



Department of Health and Human Services

Administration For Children and Families

Region V

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Bryan Samuels, Director
Illinois Department of Children
and Family Services
406 East Monroe Street, Station 70
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Dear Director Samuels:

This letter is in reference to the Program Improvement Plan (PIP), which was required due to the findings of the Illinois Child and Family Services Review (CFSR) conducted during September 15-19, 2003. The final CFSR report was issued on February 12, 2004, and the initial version of the PIP was timely submitted on April 27, 2004. After negotiations between our respective agencies, the final version of the PIP was submitted on November 30, 2004. We are pleased to inform you of the approval of the PIP.

We appreciate the time and efforts of the Illinois Department of Children and Family Services (DCFS) and the many stakeholders who were involved in the development of the PIP. We especially acknowledge Tom Berkshire and Erwin McEwen for their leadership in the PIP development process.

The Illinois PIP is a solid document that succinctly addresses items identified in the final report as needing improvement while simultaneously reflecting good child welfare practice. Several cross cutting strategies, i.e., intake process revisions, integrated assessment program, child and family meetings, foster care contract restructuring, stabilization strategies, system of care, family-centered services initiative, child and youth investment teams, and more will provide a foundation for improving performance and impacting multiple areas related to safety, permanency and well-being. Further, the PIP includes action steps that exceed mere compliance and truly focus on best practice and the best interest of youth. One example is the diligent search for parents and relatives of youth transitioning from the foster care system.

As the role of the judicial branch is critical in ensuring the achievement of the desired outcomes, we are hopeful that DCFS will continue to work closely with the Administrative Office of the Illinois Courts, as the State Court Improvement Program grantee, in implementing the PIP.

As our office stated in the final report letter, the penalty applicable to the level of non-conformity found in the CFSR will be suspended during the time period of the approved PIP. The PIP is effective the date of this letter and the first quarter will begin on this date. Please note, Section 1355.35(d)(4) of Title 45 of the Code of Federal Regulations (CFR) requires quarterly status reports be submitted describing the progress in implementing the PIP. As such, quarterly progress reports will be due one month after the end of each quarter (e.g. for a quarter ending March 6, 2005, the report would be due on April 6, 2005). Please submit supporting documentation with each progress report on PIP benchmarks and achievement dates. In addition, please provide an explanation and alternative achievement plan(s) if documentation, benchmarks, or accomplishment dates have not occurred. Lastly, please note that 45 CFR 1355.35(f) requires the elements of the PIP be incorporated into the goals and objectives of the State's Child and Family Services Plan (CFSP) and progress in implementing the PIP to be included in the CFSP Annual Progress and Services Report.

Enclosed is a copy of the approved PIP. If there are any questions, please have one of your staff contact either Ron Stevens at (312) 886-5036 or Constance Miller at (312) 886-4922.

Sincerely,

Joyce A. Thomas
Regional Administrator

Enclosure

Cc: Joan Ohl, Commissioner, Administration on Children, Youth and Families
Susan Orr, Associate Commissioner, Children's Bureau

STATE OF ILLINOIS



Department of Children and Family Services



Child and Family Services Review

PROGRAM IMPROVEMENT PLAN

November 30, 2004 final e-mail to ACF

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Illinois PIP General Information/Contact Form	
ACF Region: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input checked="" type="checkbox"/> VI <input type="checkbox"/> VII <input type="checkbox"/> VIII <input type="checkbox"/> IX <input type="checkbox"/> X <input type="checkbox"/>	
State: Illinois	
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State PIP Steering Committee Members * (name, title, organization)	
Erwin McEwen, Deputy Director of Monitoring and Quality Assurance, DCFS	
Tom Berkshire, Chief of Staff, DCFS	
Michael Holmes, Associate Deputy Director of Quality Assurance	
Yolanda Green, Director, Foster Care Utilization Review Program, University of Illinois	
Joan Nelson Phillips, Cook County Quality Assurance Manager, DCFS	
Cynthia Moreno, Deputy Director of Service Intervention, DCFS	
Mary Debose, VP of Public Policy and Advocacy, Children's Home and Aid Society	
Ray Knight, Deputy Director of Planning and Performance Management	
D. D. Fischer, Child Care Association of Illinois	
Addie Hudson, Associate Deputy Director of External Affairs, DCFS	
Jim Jones, CEO, ChildServ	
Mary Sue Morsch, Deputy Director for Placement and Permanency, DCFS	
Arthur Bishop, Deputy Director for Field Operations, DCFS	
Jean Ortega Piron, Deputy Director, Guardian and Advocacy, DCFS	
Amie Majernik, Director, Children's Home Association of Illinois Peoria	
Christy Levine, Foster Care Utilization Review Program, University of Illinois	
Velma Williams, Deputy Director, Clinical Practice and Professional Development, DCFS	

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Terry Solomon, Executive Director, African American Family Commission
Gailyn Thomas, Deputy Director, Child Protection, DCFS
Matt Hunicutt, Program Director, Child Protection, Catholic Charities
Gene Griffin, Management Team Coordinator, DCFS
Marge Berglind, President and CEO, Child Care Association of Illinois
Debra Dyer-Walker, Chief Deputy General Counsel, DCFS
Judge Patricia Martin Bishop, Presiding Judge, Juvenile Court of Cook County
John Schnier, Executive Director, Children's Division, LSSI
Mark Testa, Director, Children and Family Research Center
Mike Tardy, Administrative Office of the Illinois Courts
Denise Duval, Foster Care Utilization Review Program, University of Illinois
Robert Bloom, Jewish Children's Bureau
* Please see Appendix A for complete listing of all PIP Workgroup members

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

INTRODUCTION

The Illinois Program Improvement Plan was developed in response to findings from the Child and Family Services Review (CFSR) that was administered by the Children's Bureau (CB) and the Administration for Children and Families (ACF) in September 2003. The CFSR is a comprehensive federal review process that evaluates the effectiveness of each state's child welfare system. At the time of its on-site review, Illinois was the 45th state to undergo this comprehensive review process and the 45th state later found not to be in substantial conformity with all seven outcomes and seven systemic factors measured.

Illinois approached the development of its Program Improvement Plan (PIP) in much the same way as it had in preparing the state for the CFSR. Stakeholders from the child welfare arena were engaged early on in the process. The resulting PIP represented a cross section of ideas and initiatives that would best be able to improve the state's ability to meet the increasingly complex needs of the children and families the system served. Approximately 160 individuals, including Department and private child welfare agency staff, community service providers, and judges and attorneys from Cook County Juvenile Court and the Administrative Office of the Illinois Courts (AOIC) had input into the development of the PIP through a series of workgroups that were formed to address identified areas in need of enhancement.

Determining Target Areas in Need of Improvement

While the overall results from the CFSR are consistent with what the Department of Children and Family Services (DCFS) reported in its 7/15/03 CFSR Statewide Assessment and what was also reported in the 4/03 Governor's DCFS Task Force Report, the Department believes that results from the CFSR illuminate several key areas where significant changes in practice are immediately warranted if Illinois is to make substantive inroads into further improving outcomes for children and families. These key areas are as follows:

- Building and improving upon existing systems that reduce the recurrence rate of maltreatment and supports keeping children safely with their families;
- Creating statewide systemic supports that promote the placement of children into substitute care settings that fully meet their needs and ensures placement stability for the duration of their time in care;
- Reinvesting in the basic premise that children are best served whenever possible, in their family units by developing initiatives and supporting casework practices that promote family reunification. This includes a re-emphasis on the engagement of birth parents at the onset of intervention and in particular in the early and on-going engagement of birth fathers in the lives of their children;
- Enhancing Juvenile Court and casework practices that facilitate timely permanencies for all children;
- Developing an infrastructure that supports all-around service provision for older youth, particularly in the areas of education and mental health;

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

- Building stronger supports within the Department's private sector where the majority of children placed into substitute care in Illinois are served;
- Ensuring that all caseworkers and supervisors entrusted with the responsibility of serving children and families at risk in Illinois have the ability to fully develop their skills as child welfare professionals through comprehensive front-end and on-going training.

Identifying Strategies to Improve Outcomes

In response to these and all areas cited as being in need of improvement, the Illinois Program Improvement Plan (PIP) lays out a series of strategic initiatives in the form of action steps that will be evaluated over the course of the next two years in an effort to gauge the successful implementation of the PIP. While there are numerous initiatives reflected in the PIP, two such initiatives are considered to be the underpinnings of the PIP as they are reflected within action steps for each of the seven outcomes where the state is seeking to improve its performance. These initiatives are as follows:

1. **Foster Care Contract Re-structuring:** Beginning in State Fiscal Year 2005 (July 1, 2004), the Department began the process of restructuring existing foster care contracts with Purchase of Service (POS) providers to ensure caseloads of foster care caseworkers within the private sector are no higher than 15 cases per worker. This initiative is designed to support POS agencies by providing front line staff with caseloads that allow them the time and flexibility to better serve their clients.
2. **Integrated Assessment Program:** The Integrated Assessment Program (IAP) is expected to have a significant impact on virtually all of the seven outcomes measured as part of the CFSR process in the three domains of safety, permanency and well-being. The IAP seeks to provide comprehensive screening and assessment services to all clients entering into DCFS custody. It streamlines the collection of vital family information within the first 45 days of a child entering into the Department's care and includes the interviewing of parents, stepparents, paramours, children and caregivers in relation to making an assessment of safety and risk. The IAP also includes comprehensive medical evaluations and a formal screening process that is designed to identify child and family needs in a number of domains including home and community functioning, access to support systems, emotional and developmental status, behavior, school, and substance use. The results of these various screening and assessment activities are integrated into a comprehensive assessment report upon which a service plan will be developed in conjunction with the caregiver, birth parent and child at the initial Family Meeting. The IAP then sets the stage for ongoing Child and Family Meetings that, while falling outside the actual IAP, are utilized as a means towards reviewing the progress being made towards attaining identified goals and permanency for the child. Full statewide implementation of the IA is anticipated by June 2005 (please see a more detailed overview of the IAP beginning on page 9 of the narrative section of the PIP).

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Understanding the Illinois Program Improvement Plan

The Illinois PIP is comprised of the following three sections:

- PIP Work Plan – Action Step Analysis
- PIP Matrix
- PIP Statistical Companion Guide

The PIP Work Plan or Action Step Analysis is a narrative document that provides a framework for interpreting both the PIP Matrix and accompanying PIP Statistical Companion Guide. The PIP Work Plan details items found to be in need of improvement based on CFSR results, and provides a brief explanation as to the action steps and initiatives that will be implemented in response to those items in need of improvement.

The PIP Matrix is an item by item display of all of the planned action steps and tasks that the state intends to implement in response to the CFSR results. It is a structured framework that also identifies benchmarks and planned achievement dates for each action step, the method(s) of measuring improvement for each item and the parties responsible for overseeing the implementation of all action steps. Finally, the numerical results for each item based on the CFSR results and Illinois' performance on the national standards based on the 2003 data profile are displayed in the PIP Matrix along with corresponding long range PIP performance goals. These baseline measures and long range PIP performance goals for each outcome, item and national standard are summarized in the PIP Statistical Companion Guide.

Measuring Performance – Successfully Implementing the PIP

After considering various baseline measurement options over the past several months, the Department has decided to use the CFSR results for its baseline measure in establishing the performance goals for its PIP. This decision is based on the fact that the Department is committed to ensuring that upcoming revisions to its primary qualitative measurement strategy, the Outcome Enhancement Review, or OER, (formerly known as the Federal Preparatory Review), will continue to be consistent with the CFSR review tool and process.

The Illinois PIP reflects multiple methods for measuring improvement. One primary method of measurement will be ongoing National Child Abuse and Neglect Data System (NCANDS) and Adoption and Foster Care Analysis Reporting System (AFCARS) data submissions to ACF specific to the four national standards within Safety Outcome 1 and Permanency Outcome 1 not met by Illinois during the CFSR. A second primary method of measurement for performance across all items in the PIP will be through qualitative case record reviews. While there are several sources of qualitative case review data available within the Department and private sector that may be used in measuring PIP performance, it is the OER process that will serve as the only review process in the state currently capable of measuring performance across all items and outcomes that is consistent with the CFSR review process.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

The OER tools are currently in the process of being revised to reflect changes in the CFSR review process as well as changes in recent years in Department policy and practice. The Department plans to implement a comprehensive qualitative review strategy by 1/05 that involves the quarterly review of case records and conducting of corresponding case specific interviews as part of the OER process. A random sample of intact and placement cases from both the Department and private sector will be reviewed each quarter. Twenty-five cases from two regions, one Cook and one downstate, will be reviewed each quarter for a total therefore of 50 cases. This ensures that a sizeable number of cases from the largest metropolitan area of the state, Chicago/Cook County, are being reviewed each quarter while also ensuring that a representative sample of cases covering an entire downstate region are also being evaluated on an on-going quarterly basis. Review results will be entered into a statewide database and utilized as a method of measuring and reporting PIP performance.

In addition to measuring progress on the Illinois PIP through various data systems, the Department will also maintain a detailed tracking system to ensure that all PIP action steps and corresponding benchmarks are successfully achieved within the required timeframes as delineated in the PIP.

Integration of PIP and Child and Family Service Plan Strategies

The Department is actively engaged in the process of ensuring that its PIP activities are integrated into both the Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR).

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

CROSSCUTTING INITIATIVES IN PIP

I. INTEGRATED ASSESSMENT PROGRAM

Introduction

Findings from the CFSR address concerns pertaining to assessment, early problem identification, individualized services, and service array issues. In response to these concerns, the Illinois Department of Children and Family Services has developed a strategy that would cut across systems and allow families to navigate the child welfare system successfully. The strategy identified is the Integrated Assessment Program (IAP). The IAP will be fully implemented statewide by June 2005. The Department expects the IAP to impact performance in items throughout virtually all outcomes within safety, permanency and well-being as well as the systemic factors of case review and service array.

Historically, much of the Department's assessment efforts have been directed towards adults (to assess risk of harm to children), while only limited assessment of children's behavioral/mental health needs has been accomplished. The IAP will improve the Department's capacity to address not only critical safety and risk factors, but also necessary medical, developmental, behavioral, and emotional needs of the children. This single initiative will have the broadest impact on those areas identified as being in need of improvement by the CFSR. The IAP also has the ability to impact many of the other initiatives outlined in the PIP as it provides a wealth of information regarding the functioning and needs of Illinois children, their families and their substitute caregivers.

Specifically, the IAP seeks to provide comprehensive screening and assessment services to all clients entering into DCFS custody. In addition to the medical evaluations, administered screens and clinical interviews with each child will occur to identify developmental and behavioral/mental health needs. Caregivers and birth parents will be interviewed to ascertain the types of community and social supports needed to foster optimal permanency outcomes. All screening and assessment activities will be done jointly by casework staff and licensed clinicians within the Department. The results of these various assessments will be integrated into a comprehensive assessment report, leading to a service plan that is developed, in conjunction with the caregiver, birth parent, and client at the initial Child and Family Meeting. Additionally, other existing mechanisms for securing vital assessment data on families such as the Child Endangerment Risk Assessment Protocol (CERAP), Risk Assessment Protocol (RAP), and social history addendums continue to be required every six months as part of current Department Rule and Procedure, and together provide the avenue for ensuring on-going comprehensive assessments for children and families throughout their life of involvement with the Department. Similarly, quarterly Child and Family Meetings will continue to review progress towards attaining identified goals and permanency.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Goals of Integrated Assessment Program

The goals of the IAP that represent long-term strategies for the Department are as follows:

1. Emphasis on Prevention and Early Identification
2. Coordination of Medical and Behavioral Health Services
3. Timely Service Needs Identification
4. Timely and Culturally Appropriate Service Delivery
5. Delivery of Best Practice Services by Qualified Professionals
6. Identify Most Appropriate Placement
7. Timely Movement Towards Least Restrictive Services
8. Integration of Services with Overall Case Planning
9. Engagement of Biological Parents, Family, Children, & Foster Parents in Case Planning

Overview of the Integrated Assessment Program

The IAP process pairs the worker with a Clinical Screener to engage the family and interview the parents/guardians (including stepparents, paramours, other relevant adults in the home), children, and substitute caregivers within the first 45 days following temporary custody. Throughout the process, the Permanency Worker, Supervisor, and Clinical Screener will collaborate to synthesize all information gathered to generate one Integrated Assessment Program Report. The report recommendations from the Clinical Screener will focus on clinical assessment and treatment needs. After collaboration, this report will be presented and discussed with the family prior to the initial Child and Family Meeting. Recommendations will enable the Child and Family Team to make better decisions about safety, risk, placement, service needs, concurrent planning, and permanency throughout the life of the case.

Staff: Both administrative and direct service staff are involved in the IAP. The overall administrative and clinical responsibility for this process rests in the Division of Clinical Practice and Professional Development. It is the intent of the Department that staff administering the screening protocols be licensed in either Social Work or Clinical Psychology, and have demonstrable experience and expertise in child welfare and clinical assessment. Specific competencies must be demonstrated on the various screening instruments. Staff who are involved in the Early Childhood Screening process will hold a Master's Degree in early childhood. Sub-specialty professionals (e.g. sexual abuse, domestic violence, and AOD) will also have the appropriate degree, and licensure/certification necessary to provide services.

The responsibilities of the Clinical Screeners include reviewing records/documentation; interviewing, along with the caseworker, children, caregivers, and birth parents; preparing the IAP Report including social history data; administering and scoring age appropriate screens; and identifying risk factors and service needs of the clients.

The new program improvement plan contracting strategy that will reduce caseloads will allow staff increased time to engage in this process.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Assessments/Screens: In addition to an initial and comprehensive medical evaluation, the screening process includes a record review, administration of structured screening protocols, and interviews with the child, parent, caregivers and primary treatment providers when applicable. The caseworker and screener will jointly conduct the interviews with the birth parent and caregivers. The screening instruments consist of standardized, modified, and Department protocols. The screening protocols have been designed to identify salient information in a number of domains including home, school and community functioning, access to support systems, emotional and developmental functioning, behavior, school, substance use, and sexual activity.

New clients have been divided into three broad age groups, each receiving a somewhat different screening protocol:

- **0-3 years:** The Early Childhood Program currently screens this age group. In addition to the current use of the “Ages & Stages Questionnaire,” the “Ages and States Questionnaire – Social Emotional” will be added. Interviews with the caregiver and birth parent will now also occur. The Denver developmental assessment is also used.
- **4-5 years:** Currently, clients in this age range who reside in Chicago are referred to the Chicago Public Schools for screenings. It is hoped that DCFS can assume this responsibility both within Chicago and throughout the state. As the program rolls-out to other non-Cook areas of the state it is anticipated that current early childhood providers will be contracted to provide these screening services.
- **6-18 years:** This age group will be screened by the Integrated Assessment Program Team members, which will include Licensed Clinical Social Worker (LCSW) and clinical psychology staff, as well as needed sub-specialty disciplines. The Child and Adolescent Functional Assessment Scale (CAFAS) will be utilized to structure and score the screening results. Interviews with the birth parent and current caregiver will also occur.

Timelines within the Integrated Assessment Program: The initial IAP component occurs within the first 45 days of placement. Components include the client, parent and caregiver screening and interviews, Family Meetings, and the development of a service plan. Referrals for specialty assessments (e.g. AOD, psychology) are to be made no later than the conclusion of the 45-day Family Meeting. It is expected that subsequent Child and Family Meetings, the requirements of which are currently delineated in Department policy, will continue to occur statewide on a quarterly basis from the date of case opening. Ongoing case consultation will be provided by the Clinical Screener one month prior to every ACR throughout the life of the case. This consultation will consist of, at a minimum, review of assessment findings, treatment progress, and additional scoring of the CAFAS. In some cases, the need for additional assessments and/or treatment may be recommended.

Screening Results, Safety & Risk, and Use of Resources: Level of risk and safety is currently determined primarily based on caregiver functioning, with limited consideration of how the child’s functioning may impact questions of risk. The results of the IAP evaluation/screenings will provide a more objective and integrated picture of a child’s

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

and his or her family's strengths and service needs. The use of formal screening protocols that target specific areas of functioning and risk, clinical interviews, and coordinated case work activities will allow the Department to make better determinations of service needs. The IAP is designed to increase knowledge of the family system at the front end, and to provide more detailed information related to client functioning and needs.

Results of the IAP screening will indicate whether a child and his or her family system is in need of (1) no intervention needed at this time, continue to monitor, or (2) treatment and/or further assessment. When warranted by findings, referrals for direct intervention services (e.g., treatment) or additional assessments can be made prior to the Family Meeting. When clinically appropriate, the Clinical Screener will attend and participate at the Family Meeting.

The use of Treatment Paths to assist case planning decisions is an integral feature of the IAP. Current research and best practice standards have been identified for salient mental health and developmental problems. Identification of casework requirements, referral processes, assessment, treatment modalities and efficacies, and review standards have been developed.

The Integrated Assessment Program as a Child Welfare Training Model: The IAP provides a structure and process to foster in-depth clinical and casework training of child welfare staff. The use of an integrated assessment program model, where child welfare staff join licensed clinicians in the gathering of information, conducting clinical assessments and interviews, and participating in Child and Family Team meetings will provide new opportunities for clinical and casework training. On-going consultation with licensed clinicians around case issues will also allow staff to gain increased knowledge of individual and family dynamics and systems. Reports from public and private staff who have recently completed the initial training in preparation for use on SACWIS data entry methods have re-enforced the benefits of the information and knowledge related to assessment and case planning in ongoing service deliver.

Connecting with Resources: The identification of service providers is a critical component in the IAP. Qualified providers of assessment, treatment, and other interventions need to be identified in order to insure that service recommendations are implemented. Minimum qualifications for a number of assessment and intervention services have been identified, with development of appropriate referral, documentation, and review mechanisms continuing. Based on need, gaps in services are identified and categorized by services type, and geographical location. The professionals coordinating our new mental health initiative will be able to use this information to influence contracting and service development to begin to improve the state's overall service array.

Anticipated Outcomes of the Integrated Assessment Program

It is anticipated that the IAP will yield favorable outcomes for the Department's children and their families. With the initiation of front-end screening and assessment activities, as well as much closer collaboration between casework staff and licensed clinicians, earlier and more appropriate interventions will occur. This will result in a number of anticipated outcomes: (1) decreased rates of placement disruptions, (2) increased rates of

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

permanency outcomes, (3) decreased administration of unneeded assessments, (4) increased provision of appropriate services, (5) increased identification of service needs and allocation of resources for primary and secondary prevention activities, (6) increased bio-logical parent, family, child(ren), and foster parents involvement in case planning, (7) improved relationships child(ren) in care with parents, (8) identification of relatives available for placement, and (9) individualized services to meet unique needs.

Most importantly as the IAP relates to the Illinois PIP are its anticipated positive impacts on placement stability as well as timely permanency outcome achievements. Specifically, the IAP Report contains a section entitled Family Prognosis. Within this section, the Clinical Screener and caseworker articulate any initial reservations or support for a return home permanency goal. If grounds for the consideration of expedited termination are present, the Screener and worker will recommend that these facts be explored further and shared with the court. Furthermore, Clinical Screeners for the IAP are trained on and provided guidelines for when one must seek and when one must consider seeking expedited termination of parental rights. Grounds meeting the criteria for expedited termination will be documented in the IAP Report and discussed with both the caseworker and supervisor. The caseworker then has the responsibility to present and address such grounds within the Juvenile Court system.

Roll-out of Integrated Assessment Program

It is anticipated that the IAP will be fully operational on all standard (i.e. new) as well as on add-on child placement cases by June 2005 for DCFS and POS statewide. DCFS and POS staff and supervisors have been, or are currently in the process of being trained using the same IAP training curriculum. Both the private and public sector will have regional implementation workgroups convene bi-weekly as the IAP continues to expand across the state.

For children and their families who are already part of the DCFS system, they will be provided consultation from a Clinical Screener as “triggers” within their case are identified. Ongoing IAP activities will address those children and adolescents already in custody who experience additional trauma or risk while in our care. The triggers, or risk factors, that the Department has children to target are:

- Children with more than two permanency placement disruptions and any subsequent unplanned permanency placement change
- Children with newly diagnosed complex medical conditions
- Teen pregnancy, particularly with cases having a known or suspected psychiatric or developmental disorder, or when the pregnancy is the result of rape or incest
- Chronic truancy resulting in the youth’s academic failure in the majority of his or her classes
- Runaways, when a youth under age 18 years, returns from the second runaway occurrence within a consecutive 30-day period
- Delinquency, as defined by a youth having two or more arrest within a two-month period, or when a youth is released from a correctional, or forensic facility

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Caseworkers and supervisors are also to seek an IAP consultation when a client (i.e. birth parent, guardian, or youth) has been observed or reported to have significant changes in this or her emotional or behavioral functioning.

Finally, while budgetary constraints currently prevent the Department from utilizing IA resources for intact family cases, the IA process will be available for those post adoption or guardianship cases where the children are taken back into Department custody or otherwise brought back to the Departments' attention.

Program Evaluation of the Integrated Assessment Program

The Integrated Assessment Program is developing a formal program evaluation protocol in close collaboration with the Office of Research Institute. The evaluation will focus on (1) the administration and infrastructure of the IAP (e.g. staffing patterns, resource allocation, and adherence to timelines), (2) clinical efficacy of the various IA activities (e.g. screens, Child and Family Teams, Intervention services), and (3) Consumer satisfaction (e.g. clients, staff, agencies, and courts). A cohort of clients from placement teams, not yet involved in the IA process, will serve as a control group to study long term outcomes related to safety, permanency and well-being.

II. CONTRACT STRATEGY

Historical Context

Performance Contracting within the Illinois child welfare system was initiated in FY97. The switch from the per-diem administrative rate based on number of children and days of care was eliminated and put in its place was an administrative rate based on caseworker to caseload ratios with a predetermined number of cases expected to move out and an equal number expected as intake. Under performance contracting, cases would be assigned on a rotational basis so each agency would have equal opportunity for receiving new cases. The performance of an agency was then to be determined by the agency reaching permanencies via reunification, adoption, or subsidized guardianship on 24% of their beginning caseload. Over the years, this rate was increased to 33% in Relative Care and remained at 24% in Traditional Care. In FY04 the two contracts were combined with a performance goal of 29%.

Changes to performance contracting since its initiation in FY97 have included the addition of funding that allowed each team to add one Permanency Worker. Recruitment and emergency homes were added for traditional foster care at which time this contract also became performance based. Educational liaisons were also later added as part of enhancements to performance contracting.

All of these contract enhancements were paid for by reinvesting the savings earned through reducing the number of children in care and other savings associated with moving children to permanency. The main goal of all these reinvestments was to continue Illinois' success in having moved over 30,000 children out of the child welfare system and into permanent living arrangements.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Current Challenge

Today there are currently 19,500 children remaining in out of home placement in Illinois. The recent Federal CFSR found that Illinois had a relatively strong child welfare system with the state passing five of the seven systemic factors, and was found to not be in substantial conformity only with regards to two systemic factors - the state's case review system and its array of services. However, CFSR results also reflected that the state was not in substantial conformity with any of the seven outcomes in safety, permanency and well-being.

Having accomplished the goal of moving some 40,000 children out of care to permanent placements in Illinois, it is safe to say that the right investment was made for the right time with regards to performance contracting. Now that we have a much smaller system with only 19,500 children in care, CFSR results indicate that the state must now focus on the quality of care that is provided to those children that remain in care and their families. While other initiatives in the PIP, such as the IAP and Mental Health Initiative, will help to identify and develop needed services for the system, something must be done that allows caseworkers to have more time with their clients. These children and families present with a more difficult array of service needs than previous populations. The state also faces the challenges of its front-end redesign that brings fewer children into substitute care (i.e. 1800 in FY04), but children who also come from families who present with more complex problems and service needs. These combined factors require and demand that workers spend more time with the children and families in care and therefore require smaller caseloads in order to truly impact the many case practice areas needing improvements as cited in the CFSR.

PIP Contract Strategy

Contracting with individual providers to make some minor changes to programs or add additional services to meet the CFSR cited areas of need would only impact relatively small numbers of children and would not be cost effective. A contracting strategy that reaches the entire Traditional and Relative Foster Care populations is needed, one that will improve workload ratios to Best Practice levels for far less money and at the same time free foster care practitioners from the rigid structure of the current contract system. This strategy will allow caseworkers to be creative in meeting those case practice areas identified in need of improvement as identified in the CFSR.

This new contract strategy is simply to take the dollars in the Cook County POS contracts currently targeted towards moving large numbers of children out of the system, since this goal has largely been accomplished, and to re-invest or re-direct those dollars to reduce POS caseloads. Dollars in the current contracts targeted toward adoption/permanency workers, foster home recruitment, and emergency foster homes will be reinvested in lowering caseloads. While the percentage of permanencies required under performance contracting has remained the same, the actual number of permanencies being achieved is smaller in recent years because it is based on a smaller population of children in substitute care. There is no longer a need to have a POS caseworker dedicated towards the non-casework or more administrative support role of permanency work since this work now represents a smaller part of the overall casework. More specifically, POS

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

caseworkers whose primary role within the agency in the past may have been to complete adoption subsidies, will now be freed up to perform job duties that are geared towards casework practices that enhance performance in terms of the active engagement of birth parents, foster and adoptive parents as well as the children in the permanency planning process. The dollars contracted for counseling and education liaisons will remain the same in this initiative. The Department also intends to re-invest similar dollars in downstate foster care contracts in the same way, though such contracts are structured differently and have smaller dollar amounts available for this purpose.

The targeted caseload in this contract initiative will be 15:1 in both Cook County and Downstate Performance Based Foster Care Contracts. A study by Best Practices revealed that the Best Practice target caseload should be at 15:1 or lower for workers to provide the highest quality of care. A review of that study and comparison to the CFSR areas needing improvement demonstrates that progress could be made with smaller caseloads directly on the following items.

Finally, additional performance contracting goals that are specific to some of the action steps or goals currently outlined in the Illinois PIP will be part of performance contracting for FY05. Such goals include holding agencies accountable for showing improvements in the engagement of biological parents in the planning process, child and family and sibling visitation, and court performance.

III. ENHANCED SERVICE DELIVERY SYSTEM FOR CHILDREN IN CARE SYSTEMS OF CARE INITIATIVE

A. Introduction

The System of Care (SOC) program from its inception combined both funds and service elements from three separate programs: Each of the three programs provided an important support: Placement Stabilization provided emergency and crisis services for foster families and their children; Intensive Therapeutic Services provided intensive clinical intervention for foster families and their children; and the Wraparound System Administrative Agent provided strength-based case planning and flexible funding for foster families and their children. Although each program had proven success in helping stabilize foster care placements, the programs were operated independent from one another and each had their own entry point, referral criteria and service menu. In July 2002, the Department incorporated the strengths and funding from the three programs into a single System of Care program including crisis services, intensive therapeutic intervention, strength-based planning and flexible funding. The Department's goal was to continue to provide effective, flexible services while reducing paperwork requirements and streamlining access to services for foster parents.

The SOC program is designed so that each agency is assigned to a geographic area of the state referred to as a Local Area Network (LAN.) The geographic assignment of the SOC agencies to LANs allows them to become familiar with local resources, help advise on local resource needs and maintain a physical proximity for the child and family. In the metropolitan areas, the SOC's knowledge of the community also helps them know where not to refer a child.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

While the SOC network was first instituted in July 2002, it is considered a key initiative in the Illinois PIP as the Illinois child welfare service delivery system is only now beginning to fully feel its benefits. This is due in part to last minute changes in the planned roll out of SOC that were made just prior to July 2002 which resulted in an approximately six month lag time before SOC referrals became routine in the field. Much of FY03 was also spent communicating to the private sector the fact that SOC was intended to act in partnership with POS agencies in terms of strengthening placement stability services rather than operating as a sort of “watchdog” over the private sector. Therefore, while SOC was operational during FY03, program knowledge was initially limited which impeded its full utilization. During FY04 and continuing into FY05 then, the Department has and will continue to promote public awareness of and education about the SOC program, including training for private and public personnel, having meetings with foster parent groups and repeating articles regarding the SOC process in foster parent newsletters.

B. Overview of SOC

Eligible Populations

The SOC is designed to provide support and assistance to children in foster homes and for children who are “stepping down” to a less restrictive setting and require intensive intervention to successfully manage the transition. Targeted populations for the SOC program include:

1. Children residing in a home of relative or traditional foster care placement, and who are at risk of moving to another foster care placement or requiring more clinically intensive or restrictive living arrangements;
2. Children residing in more restrictive settings including specialized foster care homes, residential homes, or other more restrictive settings such as the Department of Corrections and require additional services and interventions in order to successfully transition to the home of relative or traditional foster care living arrangement; or
3. Children residing in Institution/Group Home placements and are transitioning to the homes of their parent(s) and there is an open family case.

Referral Process

SOC referrals may be made on a crisis or non-crisis basis. For non-crisis referrals, SOC referrals are generally made by the caseworker and are initiated whenever a family begins to experience difficulty in maintaining the child in their home. The referring caseworker must complete a one page SOC referral form, fax it to the appropriate SOC agency and then call or meet with the receiving SOC agency to provide further information about the case including the child’s history, current issues and the presenting conditions. If the child is in one of the eligible placements described above, the SOC agency must arrange for further assessment activities with the family including a Child and Family Team meeting, completion of the Child and Adolescent Needs and Strengths form, and completion of some or all components of a mental health assessment. At the end of the

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

assessment period, (no longer than 30 days), the SOC agency, in conjunction with the Child and family Team, will make a determination whether SOC services are needed, additional services are needed but can be found within existing resources, or the child requires more care than can be provided by SOC.

For crisis referrals, families or caseworkers may call a statewide 800 number and request immediate crisis intervention services. The Crisis, Assessment and Referral Entry Services (CARES) Line is available 24 hours per day, seven days per week to help referents determine if a child's emotional/ behavioral problems are threatening the stability of the placement. The SOC agency must provide phone consultation within 60 minutes or if needed, on-site intervention within four hours.

C. SOC Services

An essential characteristic of SOC is their ability to assess the individual needs of a child and family and develop a response unique to the stated strengths and needs of the child. To support this flexibility, the SOC program may offer the services and interventions directly and/or may arrange for the services and interventions to be provided through subcontracts or Memorandums of Agreements with other providers. Because of this flexibility, DCFS maintains an expectation that the SOC program will not have a waiting list for any service.

The decisions about what support is needed for the safety and well-being of the child are made during Child and Family Team meetings. The Child and Family Team is minimally composed of the SOC personnel, the caseworker and the caretaker. Other members might include other professionals involved in the case as well as people who can provide more informal support like a neighbor or an extended family member. Generally, the services and supports provided by the SOC agency are those that are outside of the contractual responsibilities of the Departmental or Purchase of Service agency but each case is individually negotiated to serve the specific needs of the child and family. The treatment plan is documented on an Individual Plan of Care and is signed off by all members of the Child and Family Team.

The SOC provider is required to have the service capacity to serve any client referred who meets the target population criteria within their LAN area. The projected average length of services is six (6) months although SOC has the flexibility to provide shorter or longer interventions dependent upon if the stability of the placement remains at risk.

Conflict Resolution: If a dispute arises between a caseworker and the System of Care agency or the caretaker and the System of Care, the DCFS regional System of Care Coordinator should be contacted for assistance. The SOC agencies are also expected to provide consultation on cases being considered for either specialized foster care and residential or group home placement. The consultation may be requested either before or after the actual referral has been made for a higher level of services. Additionally, any time a foster parent issues a Notice of Placement Change (for Cook County children only), the caseworker must make a referral to the System of Care agency and request a clinical review of placement change.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

IV. ENHANCED SERVICE DELIVERY SYSTEM FOR FAMILIES

Family Centered Services Initiative

The mission of the Family-Centered Services (FCS) Initiative, as implemented under the 1994 Family Preservation and Family Support Act, is to develop, support, and maintain a coordinated and integrated statewide network of child-centered, family-focused and community-based prevention-orientated services. In 1997, the mission of the FCS Initiative was further expanded under the Adoption and Safe Families Act (ASFA) and subsequent 2001 amendments to include the development and support of services to adoptive children and families and children that were reunified with their families after being in substitute care. In September 2003 DCFS institutionalized these programs within its service structure. This allowed the FCS Initiative to focus a portion of its services to children and families that had a “brush” with DCFS but still remained outside the child welfare system.

The Family Centered Services (FCS) Initiative is considered a key initiative in the Illinois PIP since its primary goals are to maintain families safely in their homes, schools and communities as well as to deflect families from entering the States’ child protection system. The FCS Initiative is also expected to aid in reducing the recurrence of maltreatment in Illinois.

FCS Vision

The vision of the FCS Initiative is to creatively enhance and enrich the statewide network of community-based services through expanded membership at the local, LAN and state level; improve coordination of LAN and flex funding; renew community needs assessments; develop new quality assurance measures; and increase technical assistance to the FCS programs. Parent and consumer participation at the LAN and state level is paramount to this vision.

The FCS Initiative consists of several programs in a statewide network which are not stand-alone programs and are to be viewed holistically in the LAN and leveraged to provide a comprehensive array of traditional and non-traditional services. The FCS programs enhance the capacity of DCFS to build a community-based infrastructure for service delivery.

As the Department continues to analyze its current service needs and priorities, the FCS network will explore the expansion of its service continuum to include an increased focus on educational support and intervention services within FCS programming. Currently, adolescents 13 years and older who are in foster care have been identified by DCFS as being in need of increased mental health, substance abuse, educational and support services. Adolescents in the 12-18 year age range comprise the largest category of children currently served by FCS programs.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Guiding Principles of the Family Centered Services Initiative

The core principles and values of the FCS Initiative are as follows:

- FCS services are community-based
- FCS services are family focused and work with both parents and children
- FCS services address issues and concerns that are of high priority to each family
- FCS services are culturally responsive and respectful
- FCS services build on family strengths
- FCS services enhance parents' abilities to care for their children
- FCS services ensure the safety of all family members
- FCS services connect families to other families and resources in their own neighborhood
- FCS services involve parents in the development, implementation and oversight of the program services

FCS Target Population

The FCS target population is organized into service categories based upon two referral sources: community referrals and DCFS referrals, as defined below. Community referrals often involve family prevention/support services. DCFS referrals often require family intervention/treatment services.

- **Community referrals** may include all referrals of children and families who are not currently involved in the states child protection system. This also includes closed DCFS intact family cases and child welfare referrals.
- **DCFS Division of Child Protection (DCP) referrals** may include cases referred directly from the hotline which are not opened. Indicated but closed cases may also be served.

A new category of DCFS referrals will include DCFS wards. The provision of educational enhancements, support and intervention services to this population will be explored within the context of the LAN network and FCS programming. This population will also include older youth who are "aging out" of the DCFS system and youth who are "stepped down" from more restrictive placements to appropriate community settings.

FCS Service Categories

All FCS services are classified into the four federally defined categories as detailed below.

- **Family Prevention/Support Services** are community-based, preventive activities designed to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; and

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

supportive networks to enhance child rearing abilities of parents and help compensate for the increased isolation and vulnerability of families.

- **Family Intervention/Treatment Services** typically include services designed to help families alleviate crises that might lead to out-of-home placement of their children; maintain the safety of children (and other family members) in their own homes; support families preparing to reunite or adopt and assist families in obtaining services and other supports necessary to address their needs in a culturally sensitive manner.
- **Time-limited Family Reunification Services** are services provided to children (and their parents) who are removed from their home and placed in foster care or a child care institution to facilitate the safe and appropriate reunification with the family. These services are only available for 15 months after a child is removed from the home.
- **Adoption Promotion and Support Services** are defined as services and activities designed to encourage more adoptions out of the foster care system when adoptions promote the best interest of the children. Services may include pre and post adoption services and activities designed to expedite the adoption process and to support adoptive families.

FCS Funded Services

The main FCS-funded services provided to the four federally defined categories include:

- Individual and family counseling
- Intensive case management
- Parent education and support
- Educational support and enhancement services
- Family mentoring
- Respite
- After-school programs
- Intensive home visitation
- Crisis intervention
- Advocacy
- Assessment
- Post Adoption services
- Referral and linkage
- Bi-lingual service capacity
- Transportation

Evaluating the Effectiveness of the FCS Initiative

Several quality assurance measures are currently being explored as possible methods to further analyze, review and document the progress of the FCS initiative. Such measures include an analysis of subsequent oral reports (SOR) by individual programs;

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

client/consumer satisfaction surveys, and peer/community review processes. Anecdotal evidence and data collection reflecting successful deflection from DCP in some LANs will be formalized to include standardized deflection data recording by all FCS programs. This will serve to uniformly document the FCS programs' success in deflecting families from entering the child protection system.

V. ILLINOIS CHILDREN'S MENTAL HEALTH PLAN

DCFS recently established an internal Mental Health Team composed of a Psychiatrist, Psychologist, and Social Worker. All individual team members have been identified and they all have Office of Mental Health experience as well as expertise in residential, special education, federal and downstate issues.

DCFS has developed a Mental Health Service Plan for FY05 to guide the team in its early work. In the first quarter of FY05 the team will assist in the rollout of the IAP and Residential Monitoring Unit. They will evaluate the Department's use of System of Care services, LAN utilization, and community mental health services as they currently exist. They will review the data generated by these service delivery systems to identify gaps in mental health services statewide and design a plan for bridging service gaps in all jurisdictions.

In the second Quarter of FY05 the team will develop a trauma model utilizing the data mentioned above. The treatment will address the issue of trauma because the clients interfacing with DCFS have issues with traumatic events in their life that impact current functioning. In the third quarter of FY05 they will develop a DCFS model of mental health care with consideration given to trauma treatment, psychiatric hospitalization, medication, Screening, Assessment and Support Services (SASS), Department of Human Services (DHS)/ Department of Mental Health (DMH)/ Developmentally Delayed (DD) and schools. They will also assess the over/under utilization of community-based care. In the fourth quarter of FY05 all of this information and planning will go into contracting decisions for FY06. In first quarter of FY06 DCFS will rollout its children's mental health plan.

VI. INTENSIVE STABILIZATION STRATEGIES

Introduction and Background

A small number of children within the Department's care experience a large number of placements over the course of their time in substitute care. Many children reach a point where they no longer cooperate with structured placements and use the emergency shelter as a drop in center that has an impact on overall stability in the Department in many ways. Several populations of children use the shelter. Children first entering into care may initially stay for a few days at the shelter. Children experiencing placement disruptions may stay at the shelter until another placement is located. The final population is the group of children, sometimes referred to as "cyclers" who utilize the shelter as a drop in center and rarely return to structured placements. About 70% of the discharges from the Emergency Service Center are to run away status. Many of these

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

discharges are for the same children coming and leaving before entering a structured placement.

While there are several PIP strategies that are expected to have an impact on improving placement stability for the general foster care population (i.e. IAP as a means towards ensuring better placement matching, SOC model that supports the provision of in-home mental health services for children in care and stabilizes placements) the Department will also develop programs specific for adolescents at risk of experiencing placement instability in FY05. It will use the information and practice knowledge gathered from these programs to learn to better serve this population.

PIP Strategies Regarding Intensive Stabilization

The Department will have four primary strategies for addressing those adolescents identified as in need of placement stability:

Professional Foster Care Strategy: The Department will contract with private providers to develop a professional foster care model to serve 12-16 year old adolescents experiencing placement instability. The model will have components that will do outreach work to biological families, other significant adults, informal support systems, and communities as identified by the child. The provider will try to determine if the child is running from something or to something. The program will have a respite component for foster caregivers. It will be flexible in understanding that the child may not initially stay every day in the foster home, but success will be measured by increasing the number of days per month that the child stays in the home to a point that the child is in the home everyday. During the period of reconnecting with the child, every effort must be made to have daily contact of some kind with the child. The model must have a strong clinical/mental health component to access the child's needs and deliver the services. The Department will contract with a clinical provider to work with all private providers who have this contract model. The clinical/mental health provider will then follow the child to the next placement if the child moves or is identified as needing some other form of care after stabilization.

Intensive Stabilization Centers: The Department will contract with private providers to develop a model of Intensive Stabilization Centers. The centers will provide slots and staff the center for 24 hour full capacity at all times for adolescents between the age of 16-20 experiencing instability. Twelve to fifteen adolescents will be assigned to each center. The model will have components that will do outreach work to biological families, other significant adults, informal support system, and communities as identified by the child. The provider will try to determine if the child is running from something or to something. It will be flexible in understanding that the child may not initially stay everyday in the center but success will be measured by increasing the number of days per month that the child stays in the center to a point that the child is in the center everyday. During the period of reconnecting with the child every effort must be made to have daily contact of some kind with the child. The model must have a strong clinical/mental health component to access the child needs and deliver the service. The Department will contract with a clinical provider to work with all private providers who have this contract model. The clinical/mental health provider will then follow the child to the next

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

placement if the child moves or is identified as needing some other form of care after stabilization. Older children in care from 18-20 can be transitioned to independence from the center.

Diagnostic Congregate Care Stabilization Centers: Diagnostic Congregate Care Stabilization Centers will service older wards newly entering the system between 12 and 16 years of age. It will be for those wards that may have issues identified during the Integrated Assessment Program process with family living situations. These wards are at high risk for becoming cyclers and may benefit from a period of congregative living to do further diagnostic work and planning before moving into a more permanent placement. An extensive battery of behavioral, emotional, medical and educational assessments will be conducted to determine the specific services to be provided. The natural parent or designated foster parent will be included in services to establish a setting that will be conducive to meeting the needs of all involved. Ongoing assessments will be conducted during placement to determine if the services are producing positive results or need to be modified.

Specialized Foster Care Slots for Children at Risk of Moving Up Into Residential Placements: In contrast to prior recruitment efforts that have focused on those children identified as needing to step down from high-end residential or group care into foster homes, the Department is in FY05 developing contracts with existing private foster care agencies to increase the number of specialized foster care slots for those children at risk of moving up into higher end residential placements. The Department intends to begin developing these specialized foster care slots, beginning in January 2005 with 50 slots and increasing the number of slots by 50 each quarter depending upon the need and demand for additional beds.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

PIP WORK PLAN – ACTION STEP ANALYSIS

Safety Outcome 1: Children are first and foremost protected from abuse and neglect

Findings

Although Safety Outcome 1 was substantially achieved in 90.9% of the cases reviewed, the state was not in substantial conformity with this outcome because the national standard was not met for the percentage of children experiencing more than one substantiated or indicated child maltreatment report within a 6-month period. Item 1 was rated as a strength in 12 (92%) of the 13 applicable cases because responses to reports of maltreatment were initiated and face-to-face contact established within 24 hours of receipt of the report. Although Item 2 was rated as a strength in 41 (93%) of the 44 applicable cases, the State's rate of maltreatment recurrence for 2001 (10.1%), as reported in the State Data Profile, did not meet the national standard of 6.1 percent or less.

Plans for Improvement

Illinois has several plans to manage the recurrence of maltreatment. First, Illinois will implement a mechanism to capture and analyze accurate data/information on repeat maltreatment cases in order to better inform Child Protection practices. This will be done by creating a review tool and process to examine such things as use of certain risk of harm allegations, Child Protection Service (CPS) decision-making in low-risk cases, and use of Child Welfare Services (CWS) referrals. Based on the review of data from this process, procedural changes, if warranted, will be implemented in order to ensure that front-end casework practice fully supports the accurate assessment of in-home risk thereby reducing the recurrence of maltreatment. In addition, ongoing training will be provided to DCFS and private agency staff on the allegation system, the SACWIS tracking system will be updated to capture information on estimated incidence dates for repeat maltreatment, and information systems will collect data on these estimated incidence dates.

Illinois will also implement a mechanism to strengthen the hotline so that responses to calls are timely and consistent. This will occur by updating the mandated reporter training curriculum and materials and educating the public about the allegation system and the conditions for acceptance of reports as well as providing information about unfounded reports and services available to families. Furthermore, the State Central Register (SCR) and DCFS Quality Assurance will develop an ongoing process to review calls not accepted by the hotline as well as a resolution process to ensure that such calls receive follow up when deemed appropriate. More SCR staff and a message system will also be added to expedite call responsiveness.

The Family-Centered Services (FCS) Initiative will also be strengthened in an effort to support intact families and further reduce the risk of repeat maltreatment. This will be accomplished through the completion of four primary tasks. First a program description for FCS will be developed that clearly outlines the characteristics of the target population,

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

purpose, intensity and intended outcomes of FCS services. This program description will place a greater emphasis to provide a fuller and more consistent array of services throughout the LANs that meets the needs of already closed intact families as well as families who have already had contact or intervention by the states' Child Protection system. Second, the process for referring closed intact family cases and indicated but closed investigations will be standardized in order to provide greater clarity to caseworkers as to the importance of family to community connectedness and the expectation that upon closing intact family cases, referrals should be made to the FCS program. Third, a data collection and tracking system that assesses the impact of FCS services will be developed. Finally, a peer review process will be developed that assesses the community response for at-risk families. The new data collection and peer review process is expected to produce vital and accurate information that ensures well-informed decisions around possible FCS expansion activities and an infrastructure that would support an increase in DCFS referrals to the FCS program.

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate

Findings

Illinois did not achieve substantial conformity with Safety Outcome 2. This Outcome was rated as substantially achieved in 81.2% of the cases reviewed. The Outcome was not considered in substantial conformity because there was no evidence of consistent efforts to provide appropriate services to protect children in the home and prevent their removal nor was their evidence of concerted efforts to reduce the risk of harm to children. Overall, Item 3 was rated as a strength in 23 (77%) of the 30 applicable cases. Item 4 was rated as a strength in 39 (81%) of the 48 applicable cases. CFSR findings indicated that there was a lack of comprehensive risk and safety assessments, which resulted in the delivery of inappropriate services that did not ensure safety of children or reduce risk of harm and there was a lack of diligent monitoring of children's safety in residential and group home facilities.

Plans for Improvement

Illinois will work to implement mechanisms that will ensure that appropriate services are provided to families to protect children, prevent removal from the home, when possible, and reduce the risk of harm to children in their homes and to those in substitute care.

The Department will update its policy and procedures for working with intact families to ensure that casework and supervisory staff responsible for serving intact families are provided with clearer casework guidelines based on work that has already been accomplished through Best Practice workgroups in the Department. This should result in improved assessment and planning case practices and overall decision-making for intact caseworkers and their supervisors. DCFS and POS staff statewide will be provided with training once such policies and procedures have been updated.

In effort to ensure that appropriate services are in place to prevent the removal of children from their homes and reduce the risk of harm, Illinois will annually assess its current

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

system of intact services, identify service gaps, assess barriers to accessing services, and adjust contract levels as necessary to make certain that a full array of appropriate services exist. Similarly, an AODA needs assessment will be conducted statewide in each region in order to determine gaps in AODA services. DCFS will collaborate with the Department of Human Services (DHS) to establish a system to prioritize referrals and admissions. A QA review of AODA cases will also be implemented in order to identify any barriers to the full implementation of Department policy for working with substance-affected families.

For children in substitute care, the SOC model will be used to address crisis situations and behaviors and provide supports for foster parents in order to reduce the risk in the home and maintain the placement. Children placed in residential or group care are also eligible for SOC services in order to successfully transition home or into less restrictive placements. For children in residential or group care, DCFS will develop a new residential performance monitoring unit, establish performance measures, and create a tracking system to monitor the safety of children in these types of placements.

Permanency Outcome 1: Children have permanency and stability in their living situations

Findings

Illinois did not achieve substantial conformity with Permanency Outcome 1. Case review ratings for this outcome varied substantively across the three CFSR sites, with Charleston cases determined to be substantially achieved in 83% of cases, Rock Island cases substantially achieved in 33% of cases, and Cook County cases substantially achieved in 15% of cases. Additionally, fiscal year 2001 data reported in the State Data Profile indicated that Illinois did not meet the four national standards established within the Permanency 1 outcome.

Plans for Improvement:

A series of strategic initiatives are planned with the goal of developing a sound infrastructure to support staff in promoting timely and well-planned permanency plans for children and families. Statewide implementation of the IAP by June 2005, in combination with reduced caseloads in the FY 2005 private sector contracts, will set the stage for successful planning and implementation of other specific initiatives aimed at child safety, reunification, timely adoption, improved accessibility to Alcohol and Other Drug Abuse (AODA) services, and the holistic provision of independent living services and support for youth. Because Cook County regions consistently show the largest variance in the state from the permanency national standards, while having the largest substitute care census in the state, region-specific actions have also been included in the PIP that aim to improve the efficiency of casework staff, as well as to reduce delays in the Cook County Juvenile Court.

Illinois has sought technical assistance from the National Resource Center for Foster Care and Permanency Planning to assist in the strengthening of Illinois' current reunification practices, as well as the implementation of a concurrent planning model. Preliminary

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

plans have also been made to establish a partnership with the Administrative Office of the Illinois Courts in the form of a steering committee to meet for the duration of program improvement planning. As part of the long-range Child and Family Services Plan, this steering committee will be responsible for assessing and developing plans for addressing regional variances in court procedures, as well as systemic judicial practices affecting permanency planning.

Placement stability will primarily be addressed through the ongoing provision of mental health services to children in foster homes through the SOC Services, and the development of Intensive Stabilization Programs to target older children who have recently entered substitute care, or who are experiencing instability. An improved residential care and monitoring system will also be established for children both entering and exiting residential placements. Treatment goals and discharge planning will now be more precisely detailed through on-site monitoring, tracking residential providers on key performance indicators, as well as the use of a database that trends the individual functioning of the child to assist in making clinically appropriate and timely placement decisions. Additionally, voluntary family support services will be offered to foster parents through the Family Focus Program through six sites in Cook County.

An additional new initiative designed to more effectively stabilize youth in out-of-home placements is the development of Child and Youth Investment Teams. This new process is intended to streamline decision-making processes, deliver services earlier, and foster continuity of communication about youth in care. Specifically, the new Child and Youth Investment Teams will replace the existing Placement Review Team (PRT) structure of admission to residential care and the current Specialized Foster Care Review Committee, with the Teams being empowered to identify youth's needs without restriction to program type. The team may also make direct referrals through the caseworker to the existing service provider for additional services or to the System of Care when appropriate.

The program improvement planning process also led Illinois to conduct a more in-depth analysis of each permanency national indicator, the state's Adoption and Foster Care Analysis and Reporting System (AFCARS), and the Department's data entry processes. Over the years, both the adoption and foster care computer programs underwent revisions and submission modifications to meet federal mandates and changes in procedures within DCFS. Once the PIP process started, it was determined that the continual patching of the foster care program was no longer sufficient to provide the most accurate performance and outcome results. Therefore, the Office of Information Services has begun a complete rewrite of the AFCARS foster care submission program. This element-by-element analysis will be completed and ready for implementation with the September 2004 submission.

Permanency Outcome 2: The continuity of family relationship and connections is preserved

Findings

Illinois did not achieve substantial conformity with Permanency Outcome 2. The outcome was rated as substantially achieved in 76% of the cases reviewed. Ratings for

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

this outcome varied across CFSR sites, with Charleston and Rock Island Cases achieving 100% substantially achieved ratings, while Cook cases received substantially achieved ratings in 54% of the cases reviewed. Three of six items measured within Permanency Outcome 2 were assessed to be areas needing improvement: visiting with parents and siblings in foster care, relative placement, and the relationship of the child in care with his/her parents.

Plans for Improvement

Significant changes in practice are warranted regarding insuring the on-going connections between children and their families. To that end, the PIP details a series of case practice and contracting initiatives aimed at improving performance in this area.

The Department believes that its investment in the IAP will produce dividends in all the associated P2 Items. The comprehensive nature of the IAP will assist the caseworker in case planning that assesses family strengths and bonds. In terms of family visiting, the expectation will be that casework staff use the IAP to assess both the foster parent's ability as well as his/her willingness to assist with family visitation. The IAP also should prove to be an effective strategy towards insuring children and all respective extended family members are appropriately assessed as possible caregivers for the children.

The use of the Intensive Relative Search program in Cook County will be added to Independent Living and Transitional Living program (IL/TLP) plans as an ongoing contractual requirement in order to strengthen efforts to establish family connections for youth prior to emancipation.. Training for current and future DCFS and POS casework staff towards making better use of the Diligent Search Service Center in order to locate birth parents as well as to accurately identify potential relative caretakers should also contribute to enhancing performance in items 13 and 16.

Casework staff will be afforded training regarding Department visitation policy that includes a component regarding expectations that caseworkers ensure the provision of flexible (i.e. expanded, in-home, overnights when possible) parent-child visitation as well as guidelines on how to obtain re-imburement for foster parents for conducting sibling visits.

Contractual enhancements are also expected to contribute towards improving performance in Permanency Outcome 2, most notably in the planned restructuring of POS foster care contracts that reduce caseload size. This initiative is expected to free up caseworker time so that flexible and meaningful parent-child and sibling visitation can be fully supported. The PIP also calls for decreasing the amount of time it currently takes to reimburse foster parents for conducting family visitation. Other contractual changes that are expected to enhance overall performance in Permanency Outcome 2 include revising performance contracting to incorporate an added performance indicator that insures birth parents are engaged in the case planning process.

Efforts outlined in the PIP to strengthen the engagement of birth parents, in particular fathers, include the identification of existing parent advocacy groups in order to engage them in an on-going advisory role with the Department. A Fatherhood Initiative Planning

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Committee has also recently been established which will serve as a vehicle towards making policy recommendations as well as develop a training curriculum and plan to train DCFS and POS staff on how to better engage fathers in case planning for their children.

Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs

Plans for Improvement

Illinois will work to implement mechanisms that will ensure the timely, thorough, and comprehensive assessment of needs and provision of services to children, parents, and foster parents, engage these stakeholders in the case planning process, and strengthen caseworker visitation practices with children and families.

In general, contracts will be restructured to allow for reduced caseloads, which will give caseworkers more time to better assess the well-being needs of children, parents, and foster parents, locate and link children with appropriate resources, consistently monitor the provision and progress of services, engage children, parents, and foster parents in the case planning process, and allow for more frequent and substantive caseworker visits with children and families.

The implementation of the IAP will aid in assessing and meeting the well-being needs of children and families as it is designed to gather detailed health and developmental information, provide thorough emotional, mental health, and behavioral screenings, and make recommendations for further assessment, testing, and treatment upon a child's entry into substitute care, including those children and families previously known to the Department. For children already in care, clinical consultation will be provided as "triggers" are identified (see Crosscutting Initiatives in the PIP, section I: IAP for further details). Furthermore, children, families and foster parents will be involved in the case planning process as findings from the IAP and clinical consultations are to be discussed and reviewed as part of the Child and Family Team meetings. Additionally, statewide training for supervisors will be implemented beginning April 2005.

For intact families, the Risk Assessment Protocol and Child Endangerment Risk Assessment Protocol (CERAP) as well as on-going assessment guidelines outlined in Department policy will continue to guide casework practice with intact families. As previously outlined in Safety Outcome 2, policy in working with intact families will be significantly enhanced as part of the PIP, which will include a greater emphasis on assessing short and long-term risk issues present in families and decision paths in order to appropriately address risk and service issues.

To manage crisis situations and potential placement disruptions due to the behavioral problems of children, the SOC program will allow for immediate crisis and short-term services and clinical interventions to provide support to children in relative or tradition foster homes, or those placed in group and residential placements with emotional and/or behavioral problems, as well as provide support to foster parents, in order to prevent placement disruption, increase the successful transition process from more restrictive to

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

less restrictive placement settings, and maintain children in traditional and relative care placements.

Regarding service provision specific to substance use, DCFS will conduct a regional needs assessment to determine gaps in services and barriers to the implementation of the Substance Affected Family policy. DCFS will collaborate with DASA to expand services where needed.

To meet the specific well-being needs of older youth, Illinois will use the Ansell-Casey Life Skills Assessment for initial and ongoing assessment of independent living abilities. To enhance the placement and service options for adolescents, DCFS will strengthen the policy around program plans and requirements for independent living and expand the professional foster care model to include supports for maintaining older youth in care. The Department will also provide various resources specific to the needs of older youth. Youth will have the opportunity for input into the policy development in this area through participation in focus groups. Finally, Illinois will create a system that provides opportunities for congregate living arrangements for older youth, develop transitional living placements for those youth that experience a great deal of placement instability, and establish contracts with private providers to enhance permanency planning for incarcerated, DCFS involved youth.

In addition to engaging families through the IAP, the Department's policy on concurrent planning will be strengthened to ensure birth parent, youth and foster parent involvement in planning. Child and Family Team meetings will also be more readily used to determine, review, and monitor needs and services as part of the case planning process. Additionally, improvements will be made in the diligent search process including creating a notification system for private agencies regarding the need for a diligent search, enhancing initial and ongoing trainings on the search process, monitoring by the court system that a search was completed in the required timeframe, and increasing access to the Public Aid system for locating parents in order to involve them in the case planning process. Finally, as previously noted in Permanency Outcome 2, a Fatherhood Initiative Planning Committee has recently been established which will serve as a vehicle towards making policy recommendations as well as develop a training curriculum and plan to train DCFS and POS staff on how to better engage fathers in case planning for their children.

Regarding caseworker visits with children and families, efforts will be made to strengthen visitation practices to ensure that thorough and substantive observation occurs. This will be done by updating visitation policies, defining the role and expectation of workers during visits, and providing training to new and existing caseworkers on visitation policies.

Well-being Outcome 2: Children receive services to meet their educational needs

Findings

Illinois did not achieve substantial conformity with Well-Being Outcome 2. This Outcome was rated as substantially achieved in 84.4% of the cases reviewed. The

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

Outcome was not considered in substantial conformity because there was no evidence of consistent efforts to assess children's educational needs and provide services to meet those needs. Overall, Item 21 was rated as a strength in 27 (84%) of the 32 applicable cases. CFSR results indicated that this Item was rated as a strength in 91% of applicable placement cases compared to 70% of applicable intact family cases.

Plans for Improvement

In addition to working toward enhancing existing measures and systems to meet the educational needs of children, Illinois has several plans for ensuring that children's need are thoroughly assessed and appropriate services are provided.

Contracts will be restructured to allow for reduced caseloads, which will give caseworkers more time to better assess educational needs, communicate more regularly with educational systems, locate and link children to appropriate resources, and consistently monitor the provision and progress of services. Furthermore, efforts will be made to establish and maintain ongoing communication between DCFS and area school districts. The Illinois Children's Mental Health Plan is also expected to enhance the coordination with other state and local entities around educational issues.

Enhanced training will also be provided on the expectations of caseworkers during visits with children and families. This training is designed to improve the quality of caseworker contact around educational issues for both placement and intact families. The implementation of the IAP will also aid in meeting the educational needs of children as it is designed to provide thorough developmental and functional screenings and can recommend further assessment and testing as needed.

In an effort to improve ongoing monitoring of children's academic progress, Illinois will create an Educational Passport database. This will strengthen Illinois' efforts to respond more proactively to children's educational needs and trigger advocacy services when needed. In order to increase school attendance and academic performance and decrease suspensions, expulsions, and drop-outs, DCFS will coordinate with the Local Area Networks (LANs) and the Educational Access Project to provide timely advocacy and support services to children experiencing academic difficulties.

Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs

Findings

Illinois did not achieve substantial conformity with Well-Being Outcome 3. This Outcome was rated as substantially achieved in 66.6% of the cases reviewed. The Outcome was not considered in substantial conformity because there was no evidence of consistent efforts to assess children's physical and mental health needs and provide services to meet those needs. CFSR findings indicated that this was, in part, due to a lack of service providers willing to accept Medicaid for medical and mental health care services. Mental health assessment and service provision was found to be the most problematic. Overall, Item 22 was rated as a strength in 38 (83%) of the 46 applicable

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

cases. Item 23 was rated as a strength in 23 (66%) of the 35 applicable cases. CFSR results indicated that both of these Items were rated as a strength in more placement cases than intact family cases.

Plans for Improvement

In addition to working toward enhancing existing measures and systems to meet the physical and mental needs of children, Illinois has several plans for ensuring that children's needs are thoroughly assessed and appropriate services are available and provided.

The implementation of the Integrated Assessment Program will also aid in meeting the physical and mental health needs of children as it is designed to gather detailed health information and provide thorough emotional, mental health, and behavioral screenings and can recommend further assessment, testing, and treatment as needed. While budgetary constraints currently prevent the Department from using IAP services with intact families, consideration will be given towards expanding the role of IAP to intact families in FY06 if the budget allows.

Illinois will work toward establishing linkages with vision care providers throughout the state to enlarge the service array.

Because mental health assessment and service provision was particularly problematic, a number of other initiatives specific to mental health will be implemented. DCFS' implementation of the System of Care (SOC) program will allow for immediate and short-term services and interventions to provide support to children with emotional and/or behavioral problems in order to prevent placement disruption, increase the successful transition process from more restrictive to less restrictive placement settings, and maintain children in traditional and relative care placements.

DCFS' is also participating in Illinois' Children's Mental Health Partnership to ensure that children's emotional, mental health, and behavioral needs are thoroughly assessed and appropriate services are received and monitored. As part of this process, DCFS will work to develop a model for mental health care (DCFS Child Mental Health Plan) and will enhance the monitoring system for residential treatment programs. Involvement in this multiple systems partnership will also allow for easier access to mental health services for intact families and potentially reduce the number of children taken into care as these families will be able to receive comprehensive services through various community providers.

For children in residential or group care, DCFS will develop a new residential monitoring unit, establish performance measures, and create a tracking system to monitor the safety, health and well-being of children in these types of placements. The Screening, Assessment and Support Services process (SASS) is also being enhanced with the joining between DCFS and the Department of Human Services and Department of Public Aid in July 2004 in order to jointly operate a system that provides a single entry point for foster parents and others to access 24 hours a day crisis and psychiatric screening services. Expected enhancements from this tri-department collaboration include improving the

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

states' ability as well as the ability of hospitals to provide a response to children and their families that is unique and specific to their needs, and to ensure greater provider accountability in the delivery of intensive and time-limited mental health services.

Systemic Factor - Case Review System

Item 25: Process for developing a case plan and for joint case planning with parents

Findings

According to the CFSR final report of findings, Illinois did not achieve substantial conformity with the systemic factor of Case Review System. Item 25 was rated as an Area Needing Improvement because case plans were not always reflective of children and families' needs and parents were not consistently involved in the planning process.

Plans for Improvement

Illinois will work to implement mechanisms to ensure that case plans accurately address children and families' needs and all stakeholders are involved in the planning process.

To improve the quality, accuracy, and thoroughness of case plans and monitor the engagement of stakeholders in the case planning process, Child and Family Team meetings will be more readily used to determine, review, and monitor needs and services. Case plans will be required to be individualized and updated as needed, and performance contracting goals will be added to FY05 POS contracts specific to increasing caseworker contact and engagement with children and families. Child and Family Team meeting training will also be provided to all DCFS and POS supervisors statewide.

Item 28: Provides a process for termination of parental rights proceedings in accordance with the provisions of the Adoption and Safe Families Act (ASFA).

Findings

According to the CFSR final report, Item 28 was rated as an Area Needing Improvement because the CFSR found that there were multiple barriers to pursuing the Termination of Parental Rights (TPR) in accordance with the provisions of ASFA. Primarily, the barriers identified negatively affected the timely progression toward termination proceedings.

Plans for Improvement

The program improvement planning specific to this item includes the strengthening of current casework procedures to increase the timeliness of case progression through the Juvenile Court system, the creation of new communication pathways to promote more frequent communication between casework staff and the attorneys at the Cook County Juvenile Court, and a statewide supervisory training to strengthen and ensure the use of Child and Family Team Meetings as a vehicle to timely permanency decisions.

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

In order to prevent delays related to parent notification at both court hearings and during the screening process to initiate a TPR petition, both casework and notification processes in Cook County will be improved. The Diligent Search and Service Center (DSSC) will be made more accessible to private sector foster care agencies by installing a computer workstation in the Cook County Juvenile Court building. A tickler system will be initiated to prompt caseworkers to update diligent search information prior to its expiration, so that all appropriate cases will contain a current and valid diligent search affidavit for both court dates and the TPR screening processes, thus avoiding continuances and failed screenings. Newspaper publication to parents who's whereabouts are unknown, as well as service of summons for parents whose whereabouts are known, will both occur more quickly.

Several communication pathways from the caseworker to the court will be established to promote more timely and progressive court hearings, permanency goal changes, and termination hearings. In cases where it would be appropriate to pursue expedited TPR at the dispositional hearing, a mechanism will be implemented for casework staff to directly notify the State's Attorneys Office. Critical decisions made by a casework supervisor to change a child's permanency goal to seek either reunification or termination of parental rights will now be communicated directly to the DCFS Office of Legal Services at the time the decision is made so the permanency hearing can be scheduled more quickly. In cases where a 6-month permanency hearing was not held for any reason, a computerized list will be generated of those cases and they will be motioned up for the next available date.

Other improvements to address the timeliness in Cook County Juvenile Court include a tracking system used to track and monitor the reasons for continuances. The results of the tracking system will be evaluated and measures will be enacted to resolve the most frequent reasons for the continuances. Additionally, to address any delay that the bifurcated TPR court process is perceived to cause, the court will conduct the Best Interest and Unfitness Hearings on the same day.

Systemic Factor - Service Array

Item 32: Availability of array of critical services

Item 36: Accessibility of services across all jurisdictions

Item 37: Ability to individualize services to meet unique needs

Findings

Illinois did not achieve substantial conformity with the systemic factor of Service Array. Item 35 was rated as an Area Needing Improvement because, although the state allocates significant resources to services, the level of existing services does not meet the needs of children and families involved with DCFS. The CFSR identified service gaps related to placement resources for adolescents, children's mental health, culturally responsive services, and services to address family issues of substance abuse, mental health, and domestic violence. Item 36 was rated as an Area Needing Improvement because the CFSR determined that services were not easily accessible in all parts of Illinois and long waiting lists existed in some areas. Item 37 was rated as an Area Needing Improvement

ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN

because the CFSR found that the current DCFS assessment process was not consistently effective in thoroughly identifying assessing the needs of children and families and there was a lack of individualization of services.

Plans for Improvement

Illinois will work to implement mechanisms that will improve the availability and accessibility of services to meet the needs of children and families. As part of the IAP, all variables, including cultural variables present in the family that should be considered in making service referrals will be noted in the IAP Report to help ensure appropriate follow-up.

To enhance the placement service options for adolescents, DCFS will expand the professional foster care model to include supports for maintaining older youth in care, create a system for congregate living arrangements for older youth, and develop transitional living placements for those youth that experience a great deal of placement instability.

In terms of improving overall mental health services for children and families, in addition to educational and physical health services, the implementation of the Integrated Assessment Program will allow for thorough and comprehensive evaluations of needs and individualization of services and provide recommendations for treatment. With the reduction of caseloads, caseworkers will have more opportunity to work with children and families to thoroughly and comprehensively assess and monitor needs and link to appropriate resources. DCFS will also develop a process to ensure smooth transitions between clinical providers to avoid any unnecessary delays in the treatment process and maintain consistency in the provision of services.

Illinois will make its current substance abuse resources throughout the state available to private agency caseworkers in addition to DCFS staff. Through involvement in the Illinois Children's Mental Health Partnership, intact families will have better access to community-based services, which can include substance abuse, mental health, and domestic violence treatment. Additionally, the establishment of linkages with various dental and mental health associations will increase the availability of service providers and decrease waiting lists.

Furthermore, on an annual basis, the state will assess its current service array needs and available resources and adjust provider contracts as necessary to ensure a full array of appropriate services exist – based on the current needs of the child welfare population – and waiting lists are reduced. Contracts will also be restructured to increase the number of in-home providers and allow for flexibility in funding so that there can be continuity of care when children and families transition to different services and providers. To ensure quality of services, providers will be required to maintain documentation of assessments, treatment, progress, etc. as set forth by the Integrated Assessment Program.

APPENDIX A

LISTING OF ILLINOIS PIP WORKGROUP PARTICIPANTS

PIP Workgroup Participants

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APPENDIX B

PIP TERMS AND ACRONYMS

Illinois Program Improvement Plan - Terms and Acronyms

TERM / ACRONYM	Translation (English)
A	
ACF	Administration for Children and Families
ACR	Administrative Case Review
AFCARS	Adoption and Foster Care Analysis and Reporting System
AOD/AODA	Alcohol and Other Drugs / Alcohol and Other Drug Abuse
AOIC	Administrative Office of the Illinois Courts
APSR	Annual Progress and Services Report
ASA	Assistant State's Attorney
ASFA	Adoption and Safe Families Act
C	
CAFAS	Child and Adolescent Functional Assessment Scale
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
CPS	Child Protection Services
CWS referrals	Child Welfare Services referrals
D	
DASA	Department of Alcohol and Substance Abuse
DCFS, the Department	Department of Children and Family Services
DD	Developmentally Delayed
DHS	Department of Human Services
DMH	Department of Mental Health
DSSC	Diligent Search and Service Center
G	
GAL	<i>Guardian ad Litem</i>
I	
IA	<i>Integrated Assessment</i>
IDPA	Illinois Department of Public Assistance
ISBE	Illinois State Board of Education
L	
LAN	Local Area Network
LCSW	Licensed Clinical Social Worker
N	
NCANDS	National Child Abuse and Neglect Data System
O	
OASA	Office of Alcohol and Substance Abuse
OER	Outcome Enhancement Review
P	
PIP	Program Improvement Plan
POS	Purchase of Service - DCFS contracted agencies
S	
	Statewide Automated Child Welfare Information System

SACWIS	
SASS	Screening, Assessment and Support Services
SCR	State Central Register
SOC	System of Care

Illinois Program Improvement Plan - Terms and Acronyms

TERM / ACRONYM	Translation (English)
T	
TC	Temporary Custody
TPR	Termination of Parental Rights

APPENDIX C

PIP STATISTICAL COMPANION GUIDE

**ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN
STATISTICAL COMPANION GUIDE - Resubmission**

Federal Outcomes/Items and National Indicators in Need of Improvement		CFSR Baseline 9/03	Final PIP Goal (At the end of 2 years)
FEDERAL OUTCOMES MEASURED			
Safety 1:	<i>Children are first and foremost protected from abuse and neglect</i>	90.9%	93.9%
Safety 2:	<i>Children are safely maintained in their homes whenever possible and appropriate</i>	81.2%	84.2%
Permanency 1:	<i>Children have permanency and stability in their living situations</i>	36%	39%
Permanency 2:	<i>The continuity of family relationship and connections is preserved for children</i>	76%	79%
Well-Being 1:	<i>Families have enhanced capacity to provide for their children's needs</i>	52.1%	55.1%
Well-Being 2:	<i>Children receive appropriate services to meet their educational needs</i>	84.4%	87.4%
Well-Being 3:	<i>Children receive adequate services to meet their health needs</i>	66.6%	69.6%
ITEMS MEASURED			
Item 3:	<i>Services to family to protect child(ren) in home and prevent removal</i>	77%	80%
Item 4:	<i>Risk of harm to child(ren)</i>	81%	84%
Item 6:	<i>Stability of foster care placement</i>	84%	87%
Item 7:	<i>Permanency goal for child</i>	64%	67%
Item 8:	<i>Reunification, guardianship or permanent placement w/relatives</i>	43%	46%
Item 9:	<i>Adoption</i>	40%	43%
Item 10:	<i>Permanency goal of other planned permanent living arrangement</i>	33%	36%
Item 13:	<i>Visiting with parents and siblings in foster care</i>	71%	74%
Item 15:	<i>Relative placement</i>	76%	79%
Item 16:	<i>Relationship of child in care with parents</i>	77%	80%
Item 17:	<i>Needs and services of child, parents, and foster parents</i>	54%	57%
Item 18:	<i>Child and family involvement in case planning</i>	57%	60%
Item 19:	<i>Worker visits with child</i>	83%	86%
Item 20:	<i>Worker visits with parent(s)</i>	55%	58%
Item 21:	<i>Educational needs of the child</i>	84%	87%
Item 22:	<i>Physical health of the child</i>	83%	86%
Item 23:	<i>Mental health of the child</i>	66%	69%

**ILLINOIS CFSR PROGRAM IMPROVEMENT PLAN
STATISTICAL COMPANION GUIDE - Resubmission**

Federal Outcomes/Items and National Indicators in Need of Improvement	CFSR Baseline 9/03	Final PIP Goal <i>(At the end of 2 years)</i>
NATIONAL INDICATORS		
Recurrence of Maltreatment <i>(National Standard: 6.1%)</i>	7.5%	6.6%
Stability of Foster Care Placement <i>(National Standard: 86.7%)</i>	82.4%	84.3%
Length of Time to Achieve Reunification within 12 months <i>(National Standard: 76.2%)</i>	58.1%	60.5%
Length of Time to Achieve Adoption within 24 months <i>(National Standard: 32%)</i>	13.9%	16.8%