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October 27, 2017

The Honorable Jorge L. Alonso
United States District Court for the Northern District of Illinois
219 S Dearborn Street
Chicago, IL 60604

Case: 1:88-cv-05599

Dear Judge Alonso:

Introduction

It has been a year since this court approved the B.H. Implementation Plan. The Plan included provision for the parties and the Expert Panel to regularly review progress on the Plan's objectives and initiatives, and then to submit a collaboratively prepared and agreed-upon triannual status report to the Court. Despite several extensions for filing, the Department was unable to prepare the complete draft Third Triannual Report with sufficient time to allow the Expert Panel to review and meaningfully comment on the Department's report prior to its required submission.

Regarding those sections of the Department's report that we received and reviewed by October 25, 2017, we did not have significant disagreement with the technical accuracy of the specific data the Department reported for the different initiatives. We were more concerned that the Department provided limited analysis and interpretation of the reasons when the outputs and outcomes for various initiatives failed to meet expected targets. Further, the Department did not accurately reflect the scope and complexity of certain individual initiatives themselves, the challenges already encountered at the current phase of implementation, or the recognition that successful implementation of any one of the initiatives is inextricably linked to successful implementation of other initiatives. *Finally, the Department's reports*

and actions to date do not reflect that it has an integrated process or plan to address together the inter-related challenges that are preventing class members from receiving the services they need and from securing the safety, permanence and well-being to which they are entitled. This is the basis of our judgment, discussed below, that the Department needs additional assistance in the use of implementation science principles and practices.

Despite the foregoing, through our regular meetings with DCFS leadership and Project Directors, the Expert Panel believes it has sufficient information to provide this independent report, which gives the Expert Panel's perspective on the current status of B.H. implementation and offers recommendations for specific actions we believe are needed at this critical juncture.

In the first 4 pages of this letter, we offer a brief summary of our general views regarding the status of the Department's implementation efforts. At pages 4 – 5, we offer several recommendations for immediate action by the Department that require the involvement of entities outside the Department. The remainder of this letter includes the Expert Panel's detailed discussion of the Department's implementation efforts and recommendations for additional, specific action by the Department.

Brief Summary of Status of B.H. Implementation

During the year since the Court approved the Implementation Plan, the Department has made progress in achieving several goals included therein. The Department has acted upon needed improvements in the integrity of implementation and rigor of evaluation. Some child service programs are showing promise. And we now have enough preliminary evidence to conclude that some of the other initiatives are unlikely to meet their objectives and should be discontinued or replaced once the parties and the Expert Panel agree on the criteria and process for making a decision about these initiatives and others in the future.

The progress achieved with some initiatives contrasts with the floundering we have observed with other initiatives that make up key elements of the B.H. Implementation Plan. The Department's

implementation efforts for the Immersion Sites and the Department's Core Practice Model are stalled. The Department is struggling to implement effective child and family teams for case planning, to develop enhanced and expanded community-based service arrays. Also stalled are the Department's efforts to roll out quality improvement policies and practices necessary to support quality service delivery, to identify and improve system design, and to address service delivery challenges related to individual youth in care, to the residential programs that serve them, and to the overall system of care which the Department manages. Taken together, these floundering initiatives form the very core of the overall reform required in B.H.: for the Department to create and maintain a system of services that provides for the safety, permanence and well-being of class members, including services that address their medical, behavioral health and developmental needs in settings that are as homelike as their needs permit.

The B.H. Implementation Plan calls for the Department to roll-out a functioning statewide system of services by adhering to the principles of implementation science through a "staged 'immersion' process of retraining and coaching front-line staff in a cohesive model of practice that provides children and their families with access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families."[1] The Expert Panel acknowledges that "[w]hat DCFS and the State of Illinois are undertaking is exceptionally ambitious and will require an intensity of focus to execute. Breaking down organizational silos of activity and responsibility, changing ingrained cultural habits, managing more than a thousand private contracts, and instituting new models of care with minimal negative impact on children in care is an extraordinary task."[2] The B.H. Implementation Plan thus anticipated that the parties would periodically review the progress made and negotiate appropriate revisions in the Plan once actionable evidence became available. This is a process that Sabel and Simon (2004) refer to as a *rolling-rule regime*, in which initiatives are considered provisional, are reviewed periodically, and are confirmed or revised with continuous stakeholder participation. The process is one

[1] Amended and Revised DCFS B.H. Implementation Plan, September 15, 2016, p. 25.

[2] B.H. v Sheldon 88 C 5599 Defendant's Submission Supplement to DCFS Implementation Plan, p. 2.

component of the "experimentalist" approach to consent decree management. Other components include: *negotiation* in which decisions are based on persuasion and evidence rather than fiat; and *transparency* in which the parties commit to outcome measures that are relatively specific and to methods of rigorous evaluation that facilitate disciplined comparisons to past performance, similar units, and whenever possible, randomized control groups. These three concepts guided the development of the B.H. Implementation Plan. They form the principles that must guide the ongoing review and revisions of the plan.

We find ourselves at a critical juncture with respect to the Department's readiness and willingness to continue to abide by the principles of rolling-rule regimes, negotiation, and transparency. Once again, the Department has experienced an unanticipated change in leadership. Past leadership changes have contributed to difficulties the Department has had achieving objectives of the Consent Decree. Any leadership transition poses challenges to maintaining the consistency of vision and on-going commitments to past institutional assurances. Without sustained reinforcement and additional support for the experimentalist approach from the new DCFS leadership – which to date has been lacking – we believe the Department is in danger of losing the advances already made, and that any further progress on key initiatives within the Implementation Plan and requirements of the consent decree will be stymied altogether.

Specific Recommendations for Immediate Action Involving Outside Entities

Throughout this letter, the Expert Panel makes specific recommendations about actions we believe the Department must take now if it is to fulfill its obligations under the current Implementation Plan and preserving what progress it has made to date thereunder. Our recommendations are based on the status reports of the Department's B.H. initiatives; regular meetings with the parties, with Department staff, the Department's university and evaluation partners, and other external stakeholders; and the Panel's own review and analysis of relevant information concerning the Department's B.H. initiatives contained in this report. We have discussed our concerns and the bases for our recommendations with the

parties; therefore, we are hopeful that the parties agree with the recommendations, and that together, we can agree on specific steps the Department will take and timeframes for those actions. In addition, the Expert Panel makes the following recommendations involving participants outside the Department:

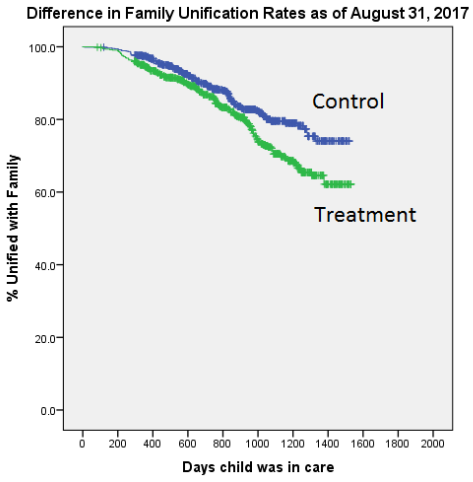
1. The Department will substantially expand the involvement of NIRN in the implementation efforts underway in and for the Immersion Sites in order to improve the chances of success. NIRN's involvement should include focus on implementation of the Department's Core Practice Model, particularly the training and coaching necessary to imbed effective child and family teams in casework practice and to implement the needed expanded array of intensive home and community-based services.
2. The Department will act on the recommendations of the Child Welfare Policy and Practice Group (of October 16, 2017) to strengthen implementation and to address challenges and obstacles to implementation in the Immersion Sites.
3. The Department will develop, in consultation with the Expert Panel, plaintiffs and its external partners, UIC, Northwestern, and Chapin Hall, the criteria and process it will use to determine and implement the types of new and expanded services and supports needed by youth in care with particularly complex behavioral health needs (e.g., "stuck" kids, youth with significant mental health and developmental needs often accompanied by aggressive behavior, youth with severe needs on the autistic spectrum, and youth who exhibit particularly dangerous and/or self-destructive behavior).
4. The Department will identify and define the behavioral health services most needed by DCFS youth that should be included in the IDHFS – Medicaid-funded MCO contract. In addition, the Department (again in consultation with the Expert Panel, plaintiffs, and other relevant stakeholders) will actively engage in planning with IDHFS to develop the MCO contract.

Given the intense level of activity that will be required under the Decree for the foreseeable future, the Expert Panel had planned to submit a separate request to augment its staffing and consultation support through the Children and Family Research Center at the University of Illinois at Urbana-Champaign. That request, as outlined in this report and in separate correspondence to the Department, was made so that the Expert Panel can fulfill its independent responsibility to review and report on the Department's progress toward meeting the needs of the plaintiff class. Immediately prior to submitting this letter, the Department's counsel informed us that the Department expects to agree to our request. If we do not reach agreement, we will then submit our request to the Court.

DETAILED REPORT AND ANALYSIS

Issues with Adherence to the Experimentalist Approach

We are pleased to report that where the Department has followed the experimentalist approach in its implementation efforts, that investment is beginning to bear fruit, particularly for those initiatives where the Department *also* adhered to the principles of implementation science. For example, the Illinois birth thru three (IB3) demonstration, which offers child-parent therapy or other trauma-informed parenting support to the caregivers and parents of children who have been taken into state custody before their third birthday, is finally showing positive results. The Department enrolled 1,606 babies in the demonstration from July 1, 2013 to December 31, 2016. Among the one-half of children assigned to the 10 agencies that offer the program, they experienced a 47% faster rate of reunification with parents or permanent guardianship with their extended family (family unification) than the one-half of children assigned to the 10 agencies that conduct "business as usual." As illustrated in the Figure above, this improvement is discernible only after these babies have spent in excess of 800 days in foster care. While the Expert Panel believes no child should spend these



critical developmental years in foster care, the progress that the program has made in expediting the discharge of these infants and toddlers from long-term foster care to permanent family arrangements is positive.

The Expert Panel is reasonably confident that the permanency improvements shown in the initiative are attributable to the IB3 program specifically because families were allocated to the intervention and comparison agencies in an unbiased manner using the Department's rotational assignment system. Rotational assignment delinks the offer of treatment from individual characteristics and prognostic factors that put infants and toddlers at differential risk of long-term foster care (e.g. inadequacy of pre-natal care, in utero substance exposure, maternal unavailability at birth, and severity of traumatic grief symptoms). Rotational assignment helps to ensure that the intervention and comparison groups look similar, on average, at the start. Therefore, if differences in outcomes subsequently emerge, we can be reasonably confident that the differences are attributable to the intervention rather than to preexisting differences at baseline (selection), changes that would have occurred in any event (maturation), and other happenings that unfold over time (history). The improvements in reunification appear to flow directly through completion of IB3 services by parents as well as indirectly through changes in agency culture (i.e., they become more family friendly). We believe that planning for rolling-out these interventions beyond Cook County should start now given this preliminary evidence of the program's efficacy. Nonetheless, it will be important to track outcomes for another year to ensure that the program is rolled out and executed with fidelity to its design, and that the differences remain positive with respect to re-entry rates and repeat maltreatment. We also anticipate that more adoptions will make-up for fewer reunifications in the comparison group, which may eventually eliminate any overall permanency differences between the intervention and comparison groups.

The ease of interpretation and clarity about future planning, which stems from taking an experimentalist approach to consent decree management, can be contrasted with the frustration, lack of clarity, and lack of progress that results when the Department undertakes initiatives without design and

implementation discipline, and reverts to its "business as usual" approach to management. For example, the Expert Panel requested over a year ago that the Department conduct a retrospective assessment of the "one-shot" initiative that the Department undertook in December of 2015 to dramatically reduce the number of youth "stuck" in and ready to step down from residential treatment programs. We were told that the effort focused on 569 youth who were in institutional care. The Panel asked for more information about where they landed, how stable the placements were, how many had run from home, been arrested, or dropped out of school. We were a little surprised that the agency didn't have this information at its fingertips as a matter of sound management practice. DCFS subsequently commissioned Chapin Hall at the University of Chicago to conduct a retrospective assessment. Because there was no comparison group for assessing differences in what might have happened in the absence of the special initiative, Chapin Hall did its best to piece together a matched sample of cases. Chapin Hall gave an oral briefing on the updated findings in September 2017 in response to our questions. Of the 569 youth included in the initiative: 81 were dropped from the assessment because they had not been in residential care for 12 months or more as of February 23, 2015; 33 remained at the target residential center as of April 30, 2017 and 21 exited care directly, leaving 434 youth in the target group. Of the 434 youth in the eventual focus group for follow-up, 191 youth made lateral moves to other residential treatment programs or other placements, meaning that 57% (326 youth) of the original 569 youth in residential programs either remained in the facility, were transferred to other similarly restrictive residential programs, or exited directly from residential care. Of the original 569 youth, 243 (43%) stepped down (or exited care directly) to less restrictive settings. In other words, a tremendous amount of activity took place, but no one knows whether the children involved are better off, not better off, or worse off than before as a result.

We recently received the full report addressing the questions we had posed. Based on the oral briefing we received, it appears that the differences in outcomes between the intervention group and the matched sample of cases were minimal, which in a sense is good news. At least the special effort did not result in inappropriate discharges for the 43% of the original focus group who stepped down. On the other

hand, we do not really know what to make of the results. Are the groups truly comparable? What lessons can be generalized from the initiative for future application? What did the Department learn about the behavioral health and other needs of the 326 youth (57% of the original 569 youth) who *remained* in restrictive residential settings and were not stepped down to home or community-based settings? Instead of a one-shot initiative, if the Department had instead adopted an experimentalist approach and limited the initiative to a random half of the 567 youth, we would have been in a much better position to track in real time the emerging differences or lack thereof. Based on the evidence, the Department would be able to decide with greater confidence whether the effort should be continued, extended, or stopped because of unfavorable results.

Requiring that the Department adhere to its promise to operate based on evidence is of critical importance. We bring this to the attention of the Court because the Department, with the new Acting Director's arrival, now appears to be diverging from the experimentalist approach it originally applied when implementing and evaluating many of the pilot initiatives in the Implementation Plan. These include the Core Practice Model through the Immersion Sites and IB3, Safe Families for Children, Pay for Success, Beyond Medical Necessity, and Regenerations, among others. For example, we learned in July of 2017 that without prior consultation with the Expert Panel the Department was planning to initiate another one-shot clinical review and stepped up discharge planning for youth who have been designated as clinically ready for discharge. The Department then expanded its review and step-down planning to include other so-called "stuck" youth in hospitals, detention facilities, or short-term emergency placements, youth who frequently have even more complex treatment and support needs than those in need of discharge plans and services to leave residential programs. While this "take-charge" attitude may sound desirable, the sad reality is that most of these youth are in need of highly specialized community-based services, especially mental health treatment, which simply don't exist in the communities to which they will be discharged.

One of the purposes of the Immersion Sites is to make certain that the appropriate plans and needed services are in place before stepping youth down to less restrictive settings. We asked the Department how a new "step-down" planning initiative focused on youth "stuck" in residential programs would fit with the broader work underway in Immersion Sites to implement the Core Practice Model and effective child and family teams with all members of the plaintiff class. The Department decided to focus on youth in residential or other high-end settings who were *not* from Immersion Sites (identifying 10 priority youth from each of the four existing administrative regions in the state). This, despite the fact that the DCFS and provider case worker staff who will be assigned case management responsibility to develop and implement discharge and service plans for these youth have not yet received coaching, training and mentoring in how to apply the Department's Core Practice Model through meaningful engagement with families and effective child and family teams. That looks and feels like an abandonment of both the Immersion Site initiative *and* the Core Practice Model that the Department has pledged to adopt. And it is potentially dangerous for youth.

Caseworkers, supervisors and other departmental regional administrative staff assigned responsibility for these youth are being asked to undertake planning and service implementation activities for youth with some of the most challenging behavioral health needs in the context of communities where the specialized treatment services many of them need either do not exist at all or have not been successfully individualized in the past to address similar youths' needs. Dr. Testa wrote to Mr. Digre, "[w]e understand the Department's desire to increase the outputs from all of the B.H. projects including the perceived need to do something quickly in the hopes that it disrupts the system-wide stasis we have been observing over the last decade. However, we've been down this road before with little tangible evidence of whether these initiatives truly worked and improved the situations for children…. So let's make sure we're not simply 'flailing' about and instead make sure we walk away with tangible evidence of how the process worked, to what effect, and what inferences can be drawn about how the lives of children have improved as a result of the initiative." (Email to Pete Digre on July 27, 2017) Past

experience has shown that the staff, time and other resources devoted to finding placements for these youth may not result in sustained improvement even for the targeted youth, and certainly will not result in the systemic or sustainable change to the DCFS system that is needed to help the next group of 300 youth who need community-based services and supports.

The Department's focus on the current group of "stuck" youth appears to assume that the services and supports these youth need *actually exist, are available and are equipped* to meet their needs, if only there were a centrally managed effort orchestrated to "match" youth with vacant "beds" in the community and direct assigned case workers to take the necessary steps to effect the match and placement. That assumption is not based on evidence. These initiatives have been tried many times before, and outside of the Immersion Sites, the necessary changes in the structure, organization and allocation of resources are not available to provide what these and other youth will need in the near and longer term future.

The June 2016 Supplement to DCFS B.H. Implementation Plan provided a clear statement of the rationale for the Implementation Plan's experimentalist approach, particularly with regard to the Immersion Sites:[3]

> What DCFS and the State of Illinois are undertaking is exceptionally ambitious and will require an intensity of focus to execute. Breaking down organizational silos of activity and responsibility, changing ingrained cultural habits, managing more than a thousand private contracts, and instituting new models of care with minimal negative impact on children in care is an extraordinary task. (p. 2)
>
> The foundation for the Implementation Plan is a Theory of Change that places an emphasis on building capacity to deliver high-quality and timely services to children and families in order to improve their functioning and expedite their goals. The Theory of Change suggests that planned interventions will act upon strategic levers -- the capacity of adults to care for children, the capacity of the system to identify and respond to needs with services, and the capacity of

[3] B.H. v Sheldon 88 C 5599 Defendant's Submission Supplement to DCFS Implementation Plan

communities to provide needed services and supports (p. 3). To this end, the implementation of the Core Practice Model via Immersion Sites is the centerpiece of the plan, and the key vehicle for improving practice and demonstrating impact and change.

The implementation of the Core Practice Model via Immersion Sites provides an opportunity to demonstrate and test new ways of thinking about and providing care to children and families and has been developed with the concept of adaptive challenges in mind. Within the Core Practice Model, front line workers and supervisors will be trained in the new model (adaptive) that shifts day to day work from compliance to critical decision-making (pp. 3 – 4).

The Implementation Plan is organized around embedding the Core Practice Model via Immersion Sites, including the establishment of the processes and procedures of the new model of practice, the reorganization of key supports, the integration of services to achieve a community-based comprehensive array of services organized in a continuum of care, development of measures to ensure that improved outcomes of family preservation and reunification and permanence are being achieved, and methods to embed the processes and procedures of the new model of practice in the culture of DCFS through training and coaching.

The Core Practice Model via Immersion Sites is the cornerstone of the plan and the efforts to transform the entire DCFS system (p. 11). Implementation of the Core Practice Model via Immersion Sites at DCFS will require a number of steps, including: considerable retraining and coaching of staff, organizational restructuring, development of a comprehensive array of services, and the consistent feedback loops of quality assurance and control. This approach facilitates initial implementation of local technical assistance, resource development, training and coaching in fewer areas at one time which should make lasting improvements more likely (pp. 14-15).

The youth currently in residential or other highly restrictive programs have specialized mental health needs that the child welfare system has not and cannot effectively address. Many of them have needs that require specialized behavioral health services, and those services either do not now exist or are not available in many Illinois communities. The Immersion Sites are beginning to identify behavioral health service gaps and to take steps to obtain or encourage development of behavioral health services to address some of the mental health needs many of their youth have. The Therapeutic Residential Performance Management Initiative (TRPMI) has also identified significant behavioral health service gaps that are preventing youth from leaving residential treatment programs to community and home-based settings. We do not yet know enough about the plan for expanding behavioral health services and care coordination through the Illinois Department of Healthcare and Family Services (Medicaid) to be able to evaluate whether it will increase access and availability of needed behavioral health services. Moreover, implementation of the planned changes to Illinois' behavioral health system for children in DCFS custody is not planned until at least 2018 and perhaps later, in 2019. In the meantime, Illinois youth in DCFS care with mental health needs will be more effectively served, and the Department will learn the most about how to frame care coordination under managed care and roll out needed changes statewide, *only* if the Department remains focused on making use of Immersion Sites as the "enabling context" within which it will design, test, evaluate and adapt responses to what Implementation Science refers to as "technical" and "adaptive" challenges like those presented by the imperative to develop service resources for high-needs youth.

The Path Forward

With the unplanned resignation of the former DCFS director, George Sheldon, and the appointment of Acting Director, BJ Walker, the state is once again experiencing a turnover in leadership, which the 2015 Report of the Expert Panel identified as contributing to past difficulties in the Department's achieving the objectives of the decree. The Acting DCFS Director comes with a wealth of leadership experience. The goals she has stated for child welfare align well with the objectives of the

consent decree. The continued involvement of Beth Solomon and Barbara Greenspan offers some continuity of leadership.

With any change in top leadership, however, come additional changes in other key leadership positions. Most notable are the resignation of Peter Digre, who led the Department's implementation of the plan and the transition of former DCFS General Counsel, Lise Spacapan, to General Counsel to the Governor, and the recent replacement of Janet Ahern by Shawn Eddings as DCFS General Counsel. Mary Nam and Marshae Terry have been hired in replacement roles for Peter Digre. To date, we have not seen this new DCFS leadership decisively reinforce the Department's commitment, as embodied in the Implementation Plan, to evidence-based negotiation, rolling-rule regimes, and transparency of implementation and evaluation.

Any transition brings new challenges in maintaining the consistency of vision and on-going commitments to past institutional assurances. Such challenges are heightened with consent decree reform. Those with experience in other states' reform efforts under consent decrees often are heavily *compliance-oriented* in enforcing adherence to agreed-upon rules through strict surveillance and centralized control. The approach that the Department is bound to take differs from the usual *compliance-oriented* approach that enforces adherence to agreed-upon rules through strict surveillance and centralized control. It is what we called in our Expert Panel Report, *results-oriented* accountability (Testa & Poertner, 2010). It is consistent with the experimentalist approach of Sabel and Simon (2004) and focuses on selecting reform strategies with the best available evidence of past success, implementing them with integrity, and evaluating their causal efficacy in attaining the desired results. It doesn't dispense with compliance-oriented accountability entirely, but instead simply suspends its application until after the entire process plays out in building credible evidence for what works best, what doesn't work as well, and what should be scaled-up, discontinued or replaced in order to promote the safety, family permanence, and wellbeing of members of the plaintiff class. The Department has had more than 20 years of experience with compliance-oriented reform efforts, and they have not worked. The Department will not succeed in

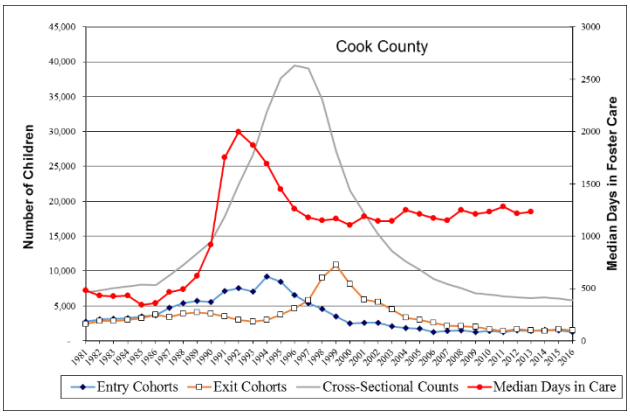
achieving compliance under the B.H. Decree if it does not adhere to its newly-adopted results-oriented approach.

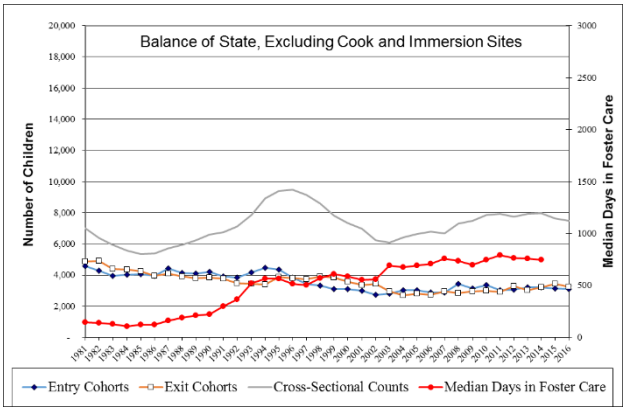
In an early meeting with the Acting Director, she noted her basic agreement with the experimentalist approach, if not with all of the consent decree's specific requirements. We grouped the various initiatives contained in the Implementation Plan under the priorities listed below, which she outlined in remarks she gave at the Illinois-Joint DCFS Summit on Continuous Quality Improvement.

No Child Should Grow Up in Foster Care	**Child Welfare Workforce Enhancement**	**Children Should Be Better Off Because of DCFS Involvement**
• Expanded state funded guardianship • Amended definition of "fictive" kin • Family finding • Safe families for children	• Care Management Entity • Immersion Sites • Core Practice Model • Residential monitoring • Implementation science • Overarching outcomes measures • DCFS reorganization • Information systems enhancement	• Therapeutic foster care • Regenerations for dually involved youth • Pay for success for dually involved youth • Illinois birth thru three (IB3) waiver • Beyond Medical Necessity • Enhanced and expanded service array in immersion sites

In our correspondence with the Acting Director, we have referenced these priorities as a way of reinforcing the following points.

- ***Acknowledging the necessity of a consent decree*:** The belief that no child should grow up in foster care is at the heart of the consent decree. The charts below illustrate the entrenched nature of the problem of long-term foster care in Cook County and balance of state regions.





The system has stabilized at a median length of stay that is the longest in the nation. Quite simply, too many children are growing up in foster care in Illinois and for far too long. The fact that the stasis of the system has persisted since the early 2000s in Cook County and longer in the balance of state, in spite of (or because of) changes in political and DCFS leadership is one of the major reasons that a supplemental implementation plan was required in order to disrupt this unhealthy equilibrium. As Sabel and Simon (2004) note, a federal court's involvement is warranted whenever public institutions have chronically failed to meet their constitutional obligations, and the normal processes of political accountability (elections and administrative appointments) have proved inadequate for solving the problem. DCFS repeatedly has shown it cannot change the current dynamic without a consent decree.

- ***Enhancing the competency of the child welfare workforce*:** The changes needed to disrupt the system in a productive way cannot be initiated and sustained without competent leadership, a supportive enabling context, and a qualified workforce with sufficient expertise to implement evidence-based practice with families and children. These are the basic principles of Implementation Science. As we noted in the Expert Panel report: "As frequently occurs with a large public agency, its capacity to advance its core mission became hampered over time by the proliferation of rules and regulation, the emergence of management silos, and the imposition of multiple-approval processes. Such 'over-bureaucratization' leads to risk-adverse, compliance-

oriented accountability in child welfare rather than results-oriented accountability that keeps the focus on children, checks whether they are being effectively served, and adapts flexibly when results are contrary to expectations." (p. 20). We recommended that DCFS start the process of positive disruption through staged implementation and a phased-based approach to evidence building in Immersion Sites before rolling-out statewide. The Department agreed to that approach but is not adhering to it. It is our recommendation that the Department step-up the involvement of NIRN in this process in order to reorient the Department and improve the prospects for success.

- ***Restoring the sense of collective efficacy that we were able to cultivate under the prior leadership*:** Stakeholders' shared belief in their collective efficacy to bring about change is essential for fulfilling the promise that children will be better off because of DCFS involvement (Bandura, 2001). An experimentalist approach, when practiced with integrity, strengthens the sense of collective efficacy of the Department as a whole by demonstrating that the desired improvements are the result of DCFS involvement. It is not sufficient to demonstrate that the Department is merely complying with a "check-list" of procedural requirements. Nor is it adequate to track outcomes in the hopes that they begin to trend in the desired direction. The B.H. Implementation Plan aims to implement evidence-supported interventions and evaluate the results with sufficient rigor in order to increase scientific confidence that the observed changes (for the better or worse) are truly attributable to DCFS involvement. In order to obtain the strongest evidence of impact, the Implementation Plan calls for conducting rigorous studies of promising interventions so the Court and the parties can compare actual results to what might have happened under "business as usual" or without DCFS involvement. Wherever feasible the Plan makes use of rotational allocation, alternation, and random assignment to form comparable groups for tracking outcomes compared to business as usual. Unbiased allocation of persons to intervention and comparison groups is the gold standard of rigorous assessment, which all business, medical, and social work schools now recommend.

The Expert Panel has been coaching B.H. Project Managers over the last year in the methods of implementing a promising or evidence-based intervention in a way that enables us to draw generalizable conclusions about what is working and what is not. We find that B.H. Project teams that developed coherent logic models, received adequate resources, implemented rigorous evaluation designs, and have access to good data-support systems exhibit the greatest sense of collective efficacy; especially after outcomes start trending in the desired direction (e.g. IB3, Safe Families for Children). Those that lack these supports are less confident (e.g. family finding, expanded state funded guardianship). Many of the projects fall somewhere in between and are still retooling their logic models or struggling to understand project shortfalls. Some initiatives have run their course and should be retired or replaced (e.g. Care Management Entity, Pay For Success for dually involved youth). Without sustained reinforcement and additional support for the experimentalist approach from DCFS leadership, we believe the Department is in danger of losing the advances already made in realizing the goals of the decree.

II. Diminished Support for and Cooperation With the Expert Panel.

Our initial efforts with the new DCFS leadership to build on the sense of collective efficacy and commitment to negotiation based on persuasive argument and hard evidence have not been met with the same spirit of collaboration and cooperation that we experienced in the past. The new DCFS leadership has discussed major changes to the B.H. Implementation Plan, without offering accompanying rationales or supporting information. The Expert Panel finds that deeply concerning, especially for two key initiatives that will be discussed more fully later in this report: 1) the planned timeframe for developing internal Master Coach capacity to train, coach and mentor front line caseworkers, supervisors and facilitators of Child and Family Teams consistent with the standards of the Department's Core Practice Model, and 2) the criteria of an effective residential monitoring system and the timeframe for developing, if possible, the internal capacity for DCFS to implement an effective residential monitoring and quality improvement system.

Just as concerning is the apparent change in attitude toward the Expert Panel's intention to step-up our monitoring activities. In the proceedings before the Court on June 20, 2017, the Court inquired of the Department's view of the Expert Panel's stepping up our monitoring activities and increasing our staff. Ms. Greenspan of the Attorneys General Office responded by acknowledging that the Order appointing us contemplates bringing on additional staff and other consultants after consultation with the Department. She noted that the parties "contemplated from the beginning that there would be various points in time when the experts' monitoring activities would be more intense than others. This is a time when I think they want to dig in on some issues that they've identified. And we welcome their participation. It's always been very productive for the Department."

We previewed portions of our staffing plan in an e-mail that Dr. Testa sent to Acting Director Walker on July 7, 2017 and did not receive a response. He followed-up with another e-mail to Mr. Digre dated July 31, 2017. In both e-mails, he expressed the Panel's intention to engage Andy Barclay as a consultant to advise the Panel on information technology issues. We received an immediate response from Mr. Digre, which raised for the first time the "zero-sum" argument that meeting our staffing needs for independent consultation could potentially weaken the Department's capacity to develop a much higher degree of autonomy in producing the analytic data that it needs to drive a continuous quality improvement process. To set up another external source of analytic data, he suggested, would not strengthen and possibly weaken that capacity by increasing the DCFS dependence on external analysis. Frankly, we remain puzzled by this argument inasmuch as previous communications with the Department (see above court transcript) have always welcomed our participation and found our contributions to be very productive for the Department.

Mr. Digre suggested that our needs were better accommodated, in lieu of the Panel's request for staffing resources, by dedicating internal department resources available from its OITS Reporting Team and Quality Assurance staff, and by making special arrangements with Chapin Hall to ensure that we receive all the data and analysis needed in a timely fashion. Frankly, we have concerns about these

assurances. To fulfill our responsibilities to monitor the Implementation Plan and to report to the Court, we need to maintain independent and unfettered access to and management of the data analytics and case reviews we determine are necessary to fulfill our responsibilities. We informed the Department that its offer of internal staffing assistance and analytic and computer programming support from Chapin Hall as filtered through the Department's existing program plans was not acceptable.

We also took steps to explore other options for meeting our staffing needs, which preserve the independence we need and maximize the Department's resources already committed to these functions. We traveled to the campus of the University of Illinois at Urbana-Champaign to meet with the incoming Dean of the School of Social Work and the Director and staff of the Children and Family Research Center (CFRC). Dr. Testa was the Director of the Children and Family Research Center prior to his joining the University of North Carolina in 2010.

We relied on the CFRC for data analytic support in preparing our 2015 Expert Panel report and have found their annual *Conditions of Children* report useful for tracking the Department's past progress in achieving outcomes. We have discussed our staffing needs with the new Dean and the current Director of CFRC. We believe our needs for independence align nicely with the substantial investment the Department is currently investing in the University of Illinois. The Center has agreed to accommodate our current needs for timely analytical and programming support. In addition, their Foster Care Utilization Review Program (FCURP) houses staff that could assist us with our case review needs. The Department, until just before we filed this letter, continued to resist this revenue-neutral solution without offering any alternative that would address the Expert Panel's need for independent, unfiltered access to data.

The length and course of our attempted negotiation with the Department for support resources has been disappointing. We hope the Department's recent communication with us will result in an agreement about our request to use CFRC for our staff and consultation needs. Important here is that these failed discussions are emblematic of a shift generally in our interactions with the Department. Often, when information or data is requested, the Department's responsive communication is poor. Several times, the

Department has resisted our requests, saying that our requests do not fall within our areas of responsibility or authority. The Expert Panel's ability to report to this Court is impaired by this lack of responsiveness and disclosure.

III. Findings and Data for the Department's Three Core Categories of Priorities

In the remainder of our report, we present data and discuss our preliminary analyses with respect to the three categories of priorities identified above: 1) ensuring that no child grows up in foster care; 2) enhancing the competencies of the child welfare workforce; and 3) confirming that children are better off because of DCFS involvement

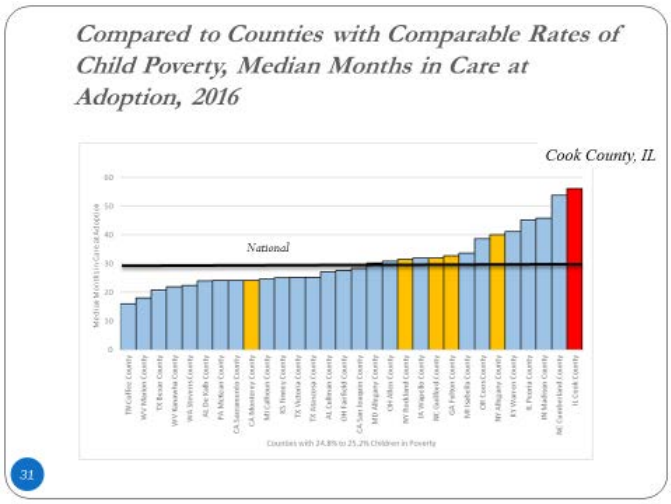
A. No Child Should Grow Up in Foster Care: The Problem of Long-Term Foster Care

Sabel and Simon (2004) make the argument that a consent decree is appropriate whenever public institutions chronically fail to meet their obligations and the normal processes of political accountability through administrative appointments and democratic elections have proved inadequate for resolving the problem. As noted above, the entrenched problem that the B.H. Implementation Plan seeks to address is the excessively long-lengths of time that infants, toddlers, older children, and adolescents spend in foster care. Over 60 years of scientific research demonstrates the adverse effects of child maltreatment and lack of stable family attachments on later physical and mental health. The best way to reverse the damage is to restore children safely to the custody of their parents, whenever feasible, or to find alternative permanent homes in a timely fashion with their extended families, legal guardians, and adoptive parents. As we stated in our Expert Panel report:

> The social and emotional wellbeing of children is best assured within the context of safe and permanent family relationships with birth parents, legal guardians, or adoptive parents, who participate the planning of individualized permanency and treatment plans crafted by child and family teams.

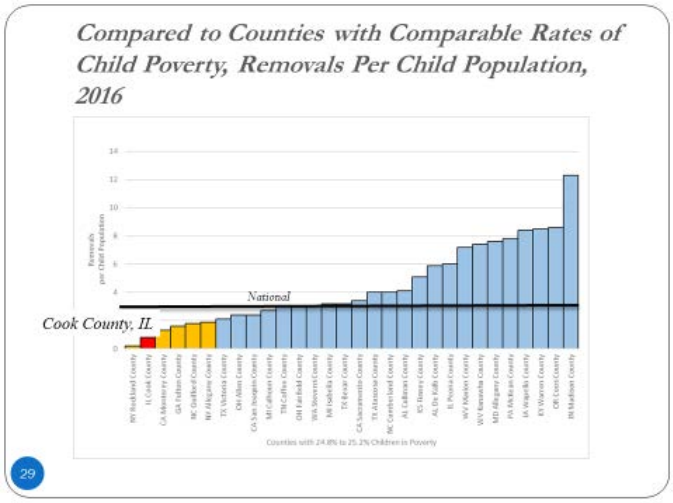
Prolonging a child's stay in foster care beyond necessity without regard to the child's sense of time is contrary to the best interests of children. Allowing adolescents to age out of state custody without legal connections to family or at least one committed adult is destructive of their future well-being. The Illinois child welfare system continues to fail our children and youth on both counts.

As illustrated in the charts above (p. 16), the median length of stay in foster care in the balance of counties outside of Cook County has stabilized at approximately 700 days since 2010. In Cook County, the median time in care is in excess of 1,200 days. When children, who are returned home within a week of removal (releases from protective custody) are removed from the calculation, the median evens out at approximately 28 months in the balance of state and 49 months in Cook County.



The Figure to the left compares the median months in care at the time of adoption to other comparable urban counties nationwide with similar rates of child poverty (25 per 100 population under 18). As noted in our Expert Panel report, the atypically long lengths of foster care in Cook County and the balance of state is partly a by-product of past successes.

Prior to 2010, Illinois had been at the forefront of a nationwide transformation of the public child welfare system. A major milestone in this transformation was the shift from long-term foster care to family permanence illustrated by the charts on page 16. From 1997 to 2010, the number of foster children fell from over 50,000 in 1997 to under 15,000 in 2010. The number in assisted adoptive and guardianship homes expanded from 12,000 to over 40,000 children in the mid-2000s. Currently there are almost 23,000 children in assisted adoptive and guardianship homes in Illinois.



The shift from long-term foster care to family permanence also occurred on the removal side, when practice in Illinois shifted from taking children out of their homes to safely preserving their placement with family. This trend is illustrated in the same set of charts by the steady decline after 1997 in the entry of children into foster care, which coincided with home of relative reform and associated safety initiatives. The result of those initiatives was to reduce the per-capita rate of removal into foster care to one of the lowest in the nation. Compared to other urban counties with similar levels of child poverty, only one county in the U.S. has a lower removal rate than Cook County (see above Figure).

The challenge these past successes pose to continued improvement now that DCFS is responsible for the care and custody of a smaller group of severely traumatized children is unmistakable. Children present more complex needs and families are more challenging to serve. Because low rates of child removal correlate with longer lengths of stay in foster care, Illinois' median time in foster care predictably ranks among the longest in the nation. *However, a low rate of child removal is no excuse for inaction in finding children with psychological, behavioral or emotional challenges permanent homes in a more timely fashion.* Instead, it calls for better ways of working with families and other interested persons (such as relatives, friends, and neighbors) in a collaborative process that brings formal resources to bear on assessing family needs, finding solutions to meeting those needs, tracking the accomplishment of agreed-upon tasks, and evaluating the results of these investments. In order for these efforts to succeed, it is essential that the process is truly collaborative and proceeds in a way that recognizes and affirms family strengths, learns what the family hopes to accomplish, and designs individualized support and services that match the family's needs and builds of their strengths.

1. Family Finding, State Funded Guardianship, and Expanded Definition of Relatives

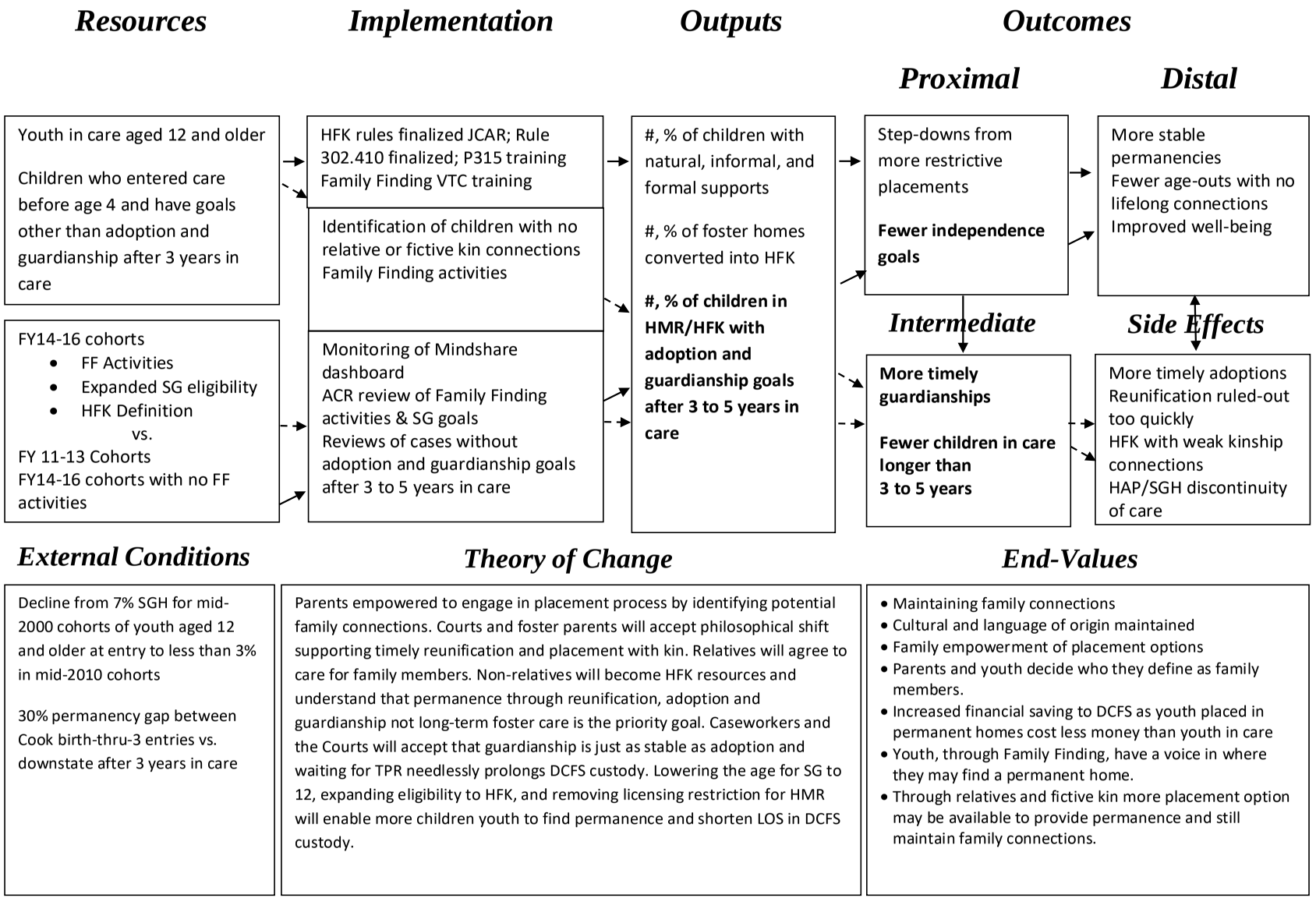
Three evidence-based, permanency enhancement initiatives have been incorporated into the B.H. Implementation Plan and are as follows:

- Family finding (tools for locating relatives who can provide a variety of supports to children and their families);
- Expanded use of state funded guardianship (subsidies for kinship homes that don't satisfy state licensing requirements);
- Amended definition of "fictive kin" (qualifies more foster families for the federal Guardianship Assistance Program).

Each of these initiatives has been enacted into law since the implementation of the Plan and the accompanying rules and regulations are either completed or in process. The logic model below illustrates the pathways through which it is expected that these permanency initiatives will translate into the outputs and outcomes of more timely guardianships, fewer days in foster care, stable permanent placements, and fewer youth who age-out of care lacking a lifelong connection to a family or at least one adult. The ability to monitor full implementation of the family finding and permanency enhancement initiatives and the impacts on program outputs and child outcomes has been hampered by the absence of a dedicated CQI reviewer or university contractual support. In the interim, Dr. Mark Testa agreed to provide temporary monitoring assistance until more permanent staffing arrangements could be made. However, as discussed above, the Department's resistance to honoring its previous commitment to provide the necessary resources makes it impossible for Dr. Testa, who has funded his time out of his university chair account, to continue offering this assistance.

The latest data on finalized guardianships during the first seven months of 2017 show a substantial improvement from the numbers posted in 2016 for the same period (see Table below). The uptick is particularly noticeable in the Immersion Sites of Lake and Mt. Vernon. Statewide the numbers

SGH/HFK/FF Logic Model



are bouncing back to the performance levels that the Department achieved in the early 2000s under the Subsidized Guardianship Waiver program.

The numbers of children discharged to permanent guardianship arrangements dropped sharply after 2009 when the waiver ended and the federal KinGap program began. KinGap is limited to children in licensed relative homes whereas non-licensed kinship homes were eligible under the waiver demonstration. The restoration of much of the eligibility criteria from the waiver to the states' IV-E GAP plan should greatly expand the utilization of subsidized guardianship as a permanency option.

Thirty-one percent of the statewide increase in guardianships is attributable to the two Immersion Sites of Lake and Mt. Vernon, which constitute only 5% of the state foster care population. It seems probable that the refocus on guardianship in these two sites is primarily responsible for the increase rather than any specific effects associated with family finding, state funded guardianship, and the expanded definition of fictive kin. Nonetheless, a refocus on guardianship in combination with these initiatives should greatly increase utilization of subsidized guardianship in future years.

Finalized Guardianships			
	Period		
Area	**Jan-Jul 2016**	**Jan-Jul 2017**	**%Δ**
Immersion Sites	13	37	184.6%
East St. Louis	2	0	-100.0%
Lake	2	16	700.0%
Mt. Vernon	4	16	300.0%
Rock Island	5	5	0.0%
Balance of State	91	136	49.5%
Cook County	85	99	16.5%
Total State	**189**	**272**	**43.9%**

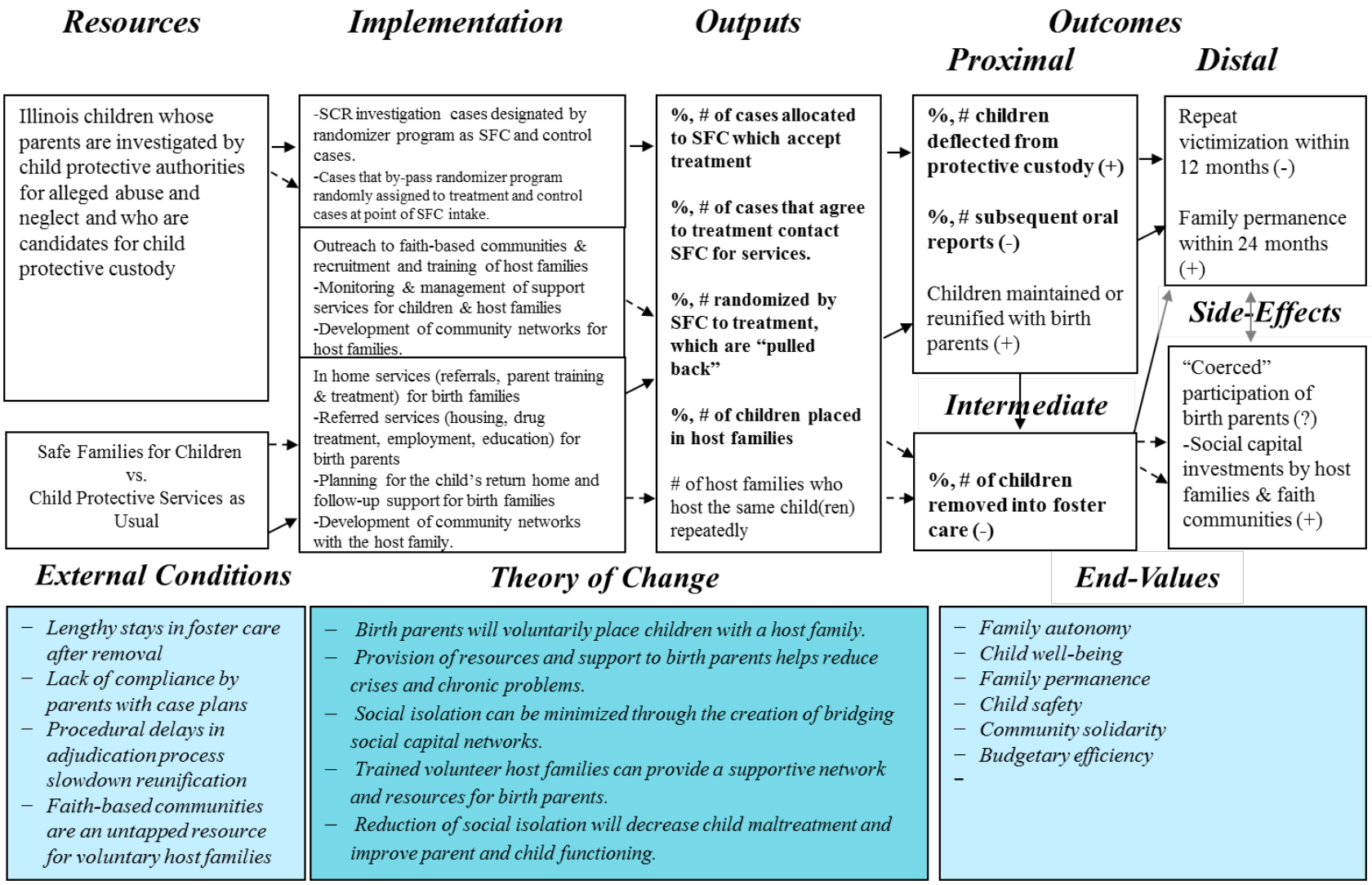
Guardianship is a permanency resource that should be pursued more diligently for children who enter foster care at ages 12 years old and older. Currently less than 30% of the exits from care involve children who entered foster care as adolescents, but they constitute 66% of the children who age-out of care or attain majority age while in foster care. Since 1981, the proportion of youth entering foster care as adolescents and who aged out or turned 18 while in care has risen from 23% to 45%. In the modern era of emerging adulthood when fewer and fewer persons are achieving full-fledged adulthood before age 25, no young adult should age out of care without formalizing a permanent legal connection to at least one older adult. Beginning in the Immersion Sites, DCFS should continue expanding its use of legal guardianship to ensure that no young person in care turns 18 without first establishing or re-establishing a formal relationship with a family or person to whom he, she or they can turn to in times of need.

2. Safe Families for Children

Family finding assumes a latent network of informal support from relatives and fictive kin, which can be activated in times of need to provide temporary help and assistance to parents whose children are at imminent risk of removal from their custody. When parents are isolated from informal networks, voluntary organizations can often serve the same function by sponsoring families with whom parents can temporarily place their children as an alternative to DCFS's taking legal custody of the children. Safe Families for Children (SFC) is a promising program to prevent the removal of children into protective custody by recruiting and overseeing a network of host families with whom parents can voluntarily place their children in times of need. Developed by LYDIA, a Chicago-based social service agency, SFC is currently operating in over 40 local sites across the U.S.

SFC is a DCFS program that preexisted the appointment of the Expert Panel and was later incorporated into the B.H. Implementation Plan. The philosophy behind the program is similar to other "deflection" programs, such as alternative response and diversion to informal kinship care, which offer a non-authoritarian response to family problems (see Logic Model). By offering an alternative to formal protective custody, SFC allows for voluntary intervention *without* forcibly removing the children into

Safe Families For Children Logic Model



foster care. According to advocates of this approach, the authoritarian approach of usual CPS procedures is not appropriate for many of the families that are investigated by DCFS and may even be counterproductive to the goals of ensuring child safety, family permanence, and the social and emotional well-being of vulnerable children and youth (Waldfogel 1998).

On average, children stay with their SFC host families for 45-55 days before they are able to return safely to the custody of their parents. After the hosting arrangement has ended, the intention is for the two families to remain in contact and sustain the "bridging social capital" (Testa, Bruhn & Helton, 2010) that ideally was built up between the families during the hosting period. The expectation is that the supportive arrangement will continue after the children are reunified with their birth family.

The brief period of voluntary hosting of children compares favorably to the many years that children remain in foster care after DCFS takes formal custody. DCFS administrative data indicated that each quarter there are from 1,200 to 1,400 families that meet the SFC hosting profile in the original target sites of Cook County and the Northern DCFS region. It includes children who are involved in "A" sequence allegations of inadequate shelter or supervision, environmental neglect, or substantial risk of abuse. The program works best when all of the siblings are under the age of 6 years old. Follow-up indicates that approximately 150 of these families will typically be re-reported for maltreatment within a year or endure the removal of the children from their custody. It is the assumption of the SFC program that DCFS could do better by these children by referring them to SFC for voluntary hosting rather than taking them into foster care.

The Arnold Foundation funded Dr. Mark Testa to conduct the evaluation of the program. The anticipated 120 family referrals from DCFS investigators for the first quarter of 2016 did not materialize as shown in the table below. It was only after SFC established a back-up randomization plan for investigators that by-passed the automated DCFS allocation system that the total number of referrals approached the desired targets. The use of two allocation procedures, however, resulted in the assignment of the same families to both the intervention and comparison groups. Further, data indicated that Cook

Quarterly Referral of Families

Phase/Quarter	Referral Source DCFS	SFC	Total
Initial Implementation			
2016 Q1	18	16	34
2016 Q2	53	54	107
2016 Q3	43	56	99
2016 Q4	35	44	79
Subtotal	149	170	319
Full Implementation			
2017 Q1	28	33	61
2017 Q2	27	31	58
2017 Q3 (as of July 30)	13	6	19
Subtotal	68	70	138
TOTAL	217	240	457

County CPS investigative staff were diverging from fidelity to the SFC model in potentially unhelpful ways. As a result, Cook County referrals were dropped from the evaluation during full implementation of the program.

To reduce the number of "cross-overs" from comparison to intervention conditions, the Department agreed to channel all referrals through a single-point of allocation. Even though the centralization of SFC referrals cleared up most of the implementation problems, such as multiple assignments and "cross-overs," the problem of low referrals persists. Reports from the field indicate that some investigators are resistant to making referrals because half of the families will be allocated to services as usual. Unfortunately, this resistance amounts to offering families "none of the loaf, if only a random half can receive some of the loaf." Originally, the expectation was that too few families would be available to host all of the referrals, so randomization was the fairest way to divvy up the requests. With all Cook County referrals now going into the intervention group, the hope is that referrals to SFC will pick-up.

By restricting the pilot to downstate regions, where multiple assignments and "cross-overs" have not been a problem, the hope is that solid evidence can be collected on the effectiveness of SFC in safely deflecting child from foster care. The results so far are encouraging. As of December 30, 2016, children referred to SFC outside of Cook County spent, on average, 14 days in foster care compared to 36 days for children assigned to business as usual for a difference of 22 days. The combined average daily administrative and maintenance costs of foster care amount to $85 per day. When applied to the average of 22 days of foster care that was averted as a result of families being allocated to the SFC intervention,

the total savings from deflection amounted to an average of $1,870 per child. On the assumption that the average length of stay of children taken into foster care in the comparison group will last much longer than 36 days, the net savings per child could into the tens of thousands of dollars. These savings would be better invested in additional "front end" resources that help children remain with their families than paying for their upkeep in foster care.

In order to generate solid evidence on the cost-effectiveness of SFC and its efficacy in maintaining children in the safe and stable care of their families, it will be important to increase the number of SFC referrals downstate and make sure CPS investigators follow-through on helping families make contact with the program. Currently, investigators follow through on only one-half of the families who agree to SFC hosting services. The Department has agreed to step-up compliance efforts in the Immersion Sites. The Expert Panel recommends that NIRN be brought in to assist in these compliance efforts as well as other B.H. initiatives in the Immersion Sites.

As the efforts to operate and evaluate the SFC model shows, incomplete compliance by the Department poses one of the most serious challenges to results-oriented accountability. Failure to inform clients of available service options is a breach of fiduciary responsibility. Less obvious but equally damaging non-compliance is the deliberate diversion of clients to experimental services when an unbiased allocation process assigns them to receive services as usual. Both actions are clear violations of implementation integrity. Each elevates worker biases and discretion over policy references and undercuts collaborative efforts to build credible evidence that would establish whether or not a promising innovation is better in achieving the desired outcomes than "services as usual." Deliberate diversion of families may feel less serious than the former because workers previously have been allowed, if not are encouraged, to devote their energies to obtaining what they believe is in their clients' best interests *irrespective* of the strength of the evidence in support of their beliefs. Many stakeholders perceive any constraint on worker discretion, even for purposes of narrowing agency uncertainty over the cost effectiveness and benefits of planned interventions, as unfair; some regard it as unethical. That is simply wrong, and NIRN can help

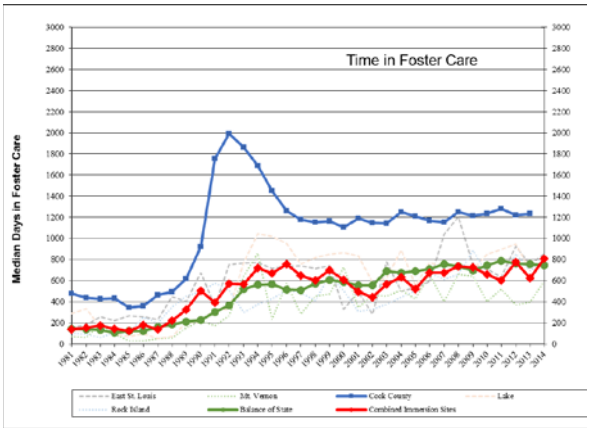
overcome these implementation challenges and improve the Department's ability to learn what works and what doesn't, and then to make good on the promise that no child should grow up in foster care.

B. Enhancing the competency of the child welfare workforce:

1. Immersion Sites

The mechanism we recommended in the Expert Panel report for improving the Department's involvement with children and families is through a staged "immersion" process of retraining and coaching front-line staff in the Department's Core Practice Model and two of its primary components, Child and Family Team Meetings (CFTM) and Quality Service Review (QSR) processes. The goal is to provide children and their families with access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanence with adoptive parents or legal guardians.

The new DCFS leadership has questioned the timeline and rationale for installing the Core Practice Model and its primary components, CFTM and QSR, in a selected set of jurisdictions serving only 10% of the plaintiff class when the need appears to be greatest in Cook County. The reason we recommended piloting the experimentalist approach in immersion sites where the problems appeared tractable and the costs of immersion were affordable was that the interventions should be validated before they are rolled out to areas where the problems were more entrenched, such as Cook County.



As illustrated in the chart, the immersion sites parallel the challenges of serving children and families outside of the jurisdiction of the Cook County Juvenile Court. Even though length of stay is lower in the Immersion Sites and balance of state (BOS), the median for both groups has been trending upward almost in lockstep. Using the non-Cook, non-Immersion Site balance of

state (BOS) downstate counties as a comparison group with the Immersion Sites affords an early glimpse of whether the immersion site process is working and merits roll out to other downstate counties as well as Cook County.

The progress registered to date is encouraging. Compared to the BOS comparison group, adoptions increased by 37% in the BOS and by 49% in the Immersion Sites in the first 7 months of 2017 compared to the same period in 2016. More striking, guardianships increased by 49% in the BOS and by 185% in the Immersion Sites. The small baseline volume of guardianships (13) finalized in the Immersion sites in 2016, however, exaggerates the magnitude of the difference. Perhaps of greater significance is the fact that reunification increased by 14% during this period in the Immersion sites, whereas it *decreased* by 14% in the BOS (see Appendix comparing differences across sites).

Despite these positive signs, it is *still too early* to tell whether the permanency improvements in the immersion sites are attributable to the CFTM model and QSR processes. Based on the reports we hear in our regular meetings with Immersion Site directors and trainers and coaches from Child Welfare Group (CWG), we believe the process is greatly enhancing the competency of the child welfare workers in engaging with and serving families. The Immersion Site directors are seeing positive changes in child and family team meetings through their provider agency workforce based on the training and coaching done by CWG. They are also receiving enthusiastic and positive feedback from providers who have participated in training and in subsequent child and family team meetings and have seen families become better engaged and get "unstuck." CWG agreed they are also seeing a lot of progress.

Yet, we also know through the same reports, meetings and phone conferences that this progress and excitement is fragile. The new DCFS leadership has expressed a preference for accelerating the roll-out of the process and stepping-up Chapin Hall's evaluation of the initiative so that a decision can be made in January of 2018 as to whether to extend or curtail the contract with CWG. In essence, that requires that CWG deviate from its model. Accelerating the timetable now after there were departmental delays executing the original contract is not only ill-advised, it threatens to undermine the CFT model

altogether, if not guarantee its failure. Based on the information shared at our last conference call, it appears that the Department will not reach its projected goal of training 25-28 master coaches by the end of December or even by the early part of next year. Instead, it looks like the revised goal is to train only 19 master coaches. The reason for this shortfall is related to staff turnover, which is a larger problem that is not unique to the Immersion Sites and needs to be addressed. Providers have voiced their concern to the Immersion Site directors that the accelerated schedule is too demanding and is imposing too heavy a burden on their supervisors and workers. For example, in the Lake County Immersion Site, a master coach dropped out because of the accelerated timetable. A CWG trainer commented on the noticeable change from the July trainings to the October trainings, which are more compact and only half-full. Additionally, in Lake County, staff criticized how quickly the Department is doing the trainings in October, limiting the time they have available to prepare and meet with families before the scheduled child and family team meetings, while also fulfilling their other job responsibilities. Providers do not feel that it is sustainable, they are more negative, and they are participating less.

In response to a DCFS request for suggestions and recommendations to strengthen implementation of the Core Practice Model, child and family teams, and QSRs in the Immersion Sites, Paul Vincent, Director of the Child Welfare and Policy Practice Group provided on October 16, 2017, several recommendations to DCFS and the Expert Panel. His recommendations, included below, were based on the experiences his staff are having in the field in Illinois, in addition to their years of experience training, coaching and embedding effective casework practice into child and family teams and overall casework with children and families in many other states.

> We [The Child Welfare Policy and Practice Group] have been conferring about ways to strengthen implementation and have some observations and strategies for us all to consider. The challenges we are encountering are not surprising for a reform in its early stages. In fact, the immersion process was adopted in part to provide a mechanism for identifying barriers early in implementation. We now have the opportunity to address the obstacles we are encountering so

the next immersion phase doesn't experience them. We have identified some of the implementation challenges we have encountered and our suggestions are below.

CHALLENGES

The Pace of Reform - Many of us recognized the ambitious pace of reform early in the process. That intensity can overwhelm some of the smaller POS agencies which have a smaller number of staff and like all the agencies, many ongoing day-to-day obligations. As a result, it can be difficult for some POS agencies to make time available for CFT training and coaching.

Staff Turnover – Continuous staff turnover and competing personal obligations (such as annual and sick leave, other DCFS training obligations) are facts of life in child welfare and impact not only POS agencies, but master coach staff as well. When staff who are developed to train and coach leave the agency, change roles and or are unavailable when training opportunities are occurring, the capacity building process is slowed and technical assistance resources are underutilized.

Geography – In larger regions, Department coaches may experience time-consuming travel between their base and POS offices, lessening their time to receive coaching themselves. Immersion sites may also be distant from the base of some Department coaches in training and commuting lessens their availability for development on-site. Some DCFS coaches having a limited number of days on site also makes it difficult to schedule team meetings with families and to provide the needed coaching to POS and DCFS staff as CFTM facilitators.

Expectations – It would be unusual for expectations to have a high level of clarity at this early stage of immersion, but limited clarity does impede progress. There are instances of POS staff not viewing the importance of training or coaching with the priority needed to command their presence or preparation for training and coaching events. Competing priorities are a factor in

this challenge. The lack of clarity can be manifested in lack of participation, selection and preparation of families and scheduling.

Accountability – Many local staff are trying to respond to expectations, but some don't see the CFT implementation process as imperative or lasting, and as a result haven't fully committed to it. If their agency leadership doesn't hold them accountable for joining the CFT developmental process, it is not clear who else has authority to do so. The Immersion Site Directors are doing great work, but as we understand it, they don't have formal authority over the POS agencies in their region. If they don't, who does?

RECOMMENDATIONS

Expand the Immersion Site Size – In the smaller sites, especially those with multiple small POS agencies, add a county (or more) to permit training and coaching to be spread over a larger number of agencies. This would lessen the pressure on a smaller number of agencies, maximize the technical assistance resources and ultimately enlarge the footprint of immersion implementation.

Re-emphasize the Importance of Immersion – It has been quite some time since excitement of the initial Summit, which kicked-off the reform. The collaborative planning that occurred in local summits in early 2017 is more recent, but there haven't been frequent collaborative meetings to assess progress and problem solve. It will be helpful to re-convene immersion site stakeholders for a discussion of lessons learned and identification of strategies to make immersion successful. This would not only be an opportunity for re-engagement and expectation setting, it would also be a forum for identifying strategies for lessening some contract obligations to give agencies time to fully join the immersion process. We have all agreed that this should be explored, but decisions are still pending.

Expect Accountability – There has been a general acknowledgement that accountability for front-line POS performance is so diffuse that there is not a functional single point of accountability that can be reasonably expected to be effective. This is a long-standing and very complex challenge, but one that seems essential to change. We don't have a simple solution to suggest and believe that addressing this issue belongs at the highest levels of the organization. However, we recommend that we explore it collaboratively to try to identify ways to at least strengthen accountability.

Re-convene the Immersion Planning Team – Quickly re-convene the immersion planning team, consisting of DCFS leadership/managers, Immersion Site Directors, CWG leadership and the Experts to identify strategies to strengthen the immersion process.[4]

The CWG's observations and analyses are consistent with ours, which we have communicated to Department leadership for the past several months. Yet the Department did not act promptly after receiving CWG's recommendations, and it instead resisted the request to even reconvene the Immersion Planning Team.

As we noted in the Introduction to this report, we are very concerned that the Department's statements in our recent discussions and the content of its latest court report, demonstrate a lack of understanding of the scope and complexity of certain individual initiatives themselves, the challenges already encountered at the current phase of implementation, and that successful implementation of any one of the initiatives is inextricably linked to successful implementation of other initiatives. We concur with the recommendations included in the Child Welfare Group correspondence and urge the Department to carefully consider them and take steps to act on them unless there is overwhelming evidence to the

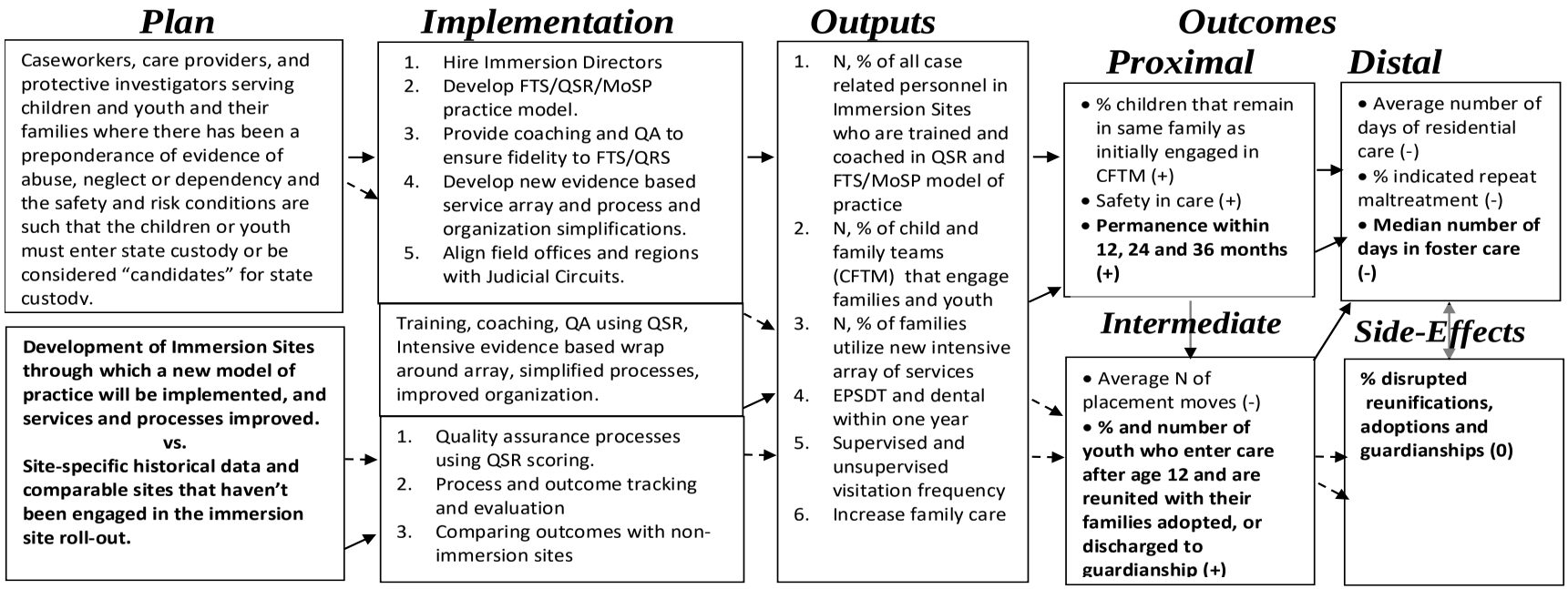
[4] Email from Paul Vincent, Director, The Child Welfare Policy and Practice Group, to Mary Nam, DCFS, and the Expert Panel, October 16, 2017

contrary. The Expert Panel is looking for evidence that the Department is still committed to the CWG model as originally designed and as it was accepted by the Department through the B.H. Implementation Plan.

We can appreciate the desire of the new DCFS leadership to accelerate the implementation of the immersion site process so a determination about sustainability can be made more quickly. As discussed by Torgerson, Torgerson, and Taylor (2015), administrators and policymakers, particularly politicians, are often anxious to implement an intervention as soon as possible. But this is a desire that must be held in check. The Department's initiatives are not tied to a particular Governor or a particular Director. What matters under the Implementation Plan is that an innovative practice must be implemented in a way that supports its chance for success rather than communicating to constituencies that new leadership is "getting down to business."

Staged implementation is often the more efficient and effective method of rollout than the so-called "big-bang" approach. For example, in a study of both approaches to the rollout of a novel method of offender supervision by probation officers, Pearson and colleagues (2010) found that broad-scale implementation was problematic because there are seldom sufficient resources to deliver adequate training to all places at the same time. Process measures indicated that the area that had adopted the staged-approach utilized services more effectively than the big-bang rollout. The Immersion Site directors and CWG do not want to give up on the process and are on board since they are truly gaining buy-in and seeing improvement. Adhering to the original timetable is critical to the collective efficacy of the process, particularly the CFT trainings, which are the core ingredient in the Immersion Site logic model. The Department has signaled an openness to reconsidering the accelerated timetable. In the interests of transparency, we have also pushed for greater specificity about the criteria the Department intends to use to evaluate this phase of the pilot and whether evaluation by the end of the year is at all feasible.

Immersion Site Logic Model



External Conditions

- IL DCFS has one of the longest lengths of stays in non-permanent care in the country. It has strong unions and provider networks. Most staff and providers are eager for better outcomes but some may resist.
- High turnover among POS case workers. Overreliance on residential care and a lack of an array of intensive in home services. Lack of focus on families and their strengths and little understanding of trauma and attachment.

Theory of Change

The QSR with FTS enhancements have proven to be effective in improving case work practice and outcomes in several states. Considerable evidence supports the effectiveness of intensive evidence-based or -supported wrap around family based services to resolve problems so that children and youth can live in families who are committed to them for life. Attachment and trauma theory has abundant evidence that the safety and security of a permanent home with consistent and committed adult parents or mentors improves self-regulation and executive function and the ability for children and youth to live in families. Case work is negatively impacted by a plethora of unnecessary procedures and by an overly complex and unaccountable organizational structure.

End-Values

- Reduced reliance on institutional care
- Increased resources available to further increase placement stability and permanency planning.
- Improved placement stability and family permanence and
- Improved family functioning

2. Enhancing the competency of the child welfare workforce: Residential Monitoring

Although DCFS has had an internal capacity to monitor residential facilities for a number of years, the July 2015 Report of the Expert Panel noted several concerns with that internal capacity to both monitor and evaluate programs and services for the youth in group homes and residential treatment centers. We noted that: (1) clinical expertise, especially related to the milieu management of youth with severe emotional and behavioral problems, is not a job requirement for residential monitors, (2) residential monitors are unable to identify poorly functioning programs, (3) residential monitors lack viable problem-resolution strategies, (4) a dearth of high-end treatment options led DCFS to continue to use inadequate treatment programs that are unable to maintain the safety and well-being of youth in its care. Thus, the Expert Panel, along with the plaintiffs, recommended that DCFS enlist the assistance and guidance of external monitors and engage some of its university partners to develop a results-oriented accountability residential monitoring system. DCFS' response to these concerns was a proposal to restructure and re-envision its monitoring capacity through several university partnerships and in accordance with implementation science.[5] DCFS partnered with Northwestern University (NW) and the University of Illinois at Chicago (UIC) to develop an improved monitoring system pilot – the Therapeutic Residential Performance Management Initiative (TRPMI). Chapin Hall was selected as the evaluator for the initiative.

In the June 2016 Supplemental Submission to the DCFS Implementation Plan, the Department acknowledged that its existing monitoring division has focused on facilities and programs. As the Expert Panel underscored, and the Department recognized, it is important to make a clinical assessment of all individual children and youth in residential programs—not simply monitor programs and facilities. Although enhanced, the redesigned monitoring system comprised of 3 pilot monitoring teams (comprised of clinical, monitoring, and quality improvement staff that are a mix of staff internal to DCFS and external with the partner universities) was similar to the primary goals of the previous monitoring

[5] B.H. v Sheldon 88 C 5599 Defendant's Submission Supplement to DCFS Implementation Plan

program.[6] The Department continued to fulfill its residential monitoring responsibilities and activities through its existing monitoring program for those residential programs not included in the TRPMI pilot.

Notably, the Department anticipates, and the Implementation Plan contemplates, that in the long-term, all caseworkers and supervisors will be trained and coached in the components of the Department's Core Practice Model to evaluate youth through a clinical lens and develop strength-based, family-focused service and permanency plans. Thus, in January 2017, the parties and the Expert Panel agreed that the primary focus of the redesigned pilots would be to monitor youth and their progress from a clinical perspective *in addition to* the regulatory monitoring to ensure program compliance.

As noted in the current and previous Triannual B.H. Reports, there have been a variety of implementation challenges for the TRPMI pilots that continue to adversely impact the pilots – filling staff positions for the pilot teams (DCFS and university partners); delays "matching" youth who are ready to leave residential programs with appropriate family-based homes (foster care, specialized foster care, therapeutic foster care) through the centralized matching process; the lack of access to and availability of needed treatment interventions and supports for youth upon return to their communities; and ongoing performance, quality and operational issues in the residential programs themselves that impact every level of the overall service system.[7] Beginning in the early months of the TRPMI pilot implementation, TRPMI staff from the external university partners informed the Department in weekly and monthly reports and meetings of the substantial challenges they were encountering when identifying youths' needs for less restrictive services, supports and living arrangements in their home communities. Many of these challenges were not unexpected and/or have existed for many years. Even with pilot TRPMI teams that are more staff and expertise-rich than the Department's existing monitoring program, once the TRPMI pilot design added the function of monitoring individual youth and their clinical progress to the pilot team's existing regulatory monitoring, the pilot teams have struggled to meet the current objectives of the

[6] Second Triannual Interim Report to the Court filed June 9 2017, Attachment S., Page ID#:2314

[7] Lessons Learned: Critical Issues Related to Residential Treatment Services in Illinois, Alan Morris, PsyD, UIC, Department of Psychiatry, Email to Mary Nam, October 13, 2017, Exhibit 1.

TRPMI pilot design.

The lack of access to and existence of needed community-based behavioral health services and family-based living settings, especially specialized and therapeutic foster care, contribute to longer stays in residential programs than are appropriate. The TRPMI pilot teams have identified a large number of youth currently placed in their assigned residential programs whose needs can be met in community and family-like settings and have identified the specific service, policy and practice barriers preventing each youth's move from the more restrictive residential program. The Department has not developed a cohesive plan to address the service gaps for youth with complex behavioral health needs.

The B.H. Implementation Plan contemplates that adjustments and changes to the plan's objectives and activities will be needed. It is important to apply a thoughtful and rigorous process when considering possible changes to the plan. Department leadership has told us that its primary goal regarding the TRPMI pilot is to "bring the work back inside the Department" as soon as possible. Rather than focusing on the recommendations that have been offered to improve and stabilize the TRPMI initiative itself, the Department has asked for assistance in crafting proposed criteria for an effective residential monitoring system, a description of the required elements, staff functions, competencies, and timeframes to demonstrate that the Department has the necessary internal capacity to effectively monitor, evaluate and promote therapeutic residential program effectiveness. But the work required to consider changes to this or other initiatives in the Implementation Plan, both internally by the Department and then collectively with the plaintiffs and Expert Panel, has not yet occurred. It is premature to consider a timeframe for changing the Plan until everyone (and the Court) is in agreement about the reasons for proposed changes and the necessary alternatives to be put in place to achieve the agreed-upon objectives of the Implementation Plan and requirements of the Consent Decree.

3. Enhancing the competency of the child welfare workforce: Care Management Entity

From the Department's earlier reports, the goals for the Care Management Entity (CME) pilot include: increasing non-traditional, community-based behavioral health supports; faster step-downs for

youth in congregate care settings; treating youth and family voice and choice as primary factors in permanency planning and mental health/behavioral health interventions; placement of youth in specialized foster care or congregate care settings rather than residential treatment facilities; increased placement stability at the foster care level; high service-intensity youth receiving necessary behavioral health supports and services in their home and community settings; decreased psychiatric hospitalization; and increased permanence. The CME pilot, which is administered though Choices, began in February 2014 and is now scheduled to continue through June 30, 2018. The Department's Triannual Status Reports contain additional details about the CME pilot and the extent to which it has met and is meeting target outputs and outcomes.

It is anticipated that the Illinois Department of Healthcare and Family Services (IDHFS) will implement a Medicaid managed care program through a Managed Care Organization (MCO) contract with IlliniCare Health Plan for the children in DCFS' care beginning in FY 2019. There are several lessons learned from the CME pilot that warrant further examination and should inform decisions about the design and operation of the Medicaid-funded behavioral health service system for youth in DCFS care:

- Several of the services included in the CME pilot have had positive impacts and should be included in the MCO benefit package for DCFS youth, e.g., mobile crisis response, therapeutic mentoring, home-based support, case/care management.
- For youth in DCFS care, their behavioral health needs make up a *portion* of their overall needs for safety, permanence and wellbeing. Plans and services to address a youth's behavioral health needs must be integrated and coordinated with the youth's overall plan developed by the DCFS child and family team. The CME pilot has included a "care manager" role to lead the team and coordinate the provision of services to address the youth's behavioral health needs. The role of the CME care manager and how it fits with the role of the DCFS/POS permanency worker has proved to be challenging during the CME pilot's duration and has led to both confusion and conflict about who is ultimately responsible for

ensuring that all of the child's needs are met through the Child and Family Team. That responsibility falls to the permanency worker/case manager as the Child and Family Team facilitator.

- The planned IDHFS MCO model contract includes a "care coordinator" role responsible for leading a multi-disciplinary team to plan and coordinate the delivery of Medicaid-funded behavioral health services. As described, this "care coordinator" role is comparable to the care manager role in the CME pilot yet the proposed MCO "care coordinator" does not have responsibility for the child's overall plan and services. That responsibility is assigned to the DCFS/POS permanency worker as the leader of the youth's Child and Family Team.
- In both the CME pilot and Regenerations, youth have received certain individualized community-based services (e.g., therapeutic mentoring, mobile crisis, case management/care coordination, home-based support) which should be incorporated into the MCO's Medicaid-funded behavioral health service system. However, the Department does not have child-specific or aggregate information readily available about the amount, frequency, duration, and per unit cost of each service provided to youth in care. Such information would assist both DCFS and IDHFS in determining the type and amounts of these community-based behavioral health services that should be routinely available for youth in DCFS care.

The implementation of the Behavioral Health Managed Care MCO contract for DCFS youth is planned for FY19, a target date that is fast approaching. Significant planning and agreements between the IDHFS and DCFS are essential if the MCO contract is to be implemented successfully. While the contract is ultimately the responsibility of IDHFS to negotiate and execute with its selected provider, DCFS is not and cannot be a passive participant in this process. Accessing more Medicaid-funded behavioral health services enables DCFS to use its child welfare resources to develop and fund other much-needed services and supports that fall outside the behavioral health service system, but are nevertheless essential for the safety, permanence and well-being of class members. We have asked to meet with the responsible individuals from or representing IDHFS, DCFS and with plaintiffs' counsel to better understand the plans

for defining and implementing the needed array of Medicaid-funded behavioral health services for DCFS youth through the MCO contract. We have asked to be included and expect to remain involved in the efforts undertaken by both departments to address the behavioral health needs of DCFS youth.

C. Learning whether children are better off because of DCFS involvement:

1. Overarching Outcomes

The Expert Panel agrees with the simple maxim: "If it ain't broke, don't try to fix it." When we signed off on the B.H. Implementation Plan, we agreed to a set of overarching outcome measures, which are substantially the same as the safety and permanency outcome measures that are currently utilized in the federal Child and Family Service Review (CFSR) process. Based on these standards, there is much about the Department's performance that is commendable, but other areas that require fixing.

- Rates of maltreatment in foster care are below the national standard of 8.5 victimizations per day of foster care for all areas during the latest reporting period from August 1, 2016 thru July 31, 2017.

Maltreatment in Care Per 100K Days			
	Cohort		
Area	8/1/14-7/31/15	8/1/15-7/31/16	8/1/16-7/31/17
Immersion Sites	6.20	8.51	4.44
East St. Louis	3.37	7.41	3.55
Lake	2.45	3.10	2.50
Mt. Vernon	9.05	15.43	4.88
Rock Island	9.79	9.32	6.83
Balance of State	5.35	5.17	5.04
Cook County	4.58	3.75	5.31
Total State	**5.67**	**5.30**	**5.07**

- Rates of placement moves per day of foster care are below the national standard of 4.2 per 1000 days in care for all areas from August 1, 2016 thru July 31, 2017.

Average Moves/1000 Days in Care			
	Cohort		
Area	8/1/14-7/31/15	8/1/15-7/31/16	8/1/16-7/31/17
Immersion Sites	3.98	2.82	2.78
East St. Louis	5.98	3.22	3.16
Lake	3.91	2.90	3.05
Mt. Vernon	4.76	2.18	3.05
Rock Island	2.38	3.01	1.93
Balance of State	3.42	2.71	2.85
Cook County	4.51	3.56	3.16
Total State	**3.80**	**2.95**	**2.93**

- Re-entry of children who have been discharged to parents, relatives, or legal guardians and enter foster care within 12 months from discharge is below the national standard of 8.3 per 100 discharges for the state as a whole during the latest reporting period from August 1, 2016 thru July 31, 2017. The Lake Immersion Site and Cook County are the exceptions.

Percent Re-entering foster care per 100 discharges			
	Cohort		
Area	8/1/14-7/31/15	8/1/15-7/31/16	8/1/16-7/31/17
Immersion Sites	5.2	3.5	3.7
East St. Louis	7.1	18.8	0.0
Lake	0.0	0.0	15.0
Mt. Vernon	0.0	0.0	0.0
Rock Island	25.0	0.0	0.0
Balance of State	7.0	6.5	6.1
Cook County	23.8	11.8	9.0
Total State	**9.6**	**6.9**	**6.1**

- Permanency within 12 months from entry in foster care is well above the national standard of 40.5% for the state as a whole during the latest reporting period from August 1, 2016 thru July 31, 2017. The sole exception is the Lake Immersion Site.

Percent discharged to permanence within 12 months of entering foster care			
	Cohort		
Area	**8/1/14-7/31/15**	**8/1/15-7/31/16**	**8/1/16-7/31/17**
Immersion Sites	32.2%	24.3%	33.0%
East St. Louis	39.0%	18.3%	19.5%
Lake	30.0%	14.9%	40.5%
Mt. Vernon	37.0%	29.6%	38.1%
Rock Island	24.7%	32.7%	31.9%
Balance of State	30.6%	27.5%	30.9%
Cook County	14.1%	14.3%	15.5%
Total State	**25.6%**	**22.9%**	**26.0%**

Maltreatment in foster care, placement moves per day, and re-entry into foster care within 12 months of discharge are each below the national standard. The only outcome measure that raises serious reason for concern, as inferred from the above data on median lengths of stay, is the low percentage of children who are discharged to permanent homes within 12 months of entry into foster care. It is sometimes suggested that Illinois's low rate of re-entry is a by-product of its low rate of permanence within 12 months of removal. But a quick comparison among geographical areas with higher rates of reunification the year prior to the re-entry calculation indicates that the correlation is far from unity. Cook County registered the lowest permanency rate at 14.3% in 2016 but a re-entry rate of 9.0, which is higher than the national standard. It will be important to learn from next year's data whether Lake's permanency rate of 40.5% in 2017 is followed by a high percentage who re-enter foster care. The lessons from the IB3

demonstration are that trauma-informed, evidence-supported parenting training programs can expedite reunification with birth parents. Serious attention should be given to offering these services to parents shortly after children's removal so that the family can be reunited sooner than the three years it currently takes in Cook County for one-fourth of infants and toddlers to be reunified with their families.

The IB3 program focuses on expediting the discharge of infants and toddlers to permanent homes. Most of the other B.H. initiatives focus on stepping adolescents down to less restrictive placements in preparation for finding them permanent homes and preventing them from aging out without a permanent connection to family or a responsible adult. These other initiatives include: therapeutic foster care, Regenerations for dually involved youth, Pay For Success for dually involved youth, and services for youth in hospitals beyond medical necessity.

2. Learning whether children are better off because of DCFS involvement: Therapeutic Foster Care

We have already commented on the success of the IB3 demonstration in expediting the discharge of infants and toddlers to nuclear and extended family settings. We have noted the importance of rigorous evaluation and the challenges with SFC implementation in Cook County. Adherence to the basic principles of implementation science distinguishes the successes of IB3 and SFC in downstate counties from other initiatives that continue to struggle.

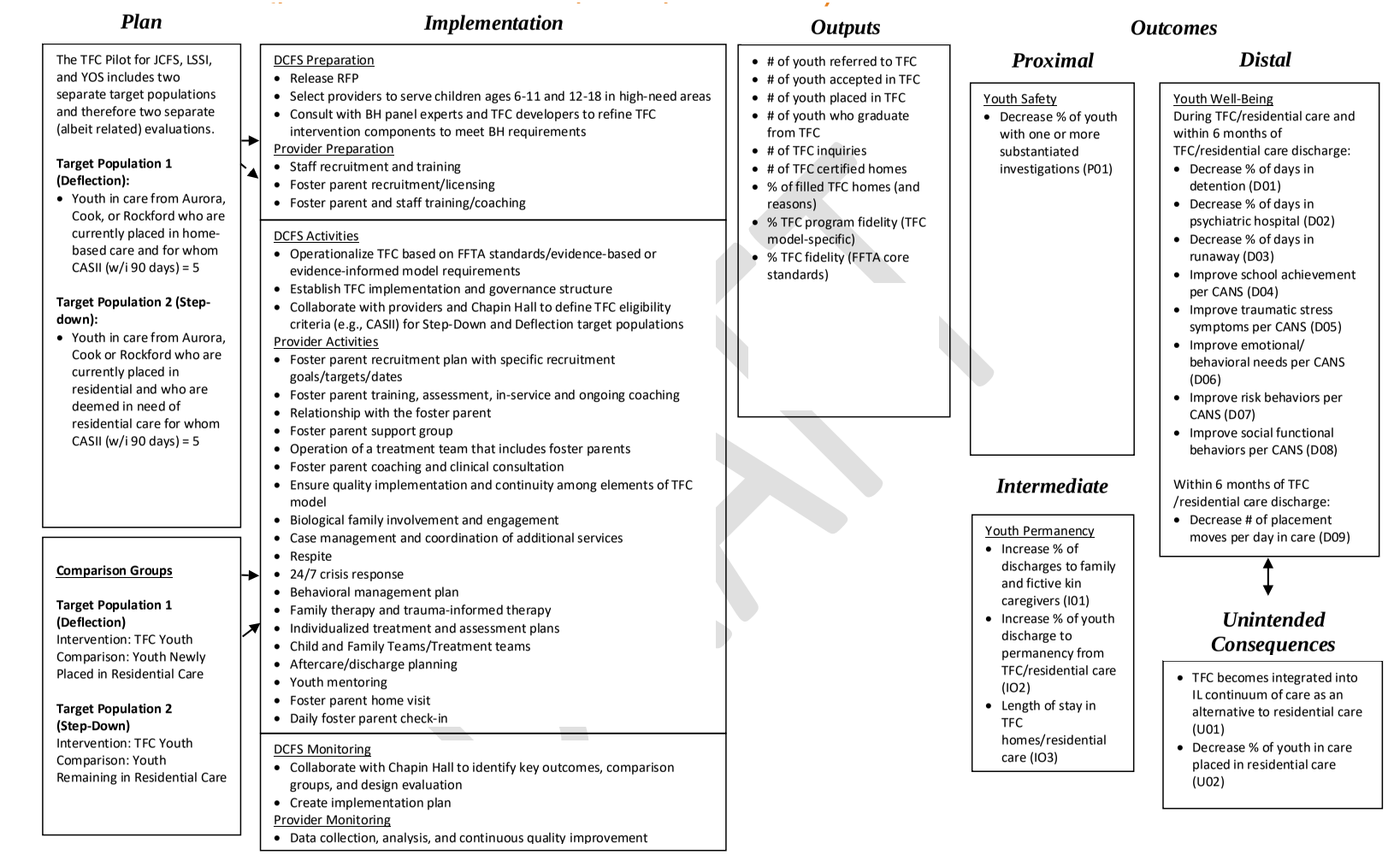
Implementation science equates programmatic success with a combination of three factors. These include: 1) selection of an intervention with the best available evidence of past success; 2) implementation of the intervention with integrity and fidelity to the previously tested design; and 3) co-creation of a supportive enabling context that promotes teamwork, shared access to data systems, and continuous quality review of programmatic outputs and client outcomes. Most of the B.H. initiatives satisfy the first criterion but fall short on the other two. The weakest of initiatives fall short on all three criteria.

One of the weakest initiatives, which pre-existed but later became incorporated into the B.H. Implementation plan is the Therapeutic Foster Care (TFC) Pilot. The initiative called for the recruitment and training of foster parents by three (3) providers to provide treatment foster care to children and youth who require the same intensity of treatment as residential care. After many false starts, the initiative settled on a moderate target of serving 40 children and youth in licensed TFC homes by April 1, 2018.

One of the reasons for the poor showing is the failure to take into account the best available evidence on the most effective methods for recruiting families who are willing and able to care for the most challenging children. As early as 2002, the Office of Inspector General, U.S. Department of Health and Human Services (USDHHS) issued a set of evidence-based recommendations for foster-parent recruitment. The key finding from the research was that most agencies use ineffective recruiting methods that cast a wide net through public service announcements but fail to engage families who are willing to care for older children with special needs. The report went on to say that states were underutilizing their most effective recruitment tool – foster parent networks: “Foster parents are effective recruiters because they share information about the need for foster parents through word-of-mouth contact and can promote the idea of fostering just by their presence in the community.” (USDHHS, 2002: p. ii.).

The latest 4-month status report submitted by the Department outlines a marketing strategy that includes a brief “one pager” placed on the internet system/D-Net used by DCFS and providers. If there is a marketing strategy that relies heavily on foster parent networks, it is not apparent from any of the TFC reports or logic models submitted by the Department (see below). The reason we draw attention to this deficiency is not to indulge in “Monday-night quarter-backing,” but to re-emphasize that there is a science of implementation that can guard against such missteps.

I. DCFS TFC Pilot Logic Model: Deflection and Step-Down (DRAFT 8-25-17)



3. Learning whether children are better off because of DCFS involvement: Regenerations

Another initiative that preceded the appointment of the Expert Panel but later was incorporated into the B.H. Implementation Plan is Regenerations for dually involved youth. The goal is to reduce the number of youth in care who are detained at the Cook County Juvenile Temporary Detention Center (JTDC), particularly those who are detained beyond their scheduled release date (RUR). The Regenerations project director participated in the Expert Panel's coaching sessions. The four-month status report is an excellent example of results-oriented management and accountability. The rigorous evaluation that Chapin Hall designed for the project is an exemplary illustration of the experimentalist approach and a model of what Sabel and Simon (2004) mean by transparency.

As noted in the logic model below, the proximal outcome for judging success is the reduction in the average number of days youth spend in Cook County Juvenile Temporary Detention Center (JTDC). The comparison group consists of a matched sample of youth with similar characteristics to the intervention group formed by propensity score matching on prognostic factors. To qualify for matching, the youth had to appear on RUR lists sometime from FY2013 to FY2015 (i.e., before any Regenerations pilot activities began).

As reported in the four-month status report, the Regenerations pilot served 70 youth in FY2017. Of these, 69 youth had known dates of RUR and the date of JTDC release. The average duration from the date of RUR and JDTC release was 39.0 days and a median of 28 days. This compares with an average of 19.9 days and a median of 6 days for the historical comparison group of 141 youth.

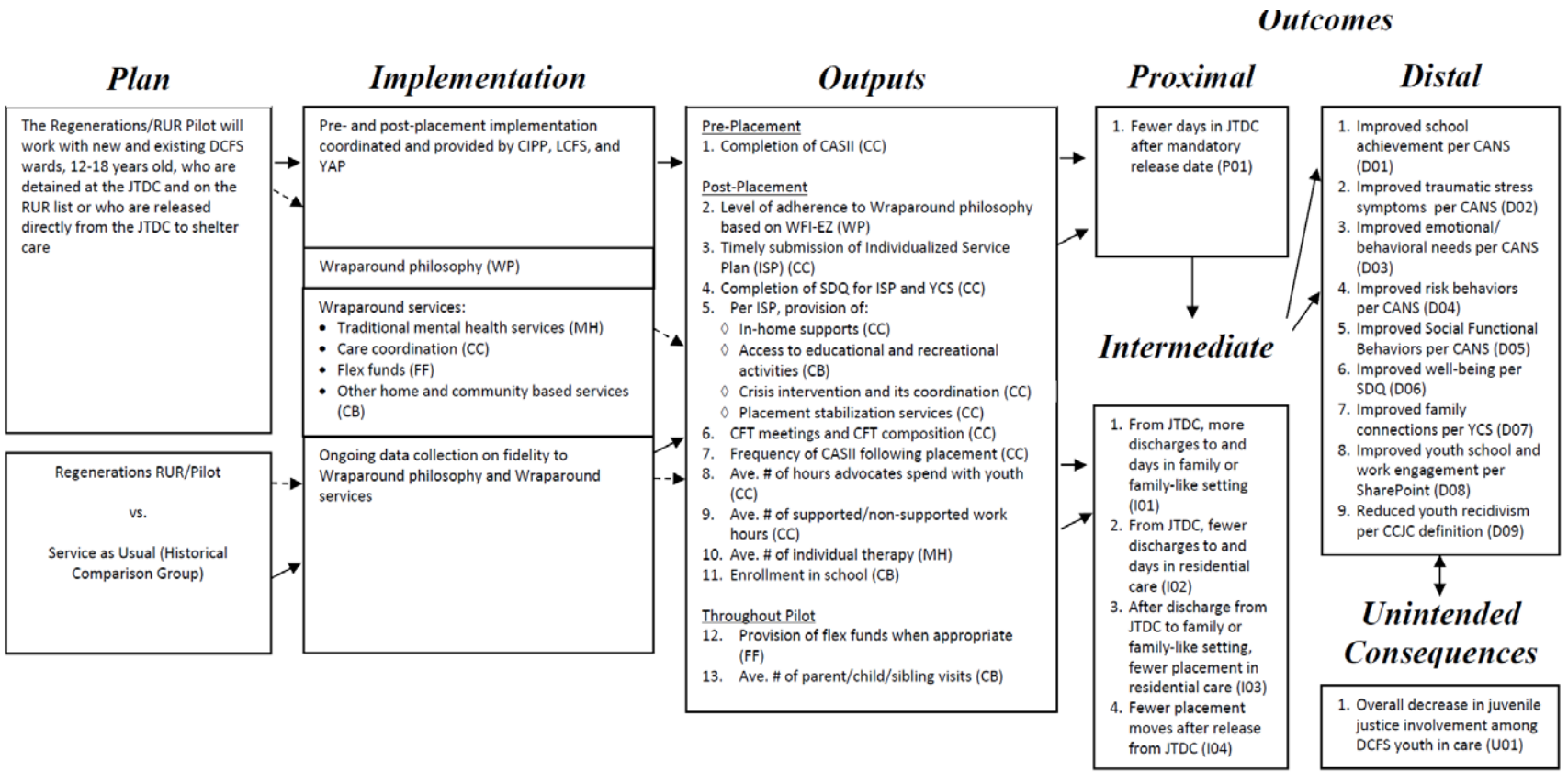
The lengthier duration in detention experienced by the intervention youth after their scheduled release date compared to the historical comparison group should be viewed within the context of where these youth went. Of the 70 youth served by Regenerations in FY2017, 45 youth (64.3%) had matching family or family-like placement records in SharePoint and DCFS CYCIS data. Of the 141 youth in the historical comparison group, only 40 youth (28.4%) were released to family or family-like settings. The

much larger proportion of Regenerations' youth who moved to less-restrictive, family-like settings overshadows their 3-week longer length of stay in detention compared to the historical comparison group. Of course, the stability of these less restrictive placements is also of some consequence. For the larger proportion of intervention youth discharged to family settings, only 3 youth (6.7%) were stepped-up to residential care after their placement in a family compared to 12 youth (30.0%) in the comparison group.

The Expert Panel concurs with the assessment of the four-month status report that the Regenerations team has done an outstanding job in improving its reporting of logic model metrics from 3 in the previous four-month status report to 12 output metrics and 6 outcome metrics in the latest four-month status report. The Panel is satisfied with the outcomes of the pilot and recommends that future monthly and four-month status reports contain only the Output and Outcomes sections of the template unless there is an indication from the output and outcome data that the previously achieved results are slipping.

The Regenerations model has the potential to serve more dually involved youth in care in Cook County and in other areas of the state if the Department defines and describes specifically the goals, interventions and methods that comprise the individual mentoring service that is a core component of the Regenerations model. In addition, the Department needs the capacity to collect and analyze the amount, frequency, duration and per unit cost of each discrete service provided on a child-specific basis.

DCFS Regenerations RUR/Pilot Logic Model 8-18-2017



Background

- Societal (e.g., poverty, racism)
- Family (e.g., lack of resources, lack of involvement)
- Child (e.g., mental illness, school problems)

Theory of Change

Youth in JTDC are at-risk for being detained beyond their release date, discharged to residential care when residential care is not necessary, and staying in residential care longer than necessary. In the context of a Wraparound philosophy and the CMCS and SAMHSA (2013) informational bulletin, federal projects have demonstrated that in addition to traditional mental health services, youth outcomes are improved by also providing 1) Intensive care coordination (often called Wraparound service planning/facilitation), 2) Family and youth peer support services, 3) Intensive in-home services, 4) Respite care, 5) Mobile crisis response and stabilization, 6) Flex funds, and 7) Other home and community based services.

End-Values

The goal of the regenerations pilot/theory of change will be to improve conditions for youth in terms of well-being, school and work engagement, and increase the likelihood that they will remain in stable family-like settings and not return to the juvenile justice system.

In conclusion, we have discussed our concerns and the bases for our recommendations with the parties; therefore, we are hopeful that the parties agree with the recommendations and that together we can agree on the actions needed going forward and the timeframes to address them. We appreciate the Court's continued commitment to ensure that members of the B.H. class receive the services that address their underlying needs and achieve the levels of safety, permanence and wellbeing the B.H. Consent Decree entitles them.

Sincerely,

Marci White, MSW

Marci White

Mark F. Testa

Mark Testa
Spears-Turner Distinguished Professor

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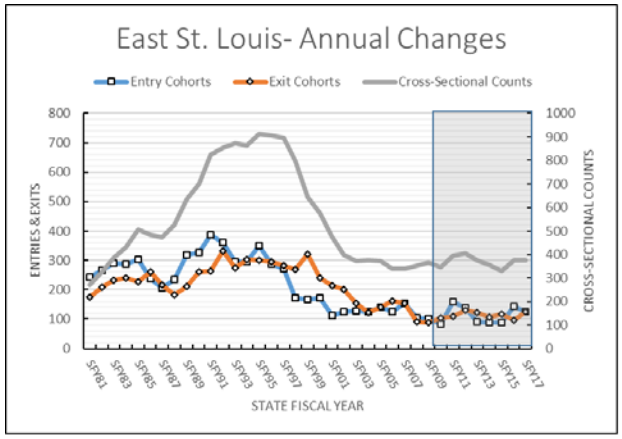
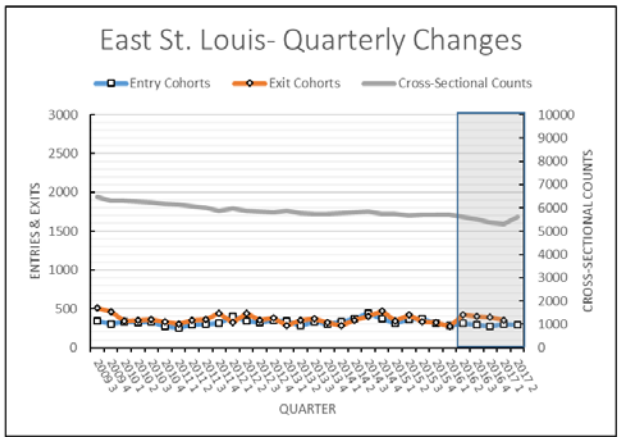
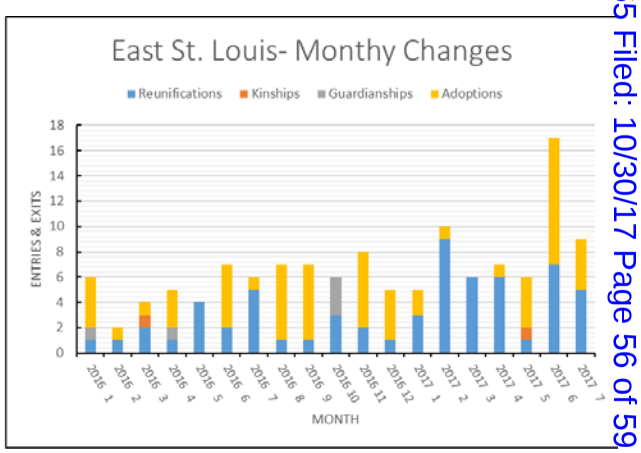
APPENDIX

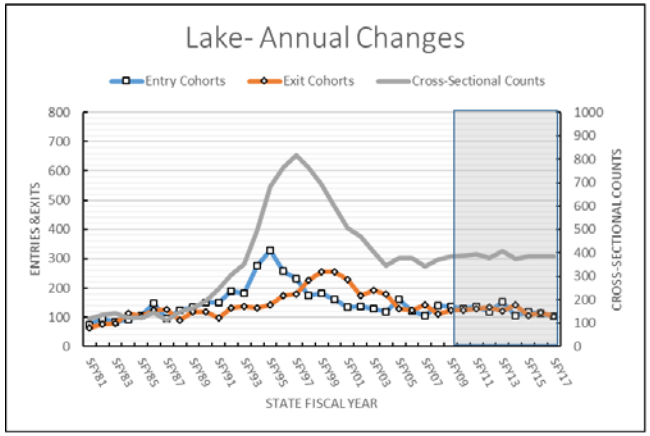
The charts aand tables below illustrate the caseflow dynamics that underlie historcial changes in the size of the B.H. plaintiff class in the Immersion Sites, Cook County, and the balance of state since 1981. The first chart provides a broad overview of annual changes. The shaded area is broken out by quarters in the next chart, which illustrates the stasis of the system since the start of FY2010. The last chart classifies permanency counts by type of legal permanence starting with the January prior to the joint submission of the B.H. Implementation Plan to the Court on February 23, 2016. The tables compared the percetage change in the volume of each tyoe of permanence for the lastest reporting period from January 1, 2017 to July 31, 2017 compared to the prior year for the same time period.

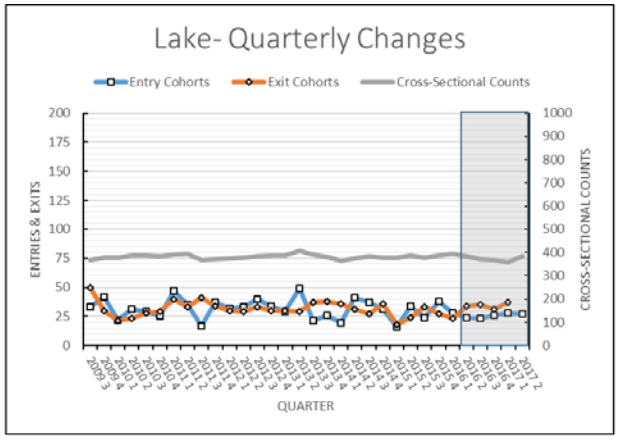


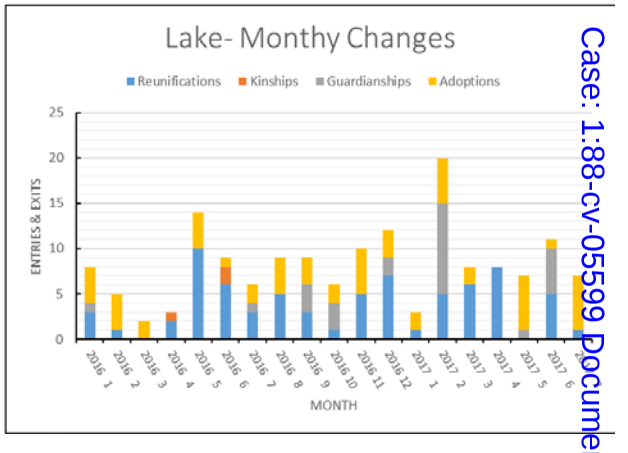




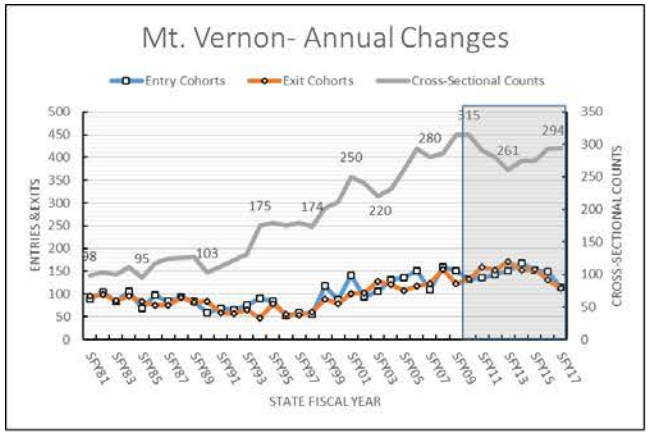
PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	15	46.7%	1	0.0%	2	-100.0%	16	131.3%	34	76.5%
Jan-Jul 2017	22		1		0		37		60	

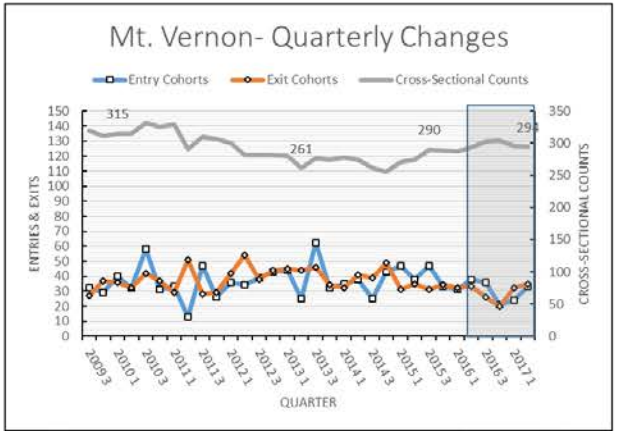


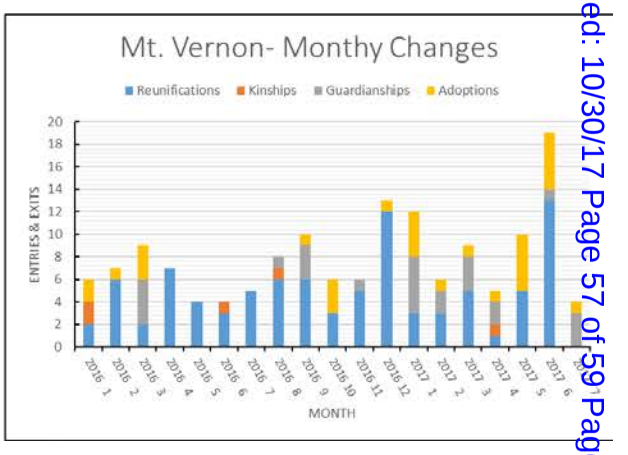




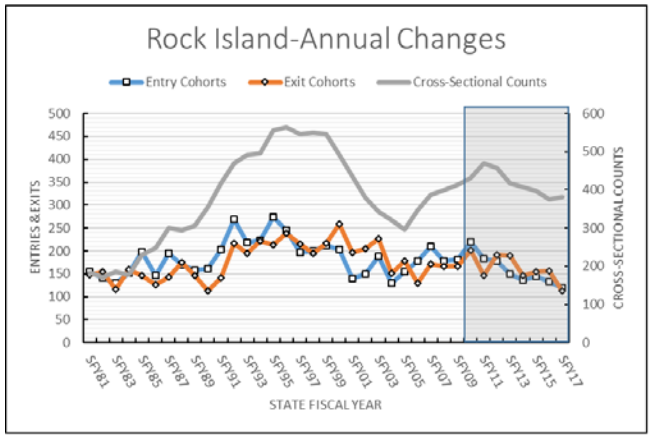
PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	6	200.0%	3	-66.7%	4	300.0%	29	3.4%	42	54.8%
Jan-Jul 2017	18		1		16		30		65	

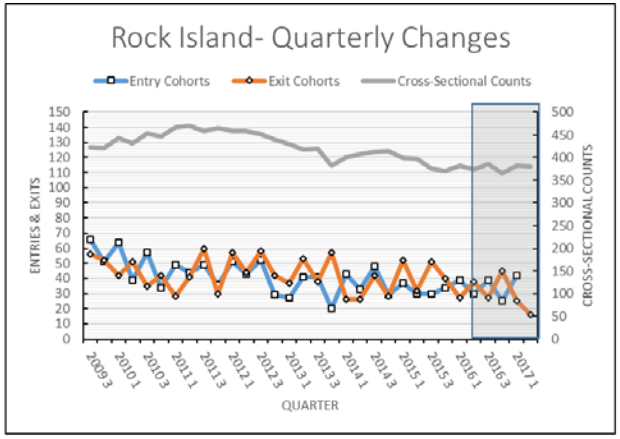


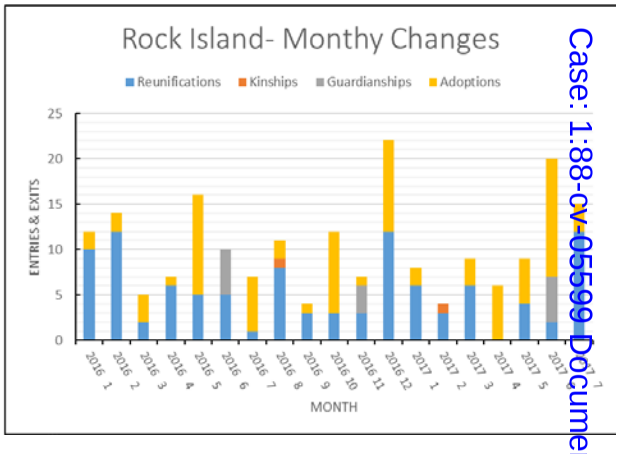




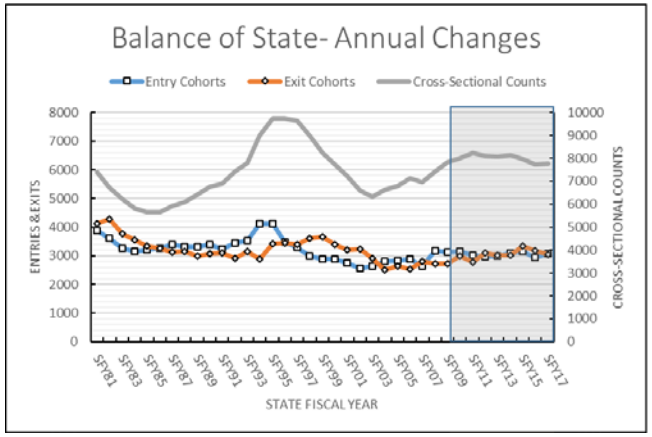
PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	15	46.7%	1	0.0%	2	-100.0%	16	131.3%	34	76.5%
Jan-Jul 2017	22		1		0		37		60	

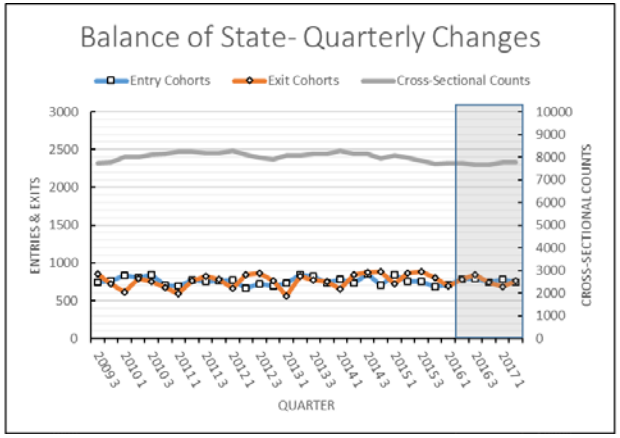


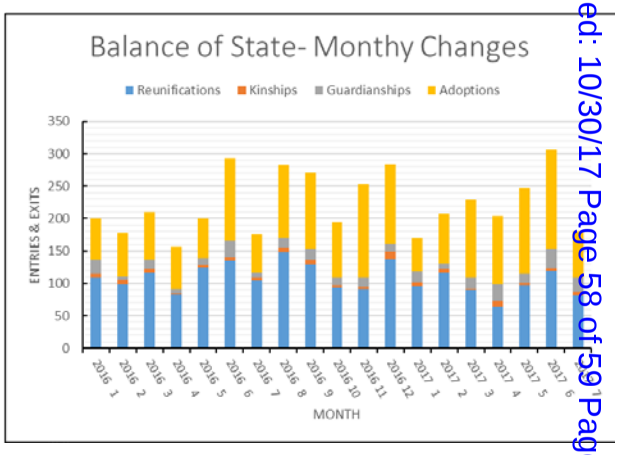




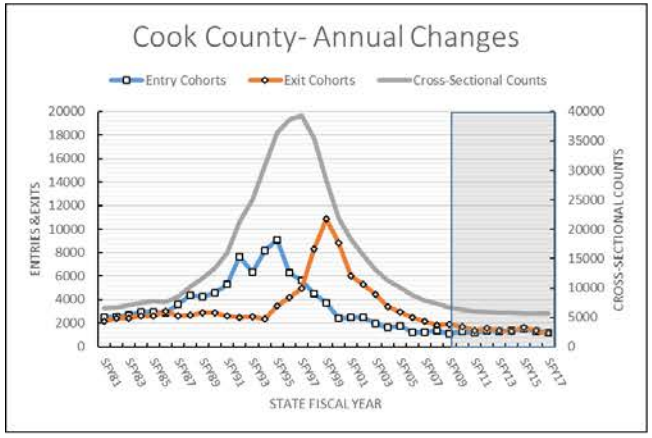
PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	25	28.0%	0	NA	5	0.0%	41	-19.5%	71	0.0%
Jan-Jul 2017	32		1		5		33		71	

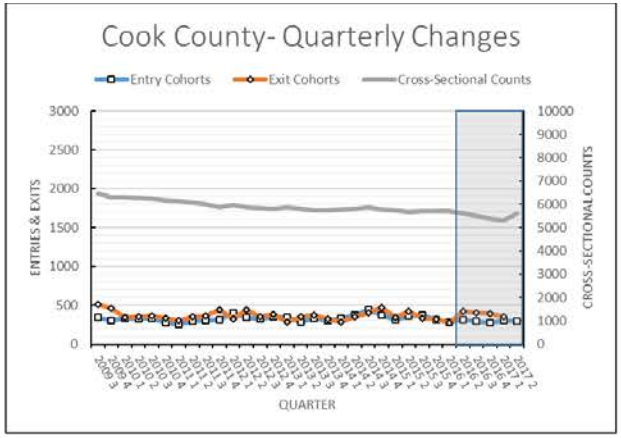


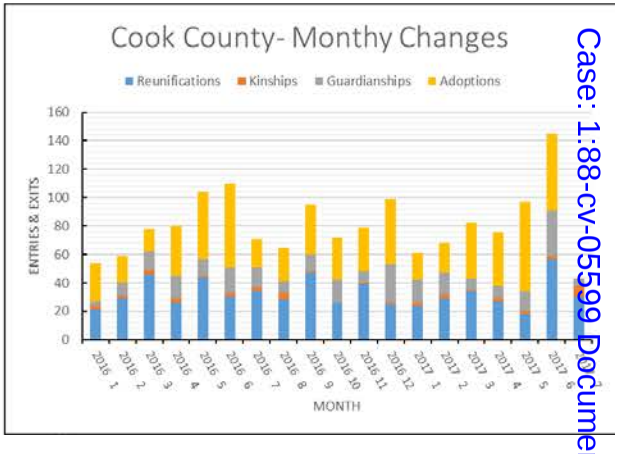




PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	518	37.1%	32	0.0%	91	49.5%	773	-13.7%	1414	9.3%
Jan-Jul 2017	710		32		136		667		1545	







PERIOD	ADOPTION		KINSHIP		GUARDIANSHIP		REUNIFICATION		ALL PERMANENCIES	
Jan-Jul 2016	223	20.2%	18	11.1%	85	16.5%	230	-4.8%	556	9.0%
Jan-Jul 2017	268		20		99		219		606	