trauma Informed Practice Program (TIPP) was launched which included partners from Northwestern University and Chicago State University. At that time a great deal effort focused on the development of a learning collaborative model for DCFS. The collaboratives promoted the "testing out" of new practices in small, rapid cycles in order to make immediate progress towards practice goals and offer ongoing opportunities to share feedback and successes in real time to further accelerate the application of new knowledge and skills in local settings and communities. The Learning Collaborative approach is a quality improvement methodology developed by the Institute for Healthcare Improvement (IHI) in 1995 and has been used in the field of health care. The original purpose for establishing the model of Learning Collaboratives was to bridge a gap between what we know works (best practices) and what practitioners in the field are actually doing. This approach is currently used by the National Child Traumatic Stress Network (NCTSN), in a range of community

agencies across the U.S., as the primary and recommended method for training and supporting practitioners in best practices for child trauma.

Currently, one of the stakeholders for FFPSA provides support for building the trauma-informed organization. For more than a decade, the IL Collaboration on Youth (ICOY), has been a part of the National Child Traumatic Stress Network, and for 7 years was a direct SAMHSA grantee, working on capacity-building around trauma, both providing training and technical assistance on developing and maintaining trauma-informed organizations. ICOY is one partner that has been identified to participate in the Clinical Learning Community to support ongoing implementation support. Our University partners and our direct experience implementing EBPs will give us access to other local and national expertise as we advance this work.

Section 8: Prevention Caseloads

Caseload size is an important factor to ensure effective case management for families and children receiving preventive services. DCFS has determined the prevention caseload sizes can be maintained at their current rates given that the candidates for prevention services will initially be limited to the population of children who are already or have recently received services through other programs. However, it is important to distinguish between the caseloads maintained by DCFS staff and the caseloads maintained by the private providers administering the EBPs. Public agency caseworkers and private providers work in partnership to serve families, keep children safe, and achieve case plan goals. Table 15 indicates the approximate DCFS staff to case ratios across the variety of program staff who will manage prevention services cases. Private provider staff to case ratios will vary by intervention.

Table 15: Staff to Case Ratio by Eligible Subpopulation

Target Subpopulation	Staff to Case Ratio*
Children and family members referred to **Intact Family Services**	1:10
Children and family members eligible for **Intact Family Recovery** (i.e. substance-exposed infants; children with family members who have substance use disorder)	1:10
Children and family members participating in supports in the **Extended Family Support program** (kinship navigator program)	1:20
Children who have exited care through **reunification** in past 6 months, and may be at-risk of re-entry	1:15
Children who have exited care through **adoption or guardianship** and may be at-risk of re-entry	1:178**
Pregnant or parenting youth currently in care or who have exited care through age 21 with children in care	1:15

*Staff to case ratio is dependent on the level of services required to meet the assessed needs of each family/child.
**Post-Adoption Workers and the Statewide Program Monitor will rely on providers to support development, submission, and adjustments to the child prevention plans as well as ongoing safety and risk monitoring. For more information, see Sections 4 and 5.

DCFS regularly oversees and monitors caseload standards through ongoing CQI practices as well as regular agency-wide performance monitoring activities using various reporting practices. DCFS administrators and supervisors are responsible for ensuring compliance through ongoing review and monitoring of caseload size.

DCFS expects all providers of all EBPs working with DCFS families as part of this five-year plan to uphold the staffing and caseload requirements specified by each EBPs model. DCFS will hold all EBP service providers contractually accountable to implementing each intervention to fidelity, including requirements of staff caseload sizes to ensure fidelity to the model.

Section 9: Assurance on Prevention Program Reporting

Appendix F contains DCFS' assurance (CB-PI-18-09 Attachment I) that it will comply with all prevention program reporting requirements put forward by the Children's Bureau. At a minimum, DCFS will provide the following information for each child that receives Title IV-E prevention services:

- Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity).
- The specific services provided to the child and/or family
- The total expenditures for each of the services provided to the child and/or family
- The duration of the services provided
- If the child was identified in a prevention plan as a "child who is a potential candidate for foster care:"
    - the child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a "child who is a potential candidate for foster care" in a prevention plan
    - whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period

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Appendix A: Erikson DCFS Early Childhood Project Work with Intact Families

This Project works to assure families with young children Birth to Three who have an Intact Family case open are assessed and/or linked to necessary early intervention services, as well as supportive services such as Home Visiting, early childhood programs, or early childhood mental health services (where available).

OITS sends a weekly tickler to the Erikson DCFS Early Childhood Project listing all children Birth to Three in newly opened Intact family cases.

The Erikson DCFS Early Childhood Project assigns EVERY family to a Developmental/Infant Mental Health Specialist based on the location where the family lives (the Project has 10 FTE's across the state- 2 Cook county, 2 Northern Region, 2 who straddle Cook County/Northern region to the South and the West, 2 in Central region, 2 in Southern region).

Developmental/Infant Mental Health Specialists perform individual outreach to the case manager of EVERY family assigned to them. This includes an email offering assessment and consultation to the case manager to support case planning and service linkage for the young children.

When they connect with the case managers, Developmental/Infant Mental Health Specialists listen carefully to the case manager's concerns and offer initial consultation around the young child(ren). From this point, there are multiple possible outcomes:

1. The case manager agrees to schedule an assessment with the Erikson DCFs EC Project at the DCFS/POS or other office space closest to the family.
2. The case manager shares immediate developmental concerns that warrant a direct referral to DHS Early Intervention. The Developmental/Infant Mental Health Specialist offers to make that referral after the case manager receives consent, or walks the case manager through making the DHS Early Intervention referral with the family.
3. The case manager indicates the child has received developmental screening elsewhere and/or the child is in a program that offers screening. The Developmental/Infant Mental Health Specialist then asks what the outcome of the screening was so they can record that CAPTA was fulfilled for this child and the outcome is recorded in the EC Data.
4. The case manager indicates the parent(s) are not willing to do the assessment. Developmental/Infant Mental Health Specialists offer to speak with the parents and/or offer feedback to the case manager about other ways to pitch the assessment.

The Assessment Process:

When families schedule and attend the assessment, the process looks like this:

- Assessments are conducted with signed parent consent. The consent form is explained, and signed by the parent(s), before any assessment activities start.
- Developmental/Infant Mental Health Specialists use the assessment to go beyond the simple use of the developmental skill checklists to include a dialogue with parents about their child(ren). Parents are offered the opportunity to talk about their parenting experiences, their

own experiences as children, and about the way stresses in their family and their DCFS involvement have impacted their child(ren) and themselves. Parents never have to talk about these things beyond their level of comfort.

- Parents are invited to participate in assessment tasks with their child rather than have the Developmental/Infant Mental Health Specialists do the tasks with the child, because we understand that the child's relationship with the parent is the most important. This also gives the Developmental/Infant Mental Health Specialist an opportunity to observe how parent and child are working together in their relationship.
- At the end of the assessment, the Developmental/Infant Mental Health Specialist offers the family an idea of impressions from the assessment and ideas about services that might be helpful to the child and family.
- After the assessment, a report written in family-friendly language is generated and includes results from the assessment tools, information from the conversation with the parent(s) and review of the family's case record, and the Developmental/Infant Mental Health Specialist's observations and thoughts. Reports are shared with the parent(s) and case manager. The report includes suggestions of ways parents can meet their children's developmental needs and strengthen their relationship, both at home and through participation in recommended services. If parents have questions or concerns about the results, Developmental/Infant Mental Health Specialists are always available to discuss them with the parent and case manager.
- Copies of the assessment tools are given to the parent(s) and the case manager.
- Parent-friendly handouts targeting relevant stages of child development and specific parenting issues are made available when indicated.

Socio-emotional screening tools utilized:

- The Devereux Early Childhood Assessment (DECA I/T/P),
- Infant Toddler Symptom Checklist (ITSC)

Assessment Tools utilized:

- The Denver II, Ages and Stages Questionnaire (ASQ-3),
- Early Childhood Screening Inventory for Preschoolers (ESI-P)

If a referral to Early Intervention is needed, the Developmental/Infant Mental Health Specialist makes the referral directly. For any EI referral made by them, Developmental/Infant Mental Health Specialists follow up by contacting DHS Early Intervention (EI) roughly a week and a month after the referrals to assure the family connected with EI and that the child was evaluated. Depending on what they find out, Developmental/Infant Mental Health Specialists offer further support. For example, if the family is not responding to EI, they contact the case manager and/or the parent to try to assure connection. If the referral expired, or the family moved, they make another referral to the proper EI location. The follow up performed depends on what information EI gives them about the referral.

For other recommended services, such as Early Head Start or an enrichment program, or early childhood mental health services, the Developmental/Infant Mental Health Specialist tries to locate a resource. The share that information with the case manager and family for follow up.

During FY20 the Project is developing a direct referral and follow up process for Home Visiting much like the one the Project has for EI.

The Project performs outreach to Intact agencies in order to support case managers engaging. Since the Project began in 2010, engagement by Intact case managers has grown from only a 20% response rate to a 68% response rate as of FY18.

At the end of the fiscal year, once all case closures are turned in (typically 3 months after the fiscal year ends) the Project gathers outcomes for all the children they received referrals for. This process has resulted in the Project noticing some trends:

> About 1/3 of young children seen by the Project require EI referral
>
> For FY 18, the Project received information that indicated 33% of children in Intact families statewide were CAPTA compliant. Reunification/Aftercare Services

When a child is formally returned home to his/her parent(s) currently a CFS 906 is completed identifying the Type of Placement as Home of parent [HMP]. The family enters *Reunification* (Traditional/Relative level of care youth) or *Aftercare* (Specialized/Medically Complex level of care youth).

Given this population is now within the prevention population, the aftercare prevention plan will need to be revised. An Aftercare Client Service Plan (CSP) must be developed with an effective date of the return home/CFS 906. This Aftercare CSP is a current reflection of the services the family will continue to do (i.e. cooperate with counseling services, random UA screens, etc.) to prevent re-entry into care while they remain involved with DCFS/POS/Court. The Aftercare CSP should reflect non-applicable Outcomes/Tasks discontinuing (i.e. Family Worker meeting with a Youth in Care in their Foster Home) as well. The Aftercare CSP must identify "***Aftercare***" as an "Additional Plan Met by This Outcome" in one Outcome in SACWIS in order to qualify as an Aftercare CSP. With an enhanced focus on prevention, the plan will include agreements to seek and build support as needed within the natural or community networks to deter further system involvement.

Outcomes commonly included in the Aftercare CSP are:

- Meeting the basic health, safety, well-being and educational/developmental needs of the child;
- Cooperating with Reunification/Aftercare requirements per DCFS Policy and Procedure;
- Cooperating with any ongoing recommended services (i.e. substance abuse treatment, mental health treatment, etc.) to maintain a safe home environment.

Each Outcome will have coordinating Tasks (i.e. attend counseling sessions, cooperate with random UA screens, etc.) included.

Appendix B: Proposed Five-Year Plan for Family Advocacy Centers in FFPSA

When considering Alternate Responses for prevention under Family First, Family Advocacy Centers (FACs) are an ideal vehicle to provide services and are already doing so. Family Advocacy Centers are primarily community-based agencies and are located across the State of Illinois. They partner with many other community and government agencies and have comprehensive networks with their own local areas. One key advantage that they have is being able to engage with clients on a community level outside of DCFS/POS.

Family Advocacy Centers work with families who are involved with the Child Welfare System and with families who have never been involved. They accept referrals for after-care when Intact and placement cases close. They accept post CWS referrals and referrals from investigations whether there was indicated or unfounded finding.

Family Advocates generally hold Bachelor and Master level degrees. They work with all age levels and have participated in training that makes them trauma informed and many are certified to provide Financial Literacy training to older youth who usually do not qualify for financial incentives and qualified youth aging out of the system.

Advocates work from a strength-based coach recovery model but employ a wide range of Evidence Based group and individual modalities with the families they serve. They offer classroom and home-based assistance.

Family Advocacy Centers report their service hours and outcomes through a centralized data base that was originally developed by the Casey Foundation then abandoned as there was inadequate oversight and monitoring regarding the data results and input by the providers. Work was done by the FC Monitors to continue the development of the data base and improve reporting/input by individual FACs.

In FY 18 Family Advocacy Centers served over 5,643 families including 7,681 children. There are 15 Advocacy Centers in Cook County, 4 in the Northern Region 9 in the Central Region and 4 FACs in the Southern Region. Of the 29 Family Advocacy Centers 2 were added in FY18 in areas demonstrating the need for services in the Northern in Region and Central Region near the Iowa border. Two locations were expanded to include additional geographic areas in the Southern and Central region of the state.

In support of the Department's vision for Family First the greatest role for FACs will be in prevention providing DCFS clients and community residents with direct support, resources, and referrals. New for this year is the initiation of DCFS Alumni Drop-In Centers for former foster care youth up to age 30 and support for the Kinship Navigator program providing support for family members who have taken on the role of caretakers for children to prevent their entry into the child welfare system. FAC Advocates

can help their clients schedule appointments and follow up to make sure that appointments are kept or re-scheduled if necessary.

As previously stated FACs have developed their own network of providers in their community. A more organized approach is planned to include a wide range of social services available through different entities including the state, county and municipal agencies. Mental health, medical care and education are other areas of consideration. Many agencies have community liaisons and that is where FACs can begin their network efforts. Specifically, each DHS office has staff designated for community liaison work. FACs have already begun to work with the WIC local area offices to promote co-referrals between the two programs.

Additionally, FAC providers are scheduled to receive training on SPIDER (Service Provider Identification & Exploration Resource) the Department's service referral search engine which is now available to the public as well. FAC clients including DCFS Alumni will also have the opportunity learn to use the search engine.

Ideally at the end of 5 years we would like to have liaisons in all these services areas not only in the local areas of Family Advocacy Centers but have an extended network that includes every local DCFS field office.

- Our first step this year will be establish liaisons for FACs within the Department that can interact with all divisions within the Department as needed.
- Secondly, we would like to establish at least one liaison in each service area for each FAC provider and expand from there.
- Over the three years we would like to expand our Family Advocacy Program to ensure that there is an FAC attached to each local area DCFS field office.

Establishing and maintaining these local networks will be key to prevent involvement or re-involvement with the Department.

All documentation for referrals, outreach and outside (FAC) community agencies will be tracked through the FAC Data Base and Quarterly Narrative Reports.

Year One.

- Refine current tracking system to demonstrate information, referrals and application assistance to indicate DHS programs specifically.
- Identify current DHS community liaisons for each FAC for ongoing contact as needed, needed referrals are driven by the need of the local population, cash assistance, medical assistance, food assistance and child care take precedence.
- Establish/Reestablish local WIC program contacts.
- Establish and maintain local housing and homelessness program contacts.

- Restore Regional FAC meetings and designate DCFS administration contacts for each FAC.
- Add at least one FAC Monitor to assist the increasing responsibilities of FAC monitors and to cover the expanding area and number of new Family Advocacy Centers.

Year Two.

- Focus on establishing and maintaining liaisons in local medical and mental health organizations, including substance abuse and domestic violence programs.
- Add two Family Advocacy Centers in Counties with highest population-based and service needs, and no such program exists.

Year Three.

- Focus on establishing and maintaining liaisons in public and private area schools.
- Add two Family Advocacy Centers in the Counties with highest population-based and service needs, and no such program exists.
- Assess the efficacy of FAC support through resources and referrals, identify services where there are no referral sources known or available.

Year Four.

- Identify local DCFS offices that still do not have a local FAC to which they can refer clients; and add at least two-Family Advocacy Centers to cover the geographical areas with the greatest need.

Year Five.

- Continue ongoing assessment of FAC support through resources and referrals
- Establish a plan to add Family Advocacy Centers to Counties or other geographical areas that are still in need.

Appendix C: Target Population Data Tables

TARGET POPULATION: REMAIN AT HOME FOLLOWING AN INDICATED INVESTIGATION

Table 1: Volume of Indicated Reports by Service Receipt in FY 2018 limited to Family Reports

	Family reports
Total number of hotline reports-family	77,418
Number of children in hotline reports that remained at home following investigation regardless of disposition (unduplicated number) [a, b, c, d]	98,313
Number of children with at least one **indicated** report (unduplicated count of children) that **remained at home** following investigation [a, b, c, d]	**23,745**
INTACT SERVICES (4 ways to enter)	
(1) Indicated group following investigation	
Child victims in indicated investigation that receive Intact services as a result of this indicated report	**5,393**
Child victims in indicated investigation that receive Intact services as a result of being a sibling in another Intact case [e]	160
Child victims in indicated investigation that receive Intact services as a result of another investigation or opened another way than investigation [g]	727
Indicated reports-TOTAL	6,280
(2) Unfounded group following investigation	
Child victims in unfounded investigation that receive Intact services as a result of unfounded report	**1,433**
Child victims in unfounded investigation that receive Intact services as a result of being a sibling in another Intact case [e]	391
Child victims in unfounded investigation that receive Intact services as a result of another investigation or opened another way than investigation [g]	1,091
Unfounded reports-TOTAL	2,915
(3) Siblings (children not identified as child victims in above investigations regardless of disposition)	**2,480**
(4) Children entering Intact services through other sources that investigation-correctly linked only [g, h]	**2,671**
Total	**11,981**[j]
NO SERVICES	
Indicated group following investigation [i]	**17,465** [k]

Note: [a] excludes children receiving Intact and placement services at the time of the report; [b] excludes children with death allegations; [c] 25,171 (18.8%) children had more than one reports in FY18; [d] calculation is based on the first unique report received for a child in FY18; [e] counts are duplicative with 2,480 number in row (3); [g] counts are duplicative with 2,671 number in row (4); [h] if unduplicated with [g] marked rows in indicated group and unfounded group following investigation, 853 is unique number of children that received Intact services outside investigations in FY18; [I] calculated subtracting children in 'Indicated reports-TOTAL' row from number of children remaining at home following indicated investigation; j this number comprises 4,786 unique cases; [k] this number comprises 10,819 unique investigations.

Table 2: Children with Indicated Reports Receiving no Services Following an Indicated Report

	% or Mean (SD)	
Socio-demographic characteristics-child, caregiver & family		
Child's gender		
Female	51.0%	
Male	48.5%	
Unknown	0.6%	
Child's race		
White	61.4%	
Black/African American	35.5%	
Unknown or Other	3.1%	
Child's ethnicity		
Hispanic	18.6%	
Not Hispanic	71.9%	
Unknown/declined	9.4%	
Child's age (mean)	7.0 (5.1)	
0-3	32.2%	
Primary language-Spanish	9.9%	
Primary language-Other	0.8%	
Disability-child	7.6%	
Initial Report characteristics		
Reporter group		
School	12.6%	
Law enforcement	50.0%	
Medical	13.7	
Social Services	11.6%	
Non-mandated	8.9%	
Not reported	3.2%	
Serious harm allegations	10.8%	
Egregious allegations	1.6%	
Abuse allegations	40.1%	
Neglect allegations	70.9%	
Top 5 primary allegations-indicated in the initial report		
Substantial risk by neglect- allegation #60	42.7%	
Inadequate supervision	12.6%	
Substantial risk by abuse-allegation#10	7.5%	
Substantial risk of sexual abuse-sibling of abuse victim #22b	7.5%	
Cuts bruises-allegation #11	6.3%	
Initial CERAP assessment		
Safe	87.1%	
Unsafe	12.9%	
Unsafe CERAP assessment present-at any time	12.6%	
% with completed CERAP	99.8%	
% with completed domestic violence screener	89.2%	

% with completed substance abuse screener	89.2%	
% with completed risk assessment	98.6%	
Psychosocial risks-child, caregiver & family		
Prior DCFS history No priors 1-3 prior reports 4-6 prior reports 6 or more prior reports	 62.0% 28.6% 6.4% 3.1%	
Prior indicated reports in the last 12 months	8.8%	
Prior unfounded reports in the last 12 months	15.6%	
Prior Intact case [a]	6.3%	
Prior foster care [a]	3.5%	
	Child level	Investigation level
Family low/none social support [b]	14.7%	13.9
Family severe environmental/financial needs [b, c]	10.2%	9.0
Caregiver's deficient parenting skills [b, c]	31.0%	32.2
Caregiver's problematic substance abuse [b, c, d]	42.5%	43.0
Caregiver's impaired mental health functioning [b, c, d]	28.1%	28.8
Domestic violence [b, c, e]	53.1%	51.8
Child service needs [b, f]	13.2%	13.4

Note: [a] these numbers should be viewed as conservative; [b] information came from risk assessment; [c] information came from CERAP; [d] information came from substance abuse screener; [e] information came from domestic violence screener; [f] comprises social, health, developmental and behavioral risk domains.

Table 2a: Comparing Children with Indicated Reports Receiving no Services, Children with Indicated and Unfounded Reports in Intact Family Services Following an Investigation

	Indicated No services % or Mean (SD)	Indicated in Intact Serv. % or Mean (SD)	Unfounded in Intact Serv. % or Mean (SD)
Socio-demographic characteristics-child, caregiver & family			
Child's gender Female Male Unknown	 51.0% 48.5% 0.6%	 50.0 50.0	 51.0 49.0
Child's race White Black/African American Unknown or Other	 61.4% 35.5% 3.1%	 67.5 30.9 1.6	 64.4 33.9 1.8
Child's ethnicity Hispanic Not Hispanic Unknown/declined	 18.6% 71.9% 9.4%	 16.6 75.2 8.2	 16.9 73.5 9.6

Child's age: mean	7.0 (5.1)	5.6 (4.8)	6.7 (5.3)
0-3	32.2%	41.3%	35.5%
Primary language-Spanish	9.9%	9.1	9.4
Primary language-Other	0.8%	0.6	0.4
Disability-child	7.6%	14.5	12.3
Initial Report characteristics			
Reporter group			
School	12.6%	15.8%	19.6%
Law enforcement	50.0%	40.8%	21.4%
Medical	13.7	18.1%	19.6%
Social Services	11.6%	7.8%	13.8%
Non-mandated	8.9%	12.9%	18.9%
Not reported	3.2%	4.7%	6.7%
Serious harm allegations	10.8%	5.2%	6.9%
Egregious allegations	1.6%	2.1%	3.7%
Abuse allegations	40.1%	26.9%	31.4%
Neglect allegations	70.9%	87.2%	77.4%
Top 5 primary allegations-indicated in the initial report			
Substantial risk by neglect- allegation #60	42.7%	53.5%	40.3%
Inadequate supervision	12.6%	9.0%	10.4%
Substantial risk by abuse-allegation#10	7.5%	5.9%	8.1%
Substantial risk of sexual abuse-sibling of abuse victim #22b	7.5%		
Cuts bruises-allegation #11	6.3%	6.1%	7.3%
Environmental neglect		6.7%	5.2%
Initial CERAP assessment			
Safe	87.1%	71.1%	83.8%
Unsafe	12.9%	28.9%	16.2%
Unsafe CERAP assessment present-at any time	12.6%	37.3%	18.9%
% with completed CERAP	99.8%	100.0%	100%
% with completed domestic violence screener	89.2%	97.6%	97.2%
% with completed substance abuse screener	89.2%	97.7%	97.6%
% with completed risk assessment	98.6%	100.0%	100%
Psychosocial risks-child, caregiver & family			
Prior DCFS history			
No priors	62.0%	50.1%	45.7%
1-3 prior reports	28.6%	36.5%	38.0%
4-6 prior reports	6.4%	8.9%	9.8%
6 or more prior reports	3.1%	4.5%	6.5%
Prior indicated reports in the last 12 months	8.8%	12.5%	9.4%
Prior unfounded reports in the last 12 months	15.6%	22.9%	25.9%
Prior Intact case [a]	6.3%	11.7%	12.5%
Prior foster care [a]	3.5%	3.2%	4.6%

Family low/none social support [b]	14.7%	33.6	24.3
Family severe environmental/financial needs [b, c]	10.2%	34.1	32.3
Caregiver's deficient parenting skills [b, c]	31.0%	56.9	44.4
Caregiver's problematic substance abuse [b, c, d]	42.5%	58.7	42.4
Caregiver's impaired mental health functioning [b, c, d]	28.1%	52.2	44.5
Domestic violence [b, c, e]	53.1%	58.7	44.9
Child service needs [b, f]	13.2%	34.2	42.7

Table 3: Child Victims Receiving Intact Services Following an Indicated or Unfounded Report

	% or Mean (SD)
Socio-demographic characteristics-child, caregiver & family	
Child's gender	
Female	50.2%
Male	49.8%
Unknown	
Child's race	
White	66.9%
Black/African American	31.5%
Unknown or Other	1.6%
Child's ethnicity	
Hispanic	16.6%
Not Hispanic	74.9%
Unknown/declined	8.5%
Child's age (mean)	5.9 (4.9)
0-3	40.1%
Primary language-Spanish	9.1%
Primary language-Other	0.6%
Disability-child	14%
Initial Report characteristics	
Reporter group [e]	
School	16.6%
Law enforcement	36.8%
Medical	18.4%
Social Services	9.0%
Non-mandated	14.1%
Not reported	5.1%
Serious harm allegations [a]	5.5%
Egregious allegations [a]	2.5%
Abuse allegations [a]	27.9%
Neglect allegations [a]	85.2%
Top 5 indicated primary allegations-for indicated group in the initial report [a]	

Substantial risk by neglect- allegation #60 Inadequate supervision Environmental neglect Cuts bruises-allegation #11 Substantial risk by abuse-allegation#10	 53.5% 9.0% 6.7% 6.1% 5.9%
Top 5 unfounded primary allegations-for unfounded group in the initial report [a] Substantial risk by neglect- allegation #60 Inadequate supervision Substantial risk by abuse-allegation#10 Cuts bruises-allegation #11 Environmental neglect	 40.3% 10.4% 8.1% 7.3% 5.2%
Initial CERAP assessment [a] Safe Unsafe	 73.8% 26.2%
Unsafe CERAP assessment present-at any time [a]	33.5%
% with completed CERAP	100%
% with completed domestic violence screener	97.5%
% with completed substance abuse screener	97.6%
% with completed risk assessment	100%
% of youth with completed CANS within last year	32%
% of caregivers with completed CANS within last year	29.7%
Psychosocial risks-child, caregiver & family	
Prior DCFS history [a] No priors 1-3 prior reports 4-6 prior reports 6 or more prior reports	 49.2% 36.8% 9.1% 4.9%
Prior indicated reports in the last 12 months [a]	11.9%
Prior unfounded reports in the last 12 months [a]	23.5%
Prior Intact case [a]	11.8% [b]
Prior foster care [a]	3.5% [b]
CERAP, Risk assessment, Domestic violence and Substance Abuse screeners	
Family low/none social support [c]	31.6%
Family severe environmental/financial needs [c, d]	33.7%
Caregiver's deficient parenting skills [c, d]	54.3%
Caregiver's problematic substance abuse [c, d, e]	55.3%
Caregiver's impaired mental health functioning [c, d, e]	50.6%
Domestic violence [c, d, f]	55.8%
Child service needs [c, g]	36.0%

Note: (a) only on those whose Intact cases were opened from investigations; (b) these numbers should be viewed as conservative; (c) information came from risk assessment; (d) information came from CERAP; € information came from substance abuse screener; (f) information came from domestic violence screener; (g) comprises social, health, developmental and behavioral risk domains.

Table 4: All Children Receiving Intact Services (adds siblings from Table 3 and children from other sources).

	% or Mean (SD)	
Socio-demographic characteristics-child, caregiver & family		
Child's gender		
Female	49.0%	
Male	49.7%	
Unknown	1.3%	
Child's race		
White	61.7%	
Black/African American	35.4%	
Unknown or Other	2.9%	
Child's ethnicity		
Hispanic	16.7%	
Not Hispanic	73.2%	
Unknown/declined	10.1%	
Child's age (mean)	7.53 (5.1)	
Primary language-Spanish	7.0%	
Primary language-Other	0.4%	
Disability-child	13.4%	
% with completed CERAP	97.3%	
% with completed domestic violence screener	78.7%	
% with completed substance abuse screener	78.8%	
% with completed risk assessment	93.5%	
% of youth with completed CANS within last year	32%	
% of caregivers with completed CANS within last year	29.7%	
Psychosocial risks-child, caregiver & family		
CERAP, Risk assessment, Domestic violence and Substance Abuse screeners		Case level-%
Family low/none social support [c]	25.7%	25.6
Family severe environmental/financial needs [c, d]	29.9%	27.9
Caregiver's deficient parenting skills [c, d]	50.0%	48.8
Caregiver's problematic substance abuse [c, d, e]	51.9%	54.6
Caregiver's impaired mental health functioning [c, d, e]	47.8%	50.9
Domestic violence [c, d, f]	52.7%	53.3
Child service needs [c, g]	33.8%	32.2
CANS assessment		
Youth's emotional/mental health functioning – clinical level [i]	9.1% [b]	
Youth's substance use or substance exposure as an infant	0.9% [b]	
Youth's struggles with parenting-for parenting youth	0.3% [b]	
Caregiver's emotional/mental health functioning-serious illness	10.1% [b]	
Caregiver's substance abuse	13.6% [b]	
Caregiver's parenting issues [i]	20.8% [b]	
Youth's past or present exposure to family violence [i]	19.4% [b]	

Note: (a) only on those whose Intact cases were opened from investigations; (b) these numbers should be viewed as conservative; (c) information came from risk assessment; (d) information came from CERAP; € information came from substance abuse screener; (f) information came from domestic violence screener; (g) comprises social, health, developmental and behavioral risk domains.

Table 5: All Children Receiving Intact Services by Child Removal During Intact Services Status

	NO Child Removal, % or Mean (SD) (n=10,359)	Child Removal, % or Mean (SD) (n=1,622)
Socio-demographic characteristics-child, caregiver & family		
Child's gender		
Female	49.1	48.0
Male	49.4	51.7
Unknown	1.4	0.3
Child's race		
White	61.6	62.7
Black/African American	35.2	36.2
Unknown or Other	3.2	1.1
Child's ethnicity		
Hispanic	18.2	7.7
Not Hispanic	71.6	82.6
Unknown/declined	10.2	9.7
Child's age (mean)	7.7 (5.2)	6.5 (4.8)
Primary language-Spanish	7.7	2.6
Primary language-Other	0.3	0.6
Initial CERAP unsafe	14.1	25.0
Psychosocial risks-child, caregiver & family		
CERAP, Risk assessment, Domestic violence and Substance Abuse screeners		
Family low/none social support [c]	24.3	33.9
Family severe environmental/financial needs [c, d]	28.0	41.2
Caregiver's deficient parenting skills [c, d]	48.2	60.7
Caregiver's problematic substance abuse [c, d, e]	49.4	66.9
Caregiver's impaired mental health functioning [c, d, e]	46.3	57.1
Domestic violence [c, d, f]	51.6	59.7
Child service needs [c, g]	32.2	43.5

TARGET POPULATION: PREGNANT AND PARENTING YOUTH AND THEIR CHILDREN

1) PREGNANT AND PARENTING YOUTH CURRENTLY IN FOSTER CARE SYSTEM

a) **Table 1: Youth Currently in Care** (goal is to know the current volume)

	Pregnant/parenting youth in care
N	**464** [a]
%	2.1%

Note: Youth in care as of 4.8.19; [a] CYCIS and TPSN data used to identify parenting youth

Table 2: Demographic and Case Characteristics for Pregnant/Parenting Youth Currently in Care

	% or Mean (SD)
Sociodemographic characteristics-pregnant/parenting youth	
Youth's gender	
Female	74.4%
Male	25.6%
Youth's race	
White	29.6%
Black/African American	69.2%
Other or Unknown	1.2%
Ethnicity	
Hispanic	12.3%
Not Hispanic	73.2%
Unknown or declined	14.5%
Primary language-Spanish	3.5%
Age (mean)	18.6 (1.5)
Region	
Central	16.3%
Cook	66.9%
Northern	8.0%
Southern	8.8%
Sub-region	
Aurora	5.8%
Champaign	4.5%
Cook Central	18.0%
Cook North	17.0%
Cook South	31.6%
East St. Louis	6.5%
Marion	2.3%
Peoria	4.8%
Rockford	2.3%
Springfield	7.0%
Service related characteristics-pregnant/parenting youth	
Length of stay in months (mean)	62.6 (40.5)
0-12 months	6.5%

12-24 months	7.3%
24-36 months	13.8%
36-48 months	15.5%
48 months or more	56.9%
Involve reason	
Abuse	14.3%
Child behavior problem	6.8%
Neglect	52.7%
Dependent	23.3%
Sexual Abuse	2.0%
Other	1.1%
Latest living arrangement	
Transitional living	20.8%
Independent living only	18.3%
Foster home specialized	13.0%
Unauthorized placement/unknown	12.8%
Home of fictive kin	10.8%
Home of Relative	9.0%
Foster home private agency	3.5%
Detention	2.8%
Whereabouts unknown or detention in the last 12 months	35.8%
Active whereabouts unknown	7.3%
Department of Corrections or detention	4.5%
Permanency goal	
Independence	48.9%
Subs. care pending independence	39.8%
Return home within 5 & 12 months	4.0%
Guardianship	1.6%
Adoption	1.0%
DCFS case (vs. POS)	10.5%
Top 10 Latest assigned agencies-accounts for 47.6% of all pregnant/parenting youth in care	
UCAN ILO TLP	9.0%
LCFS	6.5%
Aunt Marthas TPSN	6.3%
Camelot	5.0%
Thresholds	4.3%
UHLICH TPSN	3.8%
Lakeside Comm TLP	3.5%
UHLICH OMNI TPSN	3.5%
UCAN	3.0%
Caritas	2.8%
Psychosocial functioning and behavioral health- pregnant/parenting youth	
% of youth with completed CANS *within last year*	83%
Youth's emotional/mental health functioning-clinical level [a, b]	41.5%
Youth's substance abuse [a]	16.6%

Youth's struggles with parenting [a]	22.3%
Youth's past exposure to family violence [a, b]	20.5%
Lifetime mental health disorders due to known physiological conditions [c]	13.4%
Lifetime mental and behavioral disorders due to psychoactive substance use [c]	61.4%
Lifetime schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders [c]	36.1%
Lifetime mood (affective disorders) [c]	78.0%
Lifetime anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders [c]	78.4%
Lifetime behavioral syndromes associated with physiological disturbances and physical factors [c]	7.5%
Lifetime disorders of adult personality and behavior [c]	45.5%
Intellectual disabilities [c]	6.1%
Lifetime pervasive and specific developmental disorders [c]	37.7%
Lifetime behavioral and emotional disorders with onset usually occurring in childhood and adolescence [c]	70.9%
Lifetime unspecified mental disorder [c]	20.5%

Note: (a) information comes from CANS assessment; (b) these are broad categories that will contain multiple items; (c) data came from Medicaid billing, representing ICD 10 diagnosis over youth's lifetime Medicaid history.

b) Youth by entry cohort FY 17 & 18 (goal is to estimate annual influx number for services)

Table 3: Pregnant and Parenting Youth by Entry Cohort

	FY2017	FY2018
n	**58**	**32**
%	1.1%	0.5%

2) <u>AGE OUT</u> PREGNANT AND PARENTING YOUTH 18-21

Table 4: Age-Out Group

Current 18-21-year-olds who have aged out	14,085
Current 18-21-year-olds who have aged out and have a child	98[a]

Note: (a) 10 youth have duplicative records with recently reunited group

Table 5: Age-Out Group service needs.

Youth's emotional/mental health functioning-clinical level [a, b]	42.7%
Youth's substance abuse [a]	21.9%
Youth's struggles with parenting [a]	27.3%
Youth's past exposure to family violence [a, b]	26.0%

Note: (a) information comes from CANS assessment; (b) these are broad categories that will contain multiple items.

TARGET POPULATION: RECENT PERMANENCIES

Table 1: Volume of Permanencies within six months during Jan-Dec 2018

Permanency type	Jan-June 2018	Jul-Dec 2018	Total annual numbers
Including any number of days in care			
Reunifications	1212	1312	2,524 [a, b, c]
Adoptions	839	926	1765
Guardianship	218	177	395
Relatives	80	87	167
Including 8 or more days in care (Federal definition of foster care)			
Reunifications	984	1089	2,073
Adoptions	839	926	1765
Guardianship	212	177	389
Relatives	52	57	109

Note: (a) Includes 182 children with PC only status; (b) 10 children have duplicative records with pregnant and parenting population and are included in this count; (c) 7 children are 21 years old and are included in this count

*reunifications have the highest disruption rate.

Table 2: Demographic and Case Characteristics for <u>Reunifications ANY Days in Care (N=2524)</u>

	Total annual % or Mean (SD)
Sociodemographic characteristics-youth	
Youth's gender	
Female	47.7%
Male	52.3%
Youth's race	
White	53.2%
Black/African American	45.5%
Other or Unknown	1.3%
Ethnicity	
Hispanic	9.4%
Not Hispanic	77.7%
Unknown or declined	12.8%
Primary language-Spanish	
Age at discharge (mean)	7.11 (5.2)

Region	
Central	34.8%
Cook	25.6%
Northern	19.8%
Southern	19.7%
Sub-region	
Aurora	10.1%
Champaign	13.0%
Cook Administration	0.5%
Cook Central	7.9%
Cook North	7.2%
Cook South	10.0%
East St. Louis	8.6%
Marion	11.2%
Peoria	12.6%
Rockford	9.7%
Springfield	9.3%
Service related characteristics-youth	
Length of stay in months (mean)	17.2 (18.6)
0-12 months	47.2%
12-24 months	25.7%
24-36 months	15.1%
36-48 months	6.9%
48 months or more	5.2%
Involve reason	
Abuse	15.4%
Child behavior problem	1.3%
Neglect	78.0%
Dependent	3.5%
Sexual Abuse	1.7%
Initial living arrangement	
Home of Relative	46.7%
Home of Parent	21.6%
Home of fictive kin	5.2%
Foster home boarding	9.7%
Foster home specialized	2.7%
Foster home private agency	5.1%
Other (all combined)	9.0%
DCFS case (vs. POS)	38.3%
Psychosocial functioning and behavioral health-youth and family	
% of youth with completed CANS *within last year*	79.3%
% of caregiver completed CANS *within last year*	52.4%
Youth's emotional/mental health functioning-clinical level [a, b]	20.1% [c]
Youth's substance abuse or substance exposure as an infant [a]	2.2% [c]
Caregiver's emotional/mental health functioning -serious illness [a]	20.0% [c]

Caregiver's substance abuse [a]	17.6% [c]
Caregiver's parenting issues [a, b]	24.1% [c]
Youth's past exposure to family violence [a, b]	30.5% [c]

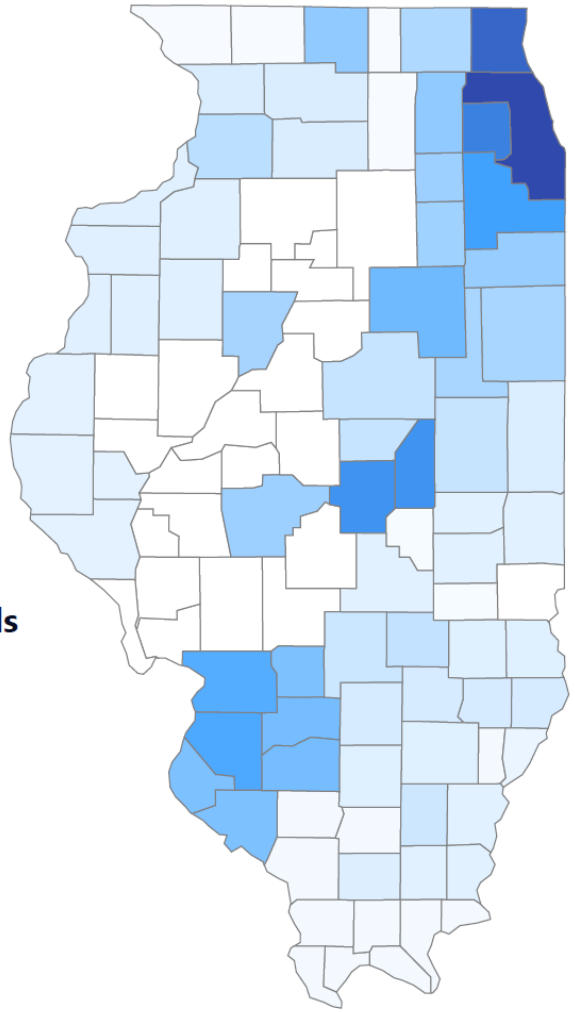
Note: (a) information comes from CANS assessment; (b) these are broad categories that will contain multiple items; (c) these numbers should be viewed as conservative.

Appendix D: Statewide Map of Newly Contracted Prevention Services[1]

Model	Capacity
CPP	183.4
MST	140.0
NPP	699.1
TF-CBT	232.0
Triple P	315.0
Total	**1569.5**

Region	Capacity
Central	487.2
Cook	107.1
Northern	457.2
Southern	518.0
Total	**1569.5**

Model	Central	Cook	Northern	Southern	**Total**
CPP	67.8		25.1	90.5	**183.4**
MST		3.6	14.4	122.1	**140.0**
NPP	279.7	21.3	187.7	210.5	**699.1**
TF-CBT	32.5	50.0	69.5	80.0	**232.0**
Triple P	107.3	32.3	160.6	15.0	**315.0**
Total	**487.2**	**107.1**	**457.2**	**518.0**	**1569.5**



Capacity reflects annual capacity for number of individuals served with parenting services.
Each provider's reported capacity is divided evenly amongst all the counties included in their service range.

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[1] Map does not include Healthy Families America, Parents as Teachers, Seeking Safety, Motivational Interviewing, Solutions Based Casework, and Wraparound