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**DIFFERENTIAL RESPONSE IN ILLINOIS:
2011 SITE VISIT REPORT**

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Executive Summary

Introduction and Methods

This Illinois Differential Response Site Visit report summarizes findings on the implementation of Differential Response (DR) in the State of Illinois by the Department of Children and Family Services (DCFS, the Department) as of July 1, 2011. These findings are part of a larger evaluation of DR conducted by the Children and Family Research Center (CFRC, the Center) and sponsored by the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR), which is funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The State of Illinois is one of three sites selected by QIC-DR in December 2010 to implement and evaluate a DR program, and the only one of the three to implement DR statewide. The other sites are a consortium of five counties in Colorado and a consortium of six counties in Ohio. The Illinois Site Visit Report examines the exploration and adoption phases of DR implementation in Illinois; provides a detailed description of the DR program that was developed; presents findings on the fidelity of DR practice to the program described in policy and statute; and assesses the core competency and organizational drivers used in the first year of project development. The report will inform the cross-site evaluation being conducted by the QIC-DR, as well as the greater child welfare community about effective strategies for implementing large-scale system reform. The theoretical framework used for this report is that developed by Fixsen and colleagues (2005) following their review and synthesis of existing implementation evaluation literature.¹

Information for this report was collected through three primary methods: (1) document review, including legislation, rules, procedures, protocols, and contracts; (2) statewide focus groups with both workers and supervisors who provided DR services and conducted child protective investigations; and (3) individual interviews and a focus group with key informants critical to DR implementation and program development. All focus groups and interviews were recorded and transcribed for qualitative analysis.

Illinois DR Program Description

Illinois's DR program, known as *Pathways to Strengthening and Supporting Families (PSSF)*, was implemented throughout the state on November 1, 2010, to offer an intervention response for handling reported child maltreatment cases deemed moderate to low risk that is an alternative

¹ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

to the established investigative pathway that requires the gathering of forensic evidence and a formal determination whether child maltreatment occurred. Cases assigned to the DR pathway undergo an in-home assessment and families are offered short-term Strengthening and Supporting Families (SSF) services. The process is intended to be voluntary, non-adversarial, and non-accusatory. Family members are not labeled perpetrators or victims and DR cases are not entered into the State Central Register.

The Illinois DR program is unique in many ways. Unlike other child welfare systems, which locate DR within Child Protective Services (CPS), the State of Illinois administers DR as a separate unit. The DR program is staffed by both public-sector (DCFS) and private-sector (community-based social service agencies) employees who work together in paired teams.

Calls made to and accepted by the State Central Register (SCR, commonly referred to as the “hotline”) as meeting criteria for child abuse and/or neglect are screened to determine if they are eligible for the DR program by meeting all of the following criteria:

- Identifying information for the family members and their current address is known at the time of the report;
- The alleged perpetrators are birth or adoptive parents, legal guardians, or responsible relatives;
- The family has no pending or prior indicated reports of abuse and/or neglect, or prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations;
- The alleged victims, or other siblings or household members, are not currently in the care and custody of the Department or wards of the court;
- Protective custody of the children has not been taken or required in the current or any previous case; and
- The reported allegation or allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect.² The following circumstances prohibit the report from being assigned to DR and the case will be assigned an investigative pathway.
 - Allegations of Mental and Emotional Impairment reports taken as abuse (Allegation #17).
 - Inadequate Supervision reports involving a child or children under the age of 8, or a child older than 8 years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety.

² Substantial Risk of Physical Injuries due to neglect (Allegation #60) was added to this list in July 2011.

- Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated.

All other allegations are considered to involve substantial child abuse and neglect, and are ineligible for assignment to DR.

Families assigned to DR are contacted by telephone by the paired DCFS/SSF team to arrange for jointly conducted in-home assessment within 3 days of case assignment. The DCFS employee (called a DR specialist) is primarily responsible for assessing child safety through the use of the State's Child Endangerment Risk Assessment Protocol (CERAP). If the assessment finds no immediate safety concerns, the DCFS DR specialist hands over the case to the private agency SSF worker who then completes a family needs and strengths assessment and provides an array of services to the family. If a child is determined to be unsafe, DCFS DR supervisors have the authority to reassign (reprocess) the case to the traditional investigative pathway.

DR services are voluntary. A family may refuse to accept services; in that event, if there are no safety concerns, the case is closed without a CPS investigation. If a family accepts services, the SSF worker can offer a wide array of strength-based and family-focused services to meet their targeted needs. The SSF agencies must deliver most services in the home over the course of 90 days, the time allowed for service provision. However, up to three 30-day service extensions may be granted for good cause based on the family's needs and the availability of funds. Twice weekly in-home visits are required. Cash assistance of up to \$400 per family is available with approval at the regional level; expenditures above this amount must be approved by the DR Project Director.

Key Findings: Program Fidelity

Screening and Eligibility

All current allegations of maltreatment eligible for DR fall under the category of neglect. For the most part, DCFS DR specialists and DR supervisors as well as private agency SSF caseworkers and supervisors reported that the allegations currently referred to DR were appropriate, although a small number of workers voiced reservations about accepting severe medical neglect cases involving chronically or seriously ill children. Many workers and supervisors suggested that "risk of harm due to neglect" (Allegation #60) cases could be appropriate for DR, because it is often reported at the same time as other allegations currently eligible. However, they also expressed concerns about the catch-all nature of this category, which can include risk of harm due to domestic violence or parental substance abuse.

The evaluation uncovered worker concerns about the DR requirement that restricts eligibility to those families with no prior reports of abuse and neglect, since neglect tends to be a chronic condition for many of the families served by the Department. By restricting DR eligibility to

those families with no prior reports, many of the families that might benefit the most from DR are denied the opportunity. These findings indicate that the Department should consider expanding DR eligibility criteria to include prior maltreatment reports for neglect, especially those that are related to the same or similar incidents.

Reassignment of Cases from DR to Investigations

DR cases may be reassigned to an investigation for several reasons. Most DCFS DR specialists and SSF workers described situations in which cases were reprocessed due to safety concerns. But these cases occurred less frequently than those reprocessed because of inherent ineligibility, caused by the SSF worker's discovery after the initial contact of prior reports or an open case on a family member. Such discovery necessitates immediate reassignment to an investigation and was the most commonly reported reason for reassignment in Illinois. DR workers expressed frustration over the disruption the reassignment caused families after time had been spent in building rapport, assessing family needs, and providing necessary services.

SSF workers also expressed frustration with the requirement that a family assigned to a DR pathway must be reassigned to an investigation if the SCR receives a second call on that family (known as a Subsequent Oral Report or SOR), regardless of whether the SOR pertains to the same allegations and issues that the family is currently working with the SSF worker to alleviate. SCR workers have the discretion of taking subsequent calls as "related information" rather than an SOR, but SSF workers report that screeners do not always use this discretion consistently throughout the State. It is recommended that unless the information from the reporter involves new allegations, it seems less disruptive for the family if additional calls (while the case is open) are taken as information only.

Paired Team Approach

The overall opinion of both the public and private agency workers about the Illinois paired team approach was generally positive, although the DCFS DR specialists and the SSF workers differed on whether two people meeting with the family was necessary, or even beneficial. DCFS DR specialists were uniform in their assessment that the paired approach was "what makes DR work," because of the seamless transition from the initial safety assessment to the provision of services. Some private agency SSF workers appreciated the benefit of having two perspectives on family strengths and needs at the inception of a case, especially when the DCFS DR specialist assigned to work with them had more extensive child protection experience. Other SSF workers questioned the necessity of having two workers in the home at the same time, citing concerns that families may be intimidated, especially when one of the workers is identified as a DCFS employee. SSF workers and supervisors in two regions reported difficulties with DCFS DR specialists that they did not feel had a "family-friendly" approach.

Safety Assessment

The DR specialists, SSF workers, and their supervisors were asked if they felt that the safety assessment protocol used in DR cases was adequate. There was consensus among all DR staff that the CERAP was a useful tool for assessing the safety in the home. One DR specialist who used to be a DCFS investigator felt that even though the tool was the same, it was being used in a more strengths-based way

Service Provision

No one reported reassigning a family eligible for DR services to the investigative pathway on the sole basis of the family refusing services. SSF workers and supervisors reported that they were pressured to keep such refusals to a minimum. Three primary types of service were most often provided to families. *Instrumental* services, such as hands-on assistance in cleaning “dirty houses,” was often cited by SSF workers as a critical need of families with allegations of environmental neglect. Workers reported a need for *informational* services to help families both locate and obtain transportation to other community-based agencies to meet specific needs. Advocating on behalf of families to help them navigate or secure services from complex systems was frequently reported as a means by which *emotional* support was provided to families.

DR Cash Assistance Program

SSF workers and supervisors expressed widespread frustration over the length of time it took to process their requests for cash assistance funds and the lack of clarity about what these funds could be used to purchase. The cash assistance application process should be simplified by giving SSF workers and supervisors clearer guidance on the types of family needs that will be approved and speeding up the process for getting the cash to the family.

Caseloads and Staffing

DCFS DR specialists have no maximum caseloads, due to their limited involvement in each case. Private agency SSF workers have a caseload capped at 12 cases per worker. During the period under review, SSF caseloads ranged from 1 to 9, with an average of 4 cases per worker, although there was considerable regional variability. The SSF workers and supervisors felt strongly that their current caseloads were about right, indicating that the number of hours workers spent with each family and the distances they traveled in most parts of the state to get to the families required such reduced caseloads.

This evaluation discovered that the caseloads of DR specialists were significantly lower than expected throughout the state. Most workers rarely handled more than one or two cases at a time. The significantly lower DCFS DR caseload affected DCFS staff negatively according to both DR specialists and investigators. DCFS investigators and supervisors reported that they understood from the beginning that a benefit of DR implementation would be a reduction in

investigative caseloads due to the diversion of cases. This has not materialized according to investigative supervisors, because too few cases are diverted and because positions vacated by investigators who transferred to the DR units were left unfilled. As a result, caseloads were higher for those who remained in investigations (e.g., 30 or more investigations in some regions). Additionally, the lower caseloads and the lower severity level of the types of cases being handled by the DCFS DR specialists were highly visible to the DCFS investigators, which often led to resentment.

Key Findings: Competency Drivers

Staff Selection

Staff selection is essential, since it is at this level that evidence-based practices and programs are actually carried out. The DCFS DR specialists and DR supervisors are governed by collective bargaining agreements between the Department and the union. Employee length of service is the prevailing and primary factor in determining who is selected to fill these positions. Private community-based agencies were selected to provide SSF program services and they were responsible for the hiring of SSF staff. SSF workers are required to have a bachelor's degree and be certified to use the CERAP. Documented experience working with youth and families also is required. Supervisors must have a master's degree and more extensive experience in working with families. The evaluation found little consistency in staff selection criteria across agencies. The primary means of recruiting SSF workers in two or three agencies was the loss of funding in other programs rather than a determination that the worker would have the requisite credentials, skill set, or temperament for DR.

Training

The inaugural group of DCFS DR specialists and supervisors and private agency SSF caseworkers and supervisors was trained together in a 4-week training program followed by a week of web-based training modules. All of the workers felt that joint training was beneficial, because it allowed them to establish rapport with one another prior to working together. Despite the opportunity for team-building that the 4-week training afforded them, they felt the training was too long and was not specific enough to prepare them for the actual work required of them. They were not provided the opportunity to work hands on with the automated data management system and were required to attend a week-long module on the safety assessment protocol, which most of the workers were already certified to use. SSF supervisors wished for specific training tailored to their needs as supervisors, which was lacking in the current training.

Although there are benefits to having one 4-week training curriculum that both DCFS DR specialists and private agency SSF workers and supervisors attend together, there are also disadvantages to a "one size fits all" training. Because of their seniority within the Department,

the DCFS DR specialists may not need to receive ALL of the modules currently included in the 4-week training, especially those that could be considered introductory. Since they are also CERAP-certified, they may not need to attend the week of training devoted to CERAP certification. Less experienced SSF workers or supervisors, however, may benefit from the more extensive training. Finally, separate modules dealing with supervision and coaching may be useful for DR and SSF supervisors.

Investigative staff were also required to attend a 1.5 hour web-based, instructor-led “control group” training on DR, which was intended to provide an overview of the purpose and rationale of the program, describe the evaluation components and the logistics of the randomization process, and provide instructions for each of the data collection activities required of them when they received a report that was randomly assigned to the control group. During the focus groups, investigative staff reported that the web-based training was not conducive to learning and that they often spent time multi-tasking instead of listening to the trainer. They also felt that the trainers did not have accurate information about the DR evaluation and were unable to answer any of the questions that were posed to them during the training. The widespread confusion about DR practice and the DR evaluation expressed by investigative staff suggests that the both the content and the method of administration of control group training may need revision. The control group training should emphasize to investigators that they will still get DR-eligible cases (in the control group) until the evaluation is over, and that DR will not affect their caseload immediately.

Supervision and Coaching

Both DCFS DR specialists and private agency SSF workers noted uniform satisfaction with their supervision. Reasons for satisfaction included the supervisors’ fostering of a good working relationship leading to a cohesive team approach; demonstrating flexibility to meet the individual needs of their workers; providing constructive feedback; being readily available to answer questions; and having the subject matter expertise and the willingness to share knowledge.

Performance Evaluation

DCFS DR specialists’ performance evaluations are governed by the master contract with the union and are therefore limited to what is agreed on through negotiation. Although the current MOU encourages “periodic informal evaluation conferences” between the DCFS DR specialists and their supervisors, and the DCFS DR supervisors and the DR Project Director, it restricts written employee evaluation to DR work performance only and must acknowledge that the assignment is voluntary and the performance evaluated is not reflective of the employee’s permanent job assignment. The DCFS Project Director reports that she had the DR supervisors and the DR specialists develop DR-specific performance objectives. The performance objectives

for the supervisors are set annually by the supervisors themselves in partnership with the DR Project Director. According to the Project Director, if performance is deemed not acceptable, they will jointly identify training needs and develop a corrective action plan. No evaluations had taken place when the focus groups were conducted, so the public agency workers had limited information to share on this topic. In the private agencies, most SSF workers reported that they had yet to be evaluated and that they expected that the evaluation would be general in nature and not targeted to DR-specific competencies.

Key Findings: Organization Drivers

Decision Support Data Systems

Significant and intensive work was done to the Department's Statewide Automated Child Welfare Information System (SACWIS) to accommodate implementation of DR. Three DCFS divisions are responsible for DR program oversight. The Department's Division of Quality Assurance is responsible for determining fidelity of programs and services provided by the DCFS directly. The Division of Monitoring is responsible for programmatic oversight of private agencies under contract with DCFS; and the Division of Budget and Finance monitors fiscal compliance. The focus groups did not produce much information related to the use of data to drive practice improvement or to help frontline staff in the SSF agencies.

Facilitative Administration

The DR program is led by the DR project director, who is primarily responsible for ongoing development of and modifications made to DR program goals and the practice model. Wide differences in sentiment existed between the public agency (DCFS) and private agency (SSF) workers about whether their suggestions and opinions were taken into consideration by DR administration: DCFS DR staff felt a strong sense of ownership of and involvement in program planning, while the private agency SSF staff felt much less involved.

The site visit also revealed some confusion and frustration about the lack of clarity of the role of the DR Project Steering Committee, which was formed to ensure proper oversight of the preparation and planning process for DR. It is recommended that project administration create opportunities for meaningful dialogue between all DR stakeholders to support the work of the frontline staff. Task-related workgroups should be established within the steering committee to examine each implementation driver and the supports needed to improve and sustain the project over time.

External Systems Intervention

Systems interventions are strategies to work with external systems and stakeholders to ensure the availability of the financial, organizational, and human resources required to support the intervention. Other than the CWAC DR Project Steering Committee, external stakeholder

groups and community members were not invited to participate in focus groups or interviews during the 2011 site visit. Thus, the information that is available about systems intervention related to DR in Illinois is very limited at this time and reflects only the views of those steering committee members who participated in the focus group. The next DR site visit, set to occur in late 2012, will collect more detailed information about the influence of external systems on the implementation of DR.

DCFS Organizational Culture and Resistance to Differential Response

The evaluation found that a certain amount of friction, or resistance, existed at all levels (administrative, supervisory, and frontline) between the Division of Child Protection (DCP) and DR. One source of this friction at the worker and supervisor levels is the difference in workload between DCFS DR specialists and DCFS investigators. Based on the Department's representation of DR to them, investigative staff believed that DR would result in a decreased workload. Unclear training regarding the need for random assignment of DR cases to a control group left investigators confused about why they were still responsible for cases they believed should have been assigned to the DR pathway. Many focus group participants described the prevailing DCFS organizational culture as one that is punitive toward workers; filled with burdensome paperwork; and overly concerned with negative outcomes, leading to bureaucratic redundancy in decision making.

Another finding relates to a perceived climate of secrecy created by the DR program, caused by the lack of information available to investigators either when DR cases are reprocessed to the investigative track or when new reports of abuse or neglect on a closed DR case are made to the hotline. Current policy requires that all information related to DR cases be sealed, meaning that it cannot be shared with investigators or other Department workers. Many workers saw this requirement as detrimental both to effective child protection efforts and to family engagement.

Recommendations

This site visit report provides a snapshot of how the DR program looked as of June 2011, approximately 8 months into the implementation process. Program implementation is a dynamic process and the DR program model in Illinois has already changed in several significant ways since the data for this report were collected:

1. The DR case eligibility criteria have been expanded to include the additional allegation of risk of harm due to neglect (Allegation #60). Although it is too soon to know how big of an impact this will have on the number of cases assigned to the DR pathway, this change will most likely increase the caseloads of both DR specialists and SSF caseworkers.

2. The 4-week training curriculum for DR specialists and SSF workers and their supervisors has been updated to include additional hands-on instruction related to SACWIS and the specifics of DR policy.
3. As of July 1, 2012, the requirement of twice weekly in-home visits from SSF workers may be reduce to once a week at the family's request. This request must be discussed between the family and the SSF supervisor, and this discussion must be documented in SACWIS. It should be noted that this request must come from the family rather than the SSF worker.

Based on the data collected during the site visit and the growing empirical literature on the factors that affect successful implementation of human services programs, some additional recommendations can be made regarding both the Illinois DR program and the competency and organizational components that support DR practice.

1. Some of the cases that are being randomly assigned to the DR pathway are actually ineligible (under the current eligibility criteria) to receive DR services, because they have prior reports that the SCR is not identifying at the time of the initial acceptance of the call. SSF workers report a tremendous amount of frustration when these cases get flipped back to investigations because a prior report is discovered after the case is opened. Two potential solutions exist to this problem. The first would be to improve the screening process employed by SCR workers so that fewer ineligible reports are put into the randomizer and sent to the DR pathway. A second solution would be to expand the DR eligibility criteria to include those families with prior maltreatment reports related to neglect, which tends to be a chronic condition. Ruling out all families with prior neglect reports excludes a significant number of the families that could potentially benefit from DR.
2. There seems to be some inconsistency at the SCR about how additional calls that come in on a family assigned to the DR pathway are handled: whether they are taken as "information only" or as an SOR, a subsequent oral report, which automatically causes the DR case to be reassigned to an investigation. Unless the information from the reporter involves new allegations, it seems less disruptive for the family if additional calls (while the case is open) are taken as information only.

3. Simplify the cash assistance process by giving SSF workers and supervisors clearer guidance on the types of family needs that will be approved and speeding up the process for getting the cash to the family.
4. Create more opportunities for meaningful dialogue between the DR workers. DCFS DR specialists and SSF workers expressed a desire to meet more often with their colleagues to exchange ideas and information. Geographic barriers may impede the ability to get together often—even within a region—but this is important, especially since new workers will not have the benefit of spending 4 weeks together in training like the inaugural group of workers did.
5. Increase the flow of information about DR to DCFS investigators, supervisors, and managers. Many of the investigation staff expressed an interest in learning more about how the implementation of DR is proceeding but had no informal or formal venues for obtaining current information. A webpage on the DCFS intranet with brief updates from the DR Project Director would be one method for communicating about DR implementation with all DCFS employees in an efficient manner. Another possible method of increasing the flow of information to the investigation staff would be to have the regional DR supervisors attend the regional supervisory forum that are attended by investigation supervisors and give period updates on DR implementation. Investigation supervisors can then pass the information along to the investigators that they supervise.
6. Review the “control group” training module on DR that is now part of the new employee training for DCFS employees. The widespread confusion among investigators about DR practice and the DR evaluation indicates that the current module may not be effective. It seems important to emphasize to investigators that they will still get DR-eligible cases (in the control group) until the evaluation is over, and that DR will not affect their caseload immediately.
7. Although there are benefits to having one 4-week training curriculum that both DCFS DR specialists and private agency SSF workers and supervisors attend together, there are also disadvantages to a “one size fits all” training. Because of their seniority within the Department, the DCFS DR specialists may not need to receive ALL of the modules currently included in the 4-week training, especially those that could be considered introductory. Since they are also CERAP-certified, they may not need to attend the week of training devoted to CERAP certification. Less experienced SSF workers or supervisors, however, may benefit from the more extensive training. Finally, separate

modules dealing with supervision and coaching may be useful for DR and SSF supervisors.

8. The role of the CWAC Project Steering Committee should be clarified. A facilitator should lead a discussion on the role of the steering committee going forward, and develop shared goals for the DR project once their role has been clearly established. A long-range strategic plan should be developed with particular attention paid to how external stakeholders will be engaged to support and champion the DR project. In addition, task-related workgroups within the steering committee should be structured to examine each of the implementation drivers as they relate to DR.

Introduction and Purpose of the Report

In December 2010, the State of Illinois was selected by the National Quality Improvement Center on Differential Response (DR) in Child Protective Services (QIC-DR) as one of three sites to implement and evaluate a DR program. Colorado and Ohio are the other sites. The Illinois and cross-site evaluations have three major components:

1. The Process Evaluation Component, which will examine the DR program that is designed and implemented; agency practices that are put into place to institute and maintain the program; attitudes of agency staff toward the program; and community feedback and involvement during the design, implementation, and sustainability phases.
2. The Outcome Evaluation Component, which will examine the characteristics of families and children who are assigned to the experimental (DR) and control (investigation) pathways; the amount of service that they receive; and the outcomes—both initial and intermediate—that result from their receipt of these interventions.
3. The Cost Analysis Component, which will examine the costs incurred in developing, maintaining, and sustaining DR, and provide comparisons of costs incurred for investigation and DR pathway families.

The process evaluation component has several purposes. First, it will examine the DR program that is designed and implemented (fidelity). In addition, it will thoroughly document the differences in practice between traditional investigation and DR to provide an understanding of specific distinctions. Some examples of process measures that will be collected include quality, quantity, and timing of worker contact with families; and worker skills, style, and approach to working with families. The level and nature of services provided also will be examined. By closely documenting implementation issues and pathway differences, the evaluation will provide valuable material for future sites that may wish to replicate successful programs. Early feedback to the participating sites may serve to improve program fidelity and may create a continuous quality improvement mechanism.

Second, the process evaluation component will assess how the sites have implemented their DR programs (implementation drivers). This assessment will involve identifying barriers to implementation, successful strategies for overcoming those barriers, and the critical role of staff buy-in and leadership during the process. Information will be gathered on: agency practices that are put into place to institute and maintain the DR program; attitudes of agency

staff toward DR; and community feedback and involvement during the design, implementation, and sustainability phases.

Third, the process evaluation will look at the effects that DR has on the agency itself. Prior research suggests that DR has a number of positive influences, including improved job satisfaction and decreased turnover among caseworkers. The evaluation will assess job satisfaction and turnover rates among caseworkers in each pathway. It also will monitor trends in the number of reports screened into the Child Protective Services (CPS) system. It is possible that screeners will begin to screen in a higher number of reports of low-risk families if DR is perceived as an effective means of ensuring that families receive needed services.

The current report, however, serves a more limited purpose and summarizes the information gathered during a site visit of the Illinois DR program in June 2011. A critical element of the process evaluation, the site visit gathers information from existing documents, frontline staff, supervisors, administrators, and other child welfare stakeholders to describe (1) the early stages of DR implementation in Illinois; (2) the core implementation components used in Illinois during the early implementation phases; and (3) the DR program that has been implemented, *both in written documentation and as described by staff*. This report is intended to provide feedback to Illinois child welfare administrators about the exploration, installation, and early implementation of DR and to identify opportunities for improvement. The information gathered through the site visit may also inform other child welfare implementation efforts that are occurring in Illinois. A second site visit of the Illinois DR program will occur in 2012 and will document the full implementation of the program and any innovations that occurred as a result of lessons learned.

The theoretical framework used for this report is that developed by Fixsen and colleagues (2005) following their review and synthesis of existing implementation evaluation literature.³ Implementation science is an emerging field of research that examines the adaptation of evidence-based interventions within real-world settings. A growing body of literature reflects the difficulty of translating research findings to effective practice, especially in the delivery of human services.⁴ The DR program, like others undertaken in the last four years by the Illinois Department of Children and Family Services (DCFS, or the Department), has benefited from the implementation science framework in helping to understand the necessary core components

³ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

⁴ Aarons, G.A., Hurlbert, M., & Horwitz, S.M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38, 4-23.

that led to child welfare practitioners using innovations successfully and effectively. These core components (also known as implementation drivers) are essential to successful human service change efforts. *Competency drivers* are mechanisms that help to develop, improve, and sustain the practitioner's ability to implement the intervention. *Organization drivers* are mechanisms that help to create and sustain hospitable organizational environments to support those practitioners in the delivery of the intervention. According to this framework, leadership must attend to both competency and organization drivers to bring evidence-informed practices successfully from concept to reality. These interactive processes are both integrated and compensatory in that a weakness in one component can be overcome by strengths in other components, but each one is critical and should be aligned to ensure the increased likelihood of success.

This site visit report is organized into the following sections:

1. Methodology. This section describes the methods that were used to collect the information used in the analysis for this report. It describes the data collection instruments that were developed, the data collection procedures, and the data analysis.
2. Overview of the Illinois Department of Children and Family Services. The section provides a brief overview of the child welfare system in Illinois prior to the implementation of DR, with a primary focus on the description of Child Protective Services. It also briefly describes other child welfare reforms being implemented in Illinois at or around the same time as DR.
3. Exploration and Planning for Differential Response in Illinois. This section describes the period before implementation when the State assessed the potential match between DR, community needs, and available resources to make the decision about whether to proceed. This section also discusses the efforts made to obtain buy-in from staff, organizations, and child welfare stakeholders and to mobilize the necessary political and financial supports.
4. Installation of Differential Response in Illinois. This section discusses the initial steps and structural supports taken by the Department after the decision was made to go forward with DR implementation, but before the first family was served.
5. Overview of the Illinois Differential Response Program. This section describes the Illinois DR program in more detail, including report screening and eligibility determinations, reassignment of reports from the DR pathway to investigations, initial contact and

assessment, case opening and services (including cash assistance services), caseloads and staffing, and case closure.

6. Site Visit Results: Differential Response Program Fidelity. This section uses the information gathered in the focus groups and interviews to describe current DR practice in Illinois.
7. Site Visit Results: Competency Drivers. This section discusses the implementation components related to staff selection, training, supervision and coaching, and performance evaluation.
8. Site Visit Results: Organization Drivers. The organizational structures necessary to support DR practice are discussed in this section, including decision support data systems, facilitative administration, and systems interventions.
9. DCFS Organizational Culture and Resistance to Differential Response. This section describes the resistance to DR among certain sections of the Department's organizational culture.
10. Conclusions and Recommendations. This section offers suggestions for program improvement, based on data collected during the site visit as well as the empirical literature on implementation best practice.

Methodology

Procedures

Information was collected during the site visit through three primary methods: (1) document review and analysis, (2) focus groups with workers and supervisors in the DR and investigation pathways, and (3) individual interviews with key informants who had unique knowledge of DR implementation and program development.

The DR project director supplied a list of documents related to the DR program in Illinois, including: (1) DR legislation; (2) Illinois Department of Children and Family Services DR rules and procedures; (3) assessment and service forms used by DR workers; (4) DR agency program plans; and (5) other materials, such as the Memorandum of Understanding between the Department and the State employees union. The content of these documents was then reviewed and analyzed, and is incorporated in this report as needed and relevant.

DR Evaluation Director Tamara Fuller, PhD, and Judge Kathleen Kearney, senior analyst, conducted the majority of the focus groups, although a few of the groups were conducted by only one of the evaluators due to logistical reasons. The evaluators conducted the focus groups with workers and supervisors in the DR and investigation pathways over a 2-week period in June 2011. Separate focus groups were conducted with DR workers, DR supervisors, DCFS investigators, and DCFS investigation supervisors. Groups were conducted in each of the four DCFS geographic regions of the State: Cook, Northern, Central, and Southern. A member of the QIC-DR (either Dr. Brett Brown or Amy Rohm) also attended most of the focus groups and assisted with note-taking. All focus groups were recorded and transcribed for analysis. Focus groups were typically held in a community-based service agency or DCFS office. In addition to the worker and supervisor focus groups, another was conducted with the DR Project Steering Committee of the Child Welfare Advisory Committee (CWAC).

Key informant interviews were conducted with DCFS Director Erwin McEwen (interviewed by Dr. Tamara Fuller), DCFS DR Project Director Womazetta Jones (interviewed by Dr. Brett Brown), and DCFS Deputy Director of Child Protection George Vennikandam (interviewed by Judge Kathleen Kearney). Interviews with Director McEwen and Deputy Director George Vennikandam were recorded and transcribed. The interview with DR Project Director Womazetta Jones was not recorded due to technical difficulties, but the interviewer took extensive notes throughout the interview and these were included in the analysis for this report. All focus group and interview activities and protocols were reviewed and approved by the Institutional Review Boards of the University of Illinois at Urbana-Champaign and the Illinois Department of Children and Family Services. Signed informed consent was obtained from each individual prior to participation.

Instrument Development

The focus group and interview protocols were developed in collaboration with the QIC-DR cross-site and local evaluation teams. A set of questions was developed to assess both fidelity to the DR core components outlined by the QIC-DR and fidelity to the Illinois DR program described in state legislation, policy, or procedures. These fidelity questions assessed the topics of DR eligibility determinations, reassignment from one pathway to another, assessment, service delivery, and case closure. A second set of questions was developed to assess the early implementations activities and the core implementation drivers as described in the Fixsen et al. (2005, 2009) implementation framework. The implementation questions assessed the topics of staff selection, training, supervision, coaching, performance evaluation, decision support data systems, facilitative administration, and systems intervention and external stakeholders. Copies of the focus group and interview protocols are provided in Appendix A.

Participant Recruitment

To gain a better understanding of the potential differences in DR implementation and practice throughout the State, focus groups were conducted regionally in each of the four major DCFS administrative regions: Cook, Northern, Central, and Southern. In each region, participants were invited from the following groups:⁵

- 1) DCFS DR specialists: Since there are only a small number of DR specialists in each region, all workers in this category were invited to attend the focus group in their region.
- 2) DCFS DR supervisors: Since there are only five DR supervisors in the entire state, all were invited to attend one focus group.
- 3) Strengthening and Supporting Families (SSF) caseworkers: Since there are only a small number of SSF workers in each region, all workers in this category were invited to attend the focus group in their region.
- 4) Strengthening and Supporting Families (SSF) supervisors: Since there are only a small number of SSF supervisors in each region, all workers in this category were invited to attend the focus group in their region.
- 5) DCFS investigators: Since there are a large number of investigators in each region of the State, several (one to four) DCFS field offices were chosen in each region and all the investigators in those offices were invited to attend the focus group.
- 6) DCFS investigation supervisors: The investigation supervisors from each of the DCFS field offices selected in each region for the investigator recruitment were invited to attend the focus group (separate from the investigators they supervise).

For all groups, invitation letters were sent to each person individually via email (see Appendix B for a copy of the recruitment letter). Table 1 shows the final number of participants in each group. The focus group with the SSF supervisors in the Northern Region was cancelled, because only one of the three supervisors was able to attend on the scheduled date and time.

Table 1. Number of focus group participants per region and group

	DR Specialists	DR Supervisors	SSF Workers	SSF Supervisors	Investigators	Investigation Supervisors
Cook	6		9	3	4	5
Northern	5	1	7	-	7	6
Central	5	2	10	3	5	7
Southern	2		7	2	3	4
Total	18	3	33	8	19	22

⁵ The roles and job descriptions of these types of workers are described more fully in the Overview of the DR Program section.

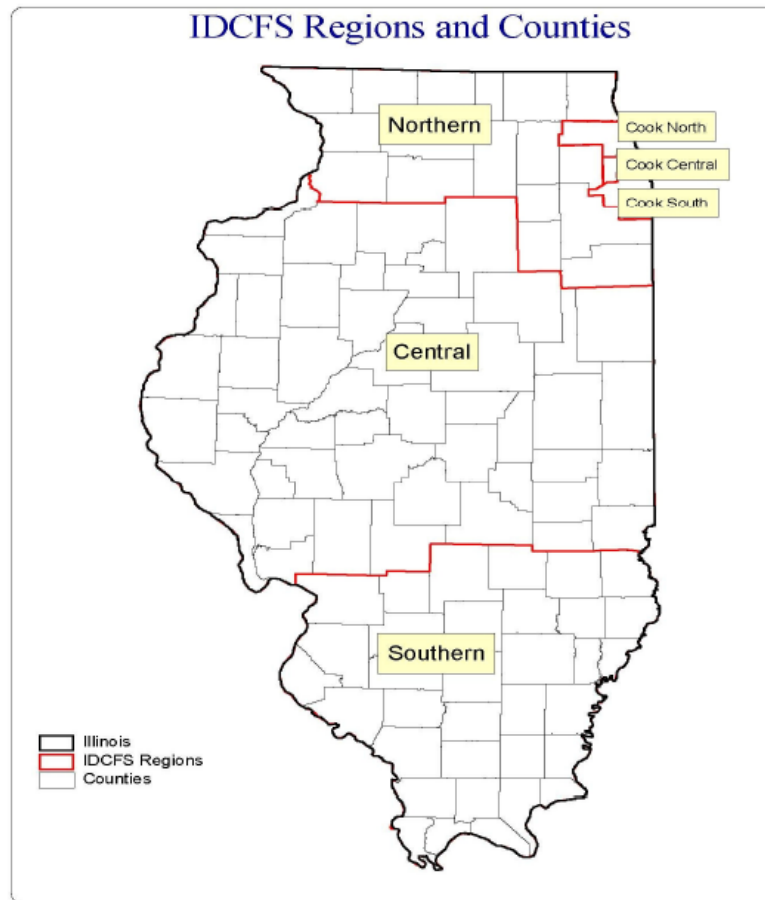
Data Analysis

An independent transcriptionist service transcribed verbatim the focus group and interview audio-recordings. The Children and Family Research Center (CFRC) evaluation team agreed on a coding framework organized using the Fixsen implementation drivers. The three CFRC evaluators reviewed and manually coded and categorized the transcripts of the focus groups and stakeholder interviews. Two of the evaluators (Dr. Fuller and Judge Kearney) participated in primary data collection; the third (Dr. Sandra Lyons) did not and provided an independent perspective. The evaluation team discussed their findings, reaching inter-coder agreement and interpretive convergence on each. Data triangulation through a review of the observational notes taken by the QIC-DR representatives (Amy Rohm and Dr. Brett Brown), and DR program documents confirmed and corroborated the findings. Representative quotes are included in this report as illustrative examples. In some circumstances, the quotes are not verbatim and may have been altered to improve readability and grammar.

Overview of the Illinois Department of Children and Family Services

Child protective services in Illinois are administered through a centralized state-run system conducted solely by DCFS rather than under contract to locally based private child welfare or law enforcement agencies. Operationally, the Department is divided into six administrative regions, with three located in Cook County (the greater Chicago area) and three in the balance of the State (see Figure 1). The Northern and Central regions are less populous than Cook County regions but contain moderately sized cities. The Southern Region, with the exception of East St. Louis, is predominantly rural.

Figure 1: DCFS Administrative Regions



Map produced by: Agency Operations Analysis, Division of POS Monitoring/QA

In FY 2011 (ended June 30, 2011) the Illinois State Central Register (SCR; commonly referred to as the child abuse hotline) received 258,999 calls that were screened for potential abuse and neglect. Of those calls, 63,043 (24.3%) met criteria for a CPS investigation and involved 101,402 children and 63,043 families.⁶ The percentage of hotline referrals screened in for investigation in Illinois is much lower than the latest available national data average of 61.9% in federal fiscal year 2009.⁷ In Illinois, CPS workers substantiate that credible evidence exists that a child was maltreated in approximately 1 of every 4 child reports of maltreatment (27.6%), which is slightly higher than the average national substantiation rate of 22.1%. In FY 2011 there were

⁶ Illinois Department of Children and Family Services (2011). *Monthly executive statistical summary for July 2011*. Retrieved from <http://www.state.il.us/DCFS/docs/execstat.pdf>.

⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2010). *Child Maltreatment 2009*. Washington, DC: U.S. Government Printing Office.

4,329 children and youth taken into protective custody in Illinois (16.3%), which is slightly lower than the national average of 20.8%.⁸

Child Protective Services in Illinois Prior to Differential Response

Since the inception of the Child Endangerment Risk Assessment Protocol (CERAP) structured safety assessment in 1995, Illinois had not made any substantial changes to its child protective system. The CERAP has been associated with significant improvements in both short-term (defined as 60 days) and 6-month maltreatment recurrence rates over time.⁹ Nevertheless, Illinois failed to meet the federal standard for maltreatment recurrence in both the first (2003) and second-round (2009) Child and Family Service Review (CFSR). Few families in Illinois received services through the public child welfare system following an investigation, even if maltreatment was substantiated. According to the most recent available federal data, 45% of children with indicated maltreatment in Illinois were provided with post-investigation services, compared to the national average of 61.2% of the 47 states reporting. An even smaller percentage of children with unsubstantiated maltreatment reports were provided with services in Illinois (11.4%) compared to the 26.2% national average.¹⁰ In addition, in 2009 Illinois had the lowest child removal rate in the nation.¹¹

Reports of child abuse and neglect are governed by rule as set forth in Title 89 of the Illinois Administrative Code §300 et seq. Prior to the installation of DR in Illinois on November 1, 2010, the State had only one response available to families whose child maltreatment reports were screened in and met the legal threshold for action: a maltreatment investigation. The investigative process begins with a call to the State Central Register (SCR), which is available 24 hours per day, 7 days a week. Reporters may call either 1-800-25-ABUSE to reach the SCR or their local DCFS office, where full-time investigative staff are located. When a call comes in, the SCR intake worker screens the information given by the reporter to determine whether the call meets the criteria for a maltreatment report. These criteria include:

- The reporter must have reasonable cause to believe that a child has been abused or neglected; and
- The alleged victim(s) must be less than 18 years of age; and

⁸ Ibid.

⁹ Fuller, T.L. & Nieto, M. (2010). *Illinois Child Endangerment Risk Assessment Protocol: FY 2010 annual evaluation*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

¹⁰ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). *Child Maltreatment 2010*. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can.

¹¹ Fuller, T.L. & Kearney, K.A. (Eds.) (2010). *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, stability, continuity, permanence and well-being*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

- The alleged victims(s) either must have been harmed or must be in substantial risk of physical injury; and
- There must be a specific abusive or neglectful incident that falls within the description of an allegation and that caused harm to the child or a set of circumstances that leads a reasonable person to believe that a child is at risk of harm; and
- If the allegations presented were true, the situation would constitute abuse or neglect as defined in the Abused and Neglected Child Reporting Act (ANCRA);
 - For abuse, the alleged perpetrator must be the child’s parent, immediate family member, any individual who resides in the same home as the child, any person who is responsible for the child’s welfare at the time of the incident, or a paramour of the child’s parent;
 - For neglect, the alleged perpetrator must be the child’s parent or any other person who was responsible for the child at the time of the alleged neglect.

Table 2 shows child abuse and neglect allegations accepted for investigation in Illinois. The allegation definitions focus on the harm or the risk of harm to the child. Many of the allegations of harm can be categorized as resulting from either abuse or neglect. Abuse allegations are coded with a 1- or 2-digit number under 30; neglect allegations are coded with a 2-digit number greater than 50.

The SCR screener transmits the accepted report and all pertinent information to the local investigative team. A DCFS investigator initiates the investigation by establishing an unannounced in-person contact (or makes a good faith effort to do so) with the alleged child victim(s) within 24 hours (or sooner if immediate harm is alleged). The investigative process is governed by specific timeframes. The initial safety assessment (using the CERAP) should occur within 24 hours after the investigator sees the alleged child victim(s). The final determination of whether the report is substantiated is to occur within 60 days, although an additional 30-day extension may be granted under certain circumstances.

The investigator can make one of two findings: a report can be “unfounded,” meaning there is no credible evidence that the child was abused and/or neglected, or a report can be “indicated,” meaning credible evidence is found. The name of the perpetrator of an indicated incident of maltreatment is placed on a registry and retained according to a schedule based on the seriousness of the allegation. The investigator may offer services or refer the child and family for services either while the report is pending or after a finding is made; however, few families receive such services.

Table 2: Illinois Allegations of Abuse and Neglect

Abuse Allegations	Neglect Allegations
Death (1)	Death (51)
Head Injuries (2)	Head Injuries (52)
Internal Injuries (4)	Internal Injuries(54)
Burns (5)	Burns (55)
Poisons/Noxious Substances (6)	Poisons/Noxious Substance (56)
Wounds (7)	Wounds (57)
Bone Fractures (9)	Bone Fractures (59)
Substantial Risk of Physical Injuries/ Environment Injurious to Health and Welfare (10)	Substantial Risk of Physical Injuries/ Environment Injurious to Health and Welfare (60)
Cuts, Bruises, Welts, Abrasions, or Oral Injuries (11)	Cuts, Bruises, Welts, Abrasions, or Oral Injuries (61)
Human Bites (12)	Human Bites (62)
Sprains/Dislocations (13)	Sprains/Dislocations (63)
Tying/Close Confinement (14)	
Substance Misuse (15)	Substance Misuse (65)
Torture (16)	
Mental and Emotional Impairment (17)	Mental and Emotional Impairment (67)
Sexually Transmitted Diseases (18)	
Sexual Penetration (19)	
Sexual Exploitation (20)	
Sexual Molestation (21)	
Substantial Risk of Sexual injury (22)	
	Inadequate Supervision (74)
	Abandonment/Desertion (75)
	Inadequate Food (76)
	Inadequate Shelter (77)
	Inadequate Clothing (78)
	Medical Neglect (79)
	Failure to Thrive (81)
	Environmental Neglect (82)
	Malnutrition (non-organic) (83)
	Lock-out (84)
	Medical Neglect of Disabled Infants (85)

Contemporaneous Child Welfare Reform Efforts

The Illinois child welfare system prides itself with being at the forefront of major child welfare reform efforts. The Department's commitment to innovative child welfare practice is evident in its record in implementing large-scale reform efforts for almost two decades. The Illinois substitute-care population exceeded 51,000 children in 1997 with 17.1 foster children for every 1,000 children, resulting in the highest prevalence rate in the nation. Through a series of interrelated permanency planning innovations, including the use of performance-based contracting and a subsidized guardianship waiver, the substitute care population was reduced to fewer than 16,000 children within a decade. In child protective services, the State's last significant reform effort began with the introduction of the structured safety assessment protocol in 1995.

In 2006, the Department began a process of transforming its overall practice model to be *family-focused, strengths-based, and trauma-informed*.¹² Through its partnerships with research universities, the Department adopted a comprehensive statewide trauma-informed practice model. A key component of this newly integrated trauma perspective was the development of trauma-informed curricula to train the entire state child welfare system staff, both public and private, through the Department's Learning Collaboratives, which are designed to enhance the transfer of learning from the classroom to the field.

Concurrent with the trauma initiative, Illinois piloted and adopted the Center for the Study of Social Policy's *Strengthening Families* program, which emphasizes prevention rather than amelioration of abuse through the building of six protective factors: (1) parental resilience; (2) social connections; (3) knowledge of parenting and child development; (4) concrete support in times of need; (5) children's social and emotional development; and (6) healthy parent and child relationships. The *Strengthening Families* program works through early child care and education programs, child welfare collaborations, and parents directly to prevent maltreatment.¹³

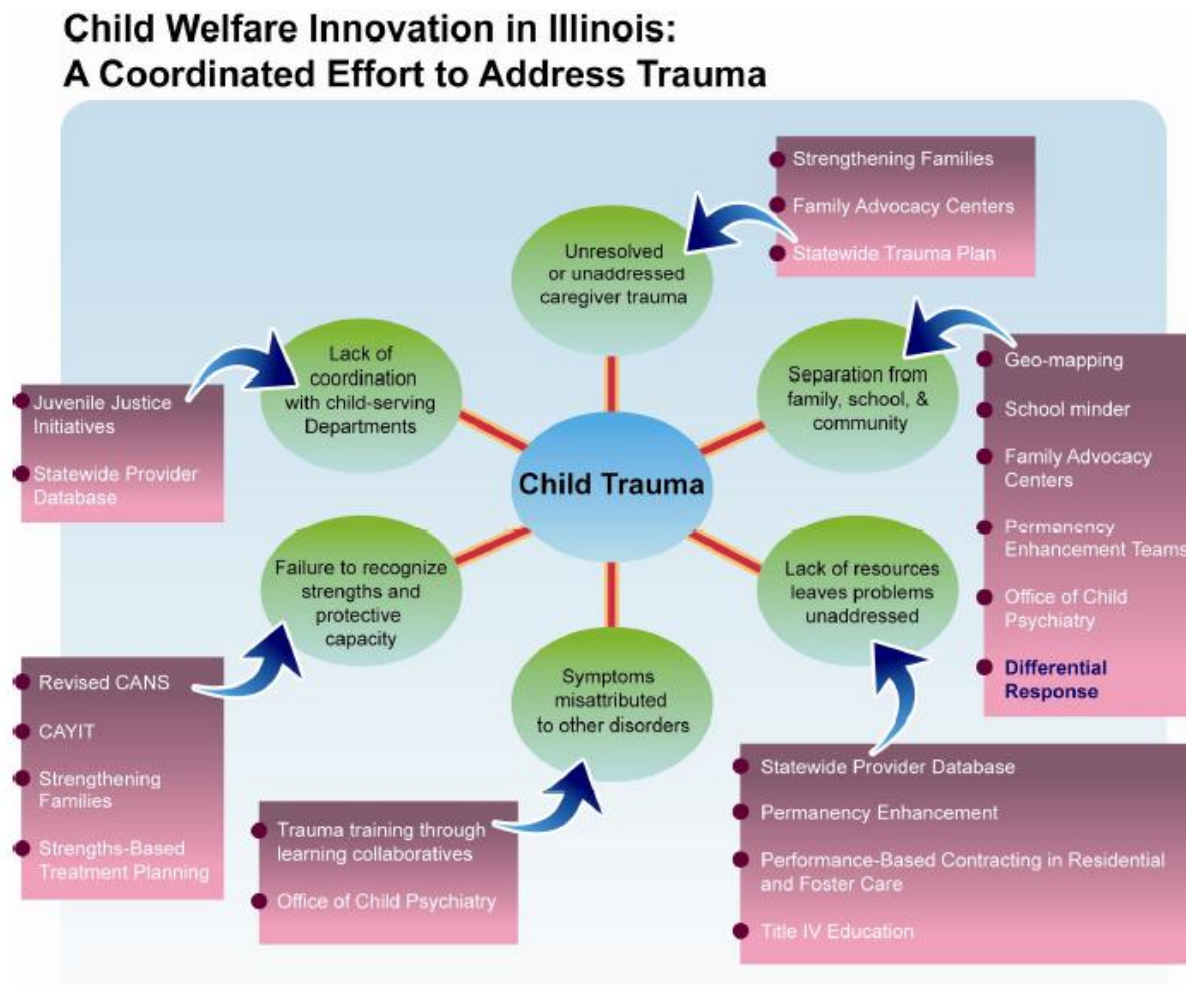
The vision of the current Illinois child welfare system is to integrate the protective factors of the *Strengthening Families* program model with its trauma practice resulting in a true paradigm shift through the resolution of child and family problems so that: children are reconnected with their families, schools, and communities; resources are identified to serve children's needs; symptoms are recognized and properly diagnosed; children's and families' strengths and protective capacities are recognized; the Department coordinates care with other child-serving

¹² Griffin, G., McEwen, E., Samuels, B., Suggs, H., Redd, J., & McClelland, G. (2011). Infusing protective factors for children in foster care. *Psychiatric Clinics of North America*, 34, 185-203.

¹³ See <http://www.cssp.org/reform/strengthening-families> for more information about Strengthening Families.

agencies; and intergenerational trauma is understood and the caregiver’s trauma is addressed. By building protective factors into the child welfare system as a whole, quality practice is supported and children heal.¹⁴ The Department has adopted a broad array of programmatic strategies to advance this vision. Figure 2 depicts the initiatives and innovations currently under way in Illinois.

Figure 2: DCFS Programmatic Strategies to Support System Innovation and Integration



The second round of the federal Child and Family Service Reviews (CFSR) was held in Illinois in 2009. Five core strategies were outlined in the Department’s Program Improvement Plan (PIP), including the implementation of DR. The PIP indicates the Department’s belief that DR will have an impact on maltreatment recurrence “because it represents a definitional shift in conditions that are considered maltreatment. In other words, recurrence will be reduced since

¹⁴ Griffin, G., McEwen, E., Samuels, B., Suggs, H., Redd, J., & McClelland, G. (2011). Infusing protective factors for children in foster care. *Psychiatric Clinics of North America*, 34, 185-203.

the definition of maltreatment is restricted; therefore, the overall level of maltreatment is reduced.”¹⁵ Another improvement strategy outlined in the PIP is the introduction of a revised CERAP tool, which will include a new risk assessment instrument incorporating various elements from the Child and Adolescent Needs and Strengths (CANS) assessment tool. The statewide roll-out of this Enhanced Safety Model is scheduled to occur by December 2012. Finally, the PIP includes continued strengthening of the Family Advocacy Centers (FACs). FACs were first established in 2004 to provide advocacy and community-based support for families to prevent children from coming into care whenever possible, and to assist those families whose children are in substitute care to successfully follow through on planning goals thereby leading to reunification. The Department committed to establishing a FAC by the end of calendar year 2011 to serve the Rockford and broader Winnebago County area with advocacy and services especially designed to target the Spanish-speaking community. According to the PIP, the FAC shall provide an array of services that DR families can access including: parent coaching, intensive mediation, counseling, referral and linkage, 24-hour crisis response, after-school programs, domestic violence support groups, and skills-building workshops.

Exploration and Planning for Differential Response in Illinois

As part of the exploration and planning phase of the implementation process, it is important to determine if a program can be sustained over time before making an informed decision about whether to implement it.¹⁶ This phase is critical to assess community needs, the evidence base of the practice being implemented, the program needs, and the availability of community resources to support it. This pre-implementation phase is best seen as the opportunity for service providers, community planning groups, advisory boards, consumers, program purveyors, and other related stakeholders to exchange information to:

- identify the need for the intervention, considering the information available;
- acquire information through the interaction with one another;
- assess the fit between the intervention program and community needs; and
- prepare the organization, staff, and resources by mobilizing information and support.¹⁷

¹⁵ Illinois Department of Children and Family Services, *Program Improvement Plan, January 31, 2011*. Retrieved from http://library.childwelfare.gov/cwig/ws/cwmd/docs/cb_web/SearchForm.

¹⁶ Fixsen, D. L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

¹⁷ Kraft, J.M., Mezoff, J.S., Sogolow, E.D., Neumann, M.S., & Thomas, P.A. (2000). A technology transfer model for effective HIV/AIDS intervention. *AIDS Education and Prevention, 12 (Supplement A)*, 7-20.

The State of Illinois used these strategies during the exploration and planning phase to learn more about DR, determine which program components would best fit the needs of Illinois families, and generate buy-in from critical child welfare stakeholders. In his interview, DCFS Director Erwin McEwen identified two primary reasons for exploring the use of DR: the low rate of services being provided to families even in indicated cases; and the desire to intervene at the earliest possible opportunity, to prevent repeat maltreatment and the likelihood of more significant harm in the future. He stated:

We had such a low rate of involvement—formal involvement in indicated cases. The number—I think it was like only 20% of the indicated cases received services post-investigation. That’s split between placement and intact family services. Even though there was this prevailing belief that we did refer those people to community services, we don’t know what they really got.

The other thing was that we also saw families that had been indicated multiple times in a progression to more serious problems. Sometimes those cases that we indicated, we really didn’t do much of anything with—an indicated report in and of itself really did not stop the trajectory of the family problems. I thought that doing something differently might stop that trajectory.

As part of the exploratory process, Director McEwen asked the Children and Family Research Center (CFRC) of the University of Illinois at Urbana-Champaign to review existing literature on DR. Following the CFRC’s submission of findings, Director McEwen convened a task group of interested child welfare stakeholders to attend a 2-day peer-to-peer technical assistance conference sponsored by Casey Family Programs with representatives from Minnesota who were responsible for the implementation and management of DR in that state. The event, which occurred on July 15-16, 2009, highlighted the lessons learned and allowed for extensive dialogue between Minnesota staff and the Illinois child welfare stakeholders to discuss the potential benefits and challenges of bringing DR to Illinois. At the end of this 2-day meeting, an action plan was created that outlined the steps that would be taken to develop the Illinois DR program.

One of these action steps was the development of a DR task group that would carry the momentum from the peer-to-peer meeting forward and work together to envision and design the program. In addition to most of the Illinois participants who had been at the peer-to-peer meeting, other DCFS staff were invited to participate in the DR task group, including staff from the DCFS Office of the Inspector General (OIG), the DCFS Deputy Director and Associate Deputy Directors of Child Protection (DCP), counsel from the Cook County public guardian’s office, staff

from DCFS Divisions of Training and Information Technology/Statewide Automated Child Welfare Information System (SACWIS), and research staff from the CFRC at the University of Illinois. After an initial day-long meeting on August 31, 2009, the DR task group formed four subcommittees to develop various aspects of the Illinois DR program: Staffing, Training and Tools, Data and SACWIS, and “Factors.” The Factors subcommittee, composed largely of staff from DCP and the OIG, was tasked with developing an initial set of criteria for determining which cases would be eligible to receive DR services. Members reviewed each of the current DCFS allegations (Table 2) and examined data on the number of children who received each allegation in the previous year, the age and race of these children, and the types of harm they experienced. Each subcommittee met two to four times during the month of September 2009 to decide on critical components of the DR program, such as eligibility criteria, staff qualifications, training requirements, assessment tools, and SACWIS modifications. At the end of the month, each subcommittee gave its recommendations to Director McEwen and the initial DR task group was then dissolved. Many, although not all, of these recommendations were included in the DR program that was later implemented in Illinois.

In his interview, Director McEwen described several issues that the group considered when designing the initial DR program, including staff selection, public versus private agency selection, and workforce readiness and training:

Director McEwen: When considering who would provide the DR services, the prevailing wisdom was that this would be child protective investigators. I always thought Intact Family Workers would be the better suited to do it, because they already were used to navigating risk in these families while the kids were at home.

Also, at the peer to peer TA [technical assistance] meeting in Minnesota the idea of having private agencies provide services was introduced. I always thought that the foster care agencies may have a challenge in doing this work, because they’re used to having this mandated engagement, and this was going to be voluntary engagement. I thought this represented a different skill set than what foster care agency workforce might have.

A critical first phase of a systemic change process is creating readiness for change through enhancing both the motivation and capability of stakeholders.¹⁸ Fixsen et al. (2005) further refine this phase as necessary to:

¹⁸ Adelman, H.S. & Taylor, L. (2003). On sustainability of project innovations as systemic change. *Journal of Educational and Psychological Consultation*, 14, 1-25.

- Develop an understanding of the local big-picture context for all relevant interventions; develop an understanding of the current status of efforts; delineate how the innovation can contribute with respect to the larger agenda; articulate cost effective strategies.
- Mobilize interest, consensus, and support among key stakeholders; identify champions and other individuals who are committed to the innovation; plan and implement a social marketing strategy to mobilize a critical mass of support; plan and implement strategies to obtain support of key policy makers.
- Clarify feasibility; clarify how the functions can be institutionalized through existing, modified, or new infrastructure and operational mechanisms, clarify how necessary changes can be accomplished; and formulate a long-range strategic plan.¹⁹

Department leadership determined that a comprehensive communication plan to explain DR to DCFS child protective services and child welfare staff and local community stakeholders was a necessary first step to embed DR as part of the Department's bigger vision of child welfare reform. They also believed the communication outreach would increase interest in the DR program, mobilize support, and allay fears and clear up misconceptions. A series of 11 "town hall meetings" was held throughout the State between August and October 2010. DCFS Director McEwen and DR Project Director Womazetta Jones presented the proposed DR program to frontline staff, answered questions, and received comments. Child welfare leadership summits also were held in each DCFS region bringing together DCFS regional leadership staff, local private agency executives, and other invited community leaders and child welfare stakeholders for a day of presentations on various DCFS initiatives, including DR. Finally, as part of the statewide roll-out of DR, regional summits devoted solely to DR were convened in April 2011. The Department's DR specialists and supervisors, the private agency SSF workers and supervisors, state and regional DCFS leadership staff, local community service providers, and DCFS child protective supervisors were invited to participate. In her interview, DR Project Director Jones reported that as of June 2011 more than 25 presentations on DR had been made throughout the State.

All focus group and individual stakeholders interviewed were asked how they first heard about DR. The responses were varied and broad-ranging. The majority of frontline staff learned about DR from communication with a colleague or supervisor, through job postings of new DR

¹⁹ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

positions, or at work-related meetings such as a staff meeting or quality assurance meeting where DR was discussed.

DR specialist: I first heard about it at an all-staff meeting, like, when it was in, like, early development and it was kind of an up-and-coming thing; and then I didn't hear much about it for a long time.

DR specialist: I think I heard about it at a QA meeting--a quality assurance meeting.

DR specialist: I think it was right before the posting came out, or when the posting came out. It was a pilot project that the department was doing.

Investigator: I first heard about, oh, man, it was months ago. I did some kinda online training or teleconference training.

SSF worker: I actually went to a conference where the director was talking about the DR prior to it being you know, out. And he said look for the postings, and so he talked about it in that conference....

Supervisors and members of the DR Project Steering Committee were more likely to have learned of DR by attending a meeting where the director spoke about DR, such as at a Child Welfare Advisory Committee meeting or a leadership summit; by reading an article about DR; or by attending a national meeting where the DR was discussed:

SSF supervisor: I attended a meeting that Director McEwen was giving an informational talk about it—it was still in its theoretical stages. So that was probably almost a year before the actual implementation of it. He was just describing this unique concept of a DCFS worker and a POS [Purchase of Service, private agency contractor] going out together and not doing an investigation, so it was just information only at the time.

DR Project Steering Committee member: I was at a meeting with the director in, I think, February or January of '09 about other legislative initiatives. He brought this up as something he was looking into and [he said] 'I'll send you guys some information I have.' A couple weeks later, an amendment was filed to what was then the shell bill that basically put it out there.

DR Project Steering Committee member: What I can remember, probably a couple years ago, when the director talked about wanting to meet with communities and just kind of discuss with communities in terms of some of these stats. It was a way of presenting the whole idea, concept around Differential Response.

Installation of Differential Response in Illinois

Once the decision was made to adopt DR, the State had tasks and activities to accomplish before the first consumer could be served. These activities defined the installation stage of DR implementation and revolved around putting in place the structural supports necessary to move the program from concept to practice. These start-up tasks typically include ensuring the availability of funding streams; developing human resource strategies; and developing policy, referral mechanisms, reporting frameworks, and outcome expectations. During this installation phase, additional resources may be needed to realign current staff, hire new staff members to meet the qualifications required by the program, secure office space and technology, and advance up-front costs while staff members are in training.²⁰

Legislative Changes

The passage and enactment of the Illinois Differential Response Program Act (Public Act 096-0760) in August 2009 was a significant accomplishment that was conducted simultaneously with the exploration and planning phase. By amending the Illinois Children and Family Services Act and the Abused and Neglected Child Reporting Act (ANCRA), it provided the authority for the Department to implement a 5-year demonstration of DR. This legislation includes the core elements of DR as identified by the QIC-DR, including a discrete pathway for eligible cases and the provision of voluntary services with no formal determination of maltreatment. The legislation also requires an independent evaluation be conducted to determine if the DR program is meeting its stated goals.

According to Director McEwen, the process of introducing DR legislation to Illinois lawmakers was a well-planned and strategic process. The strategy was to present the idea to a few key members of the Illinois Senate and then introduce it in the Illinois House of Representatives. Director McEwen identified a small number of senators who had a human services background and discussed the idea with them. According to the Director, the senators immediately “got it and understood it” and agreed to sponsor the legislation. Sponsored by Senators Mattie Hunter, Jacqueline Y. Collins, Emil Jones III, and Martin A. Sandoval, Senate Bill 0807 (SB0807) was originally filed on February 6, 2009.²¹ It passed in the Illinois Senate on March 26, 2009.

²⁰ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

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<http://www.ilga.gov/legislation/billstatus.asp?DocNum=0807&GAID=10&GA=96&DocTypeID=SB&LegID=41702&SessionID=76&SpecSess=>

Director McEwen indicated that things did not go as smoothly when the legislation was introduced in the Illinois House of Representatives, noting opposition from several parties, including the union, the Cook County Public Guardian, and the DCFS Office of the Inspector General. The union's opposition centered on the potential impact of DR on the DCFS workforce and the amount and type of work that they do. The opposition from the public guardian and the OIG focused more on the potential impact on child safety, since there would not be a requirement to make initial contact within 24 hours of the accepted report. Director McEwen described how he helped move the legislation forward:

That's a huge cultural shift in Illinois. They were worried that kids could be languishing in dire situations and DCFS is not going to be out there in 24 hours. Part of that discussion was really saying that... 'Hey, a lot of times when we go out there in 24 hours, the precipitating incident...could have happened weeks ago. It could have happened months ago. The kid just discloses now.' Also, DR would not be applicable for serious or egregious cases.

At the end of the day I got all three sides to withdraw their opposition in writing based on an agreement that we would sit down and we would talk about it. We would hammer out what this looks like. We would bring everybody into the room. I came up with the novel idea of asking them to trust me.

Director McEwen believes that the fact that there was a "sunset clause" for the DR program in Illinois was another contributing factor to it getting passed in the legislature. The legislation calls for a 5-year demonstration period: If the results are not as expected, the project will not move forward. According to the Illinois General Assembly website, SB0807 arrived in the House of Representatives on March 26, 2009. Sponsors included Representatives Mary E. Flowers, Constance A. Howard, LaShawn K. Ford, and Monique D. Davis. It passed both houses on May 30, 2009, and was approved by Illinois Governor Patrick Quinn on August 25, 2009, as Public Act 96-0760 (Appendix C).

Establishment of Rules and Procedures

Following enactment of the legislation authorizing the DR demonstration project, the Department promulgated procedures to enact the program. The Illinois Administrative Code was amended in August 2010 to add a new section to allow for DR (Illinois Administrative Code §300.45). The amendment provides for DR to be implemented without a formal substantiation of alleged maltreatment and provides that a record of the case will not be entered in the State Central Register. Further, it provides that participation is voluntary and that cases will be closed if families refuse DR services and no safety and/or risk issues are identified as a result of the safety assessment. However, it also provides that if it is determined that a child's safety is compromised by the family's refusal, the case may be reassigned to the investigative pathway. The rule makes clear that if at any time during DR service provision the DR caseworker has reasonable cause to believe that a child in the family has been or is being abused or neglected and is at risk of harm, the caseworker will contact the hotline without delay to make a report of abuse or neglect. Please see Appendix D for a copy of the DCFS Differential Response Rule and Procedures.

Formation of a DR Project Steering Committee

To ensure proper oversight of the preparation and planning process for DR, a Differential Response Project Steering Committee was established under the auspices of the Illinois Child Welfare Advisory Committee (CWAC). CWAC was created by executive order of the governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department on "programmatic and budgetary matters related to the provision of purchase of child welfare services" (Illinois Administrative Code §428.50). All CWAC subcommittees and workgroups have representatives from both the public and private sectors. The CWAC subcommittees and workgroups are the primary means used by the Illinois child welfare system to ensure meaningful collaboration, effective feedback, and communication between the Department and private-sector partners on policy and practice matters. Project steering committees have been established under CWAC for specific reform efforts with system-wide impact such as performance based contracting.

The CWAC DR Project Steering Committee was established in January 2010 with appointed members including representatives from private child welfare agencies, the Office of the Public Guardian, *Strengthening Families Illinois*, the Child Care Association of Illinois (CCAI), the Illinois Collaboration on Youth (ICOY), and the DR evaluators. The DR Project Steering Committee is co-chaired by DCFS DR Project Director Womazetta Jones and Richard Calica, CEO of the Juvenile Protective Association. The Steering Committee met bimonthly from January 2010 until March 2011, at which time the meeting frequency was reduced to once every quarter.

Four subcommittees were initially formed: Policy, Curriculum, Implementation, and Data Test Workgroup. CWAC DR meetings typically include an update from Project Director Jones about the status of DR implementation in Illinois and occasional updates from various subcommittee chairs. For example, members discussed the percentage of families refusing DR services in various regions of the state and developed a case review method for examining this issue further. The evaluation director also has apprised the DR CWAC committee of evaluation activities on several occasions.

Private Agency Selection

During this stage of implementation, the Department selected the private agencies responsible for providing DR services in each of its regions. The contracts were sole-sourced to nonprofit agencies, some of which had existing contracts for child welfare-related services, and some that had provided family and home-based services in local communities but had not previously provided contractual child welfare services for DCFS. To offset start-up costs, the Department agreed to pay each agency a set case rate from the inception of the contract even though it was not expected that the agency would serve that number of clients until much later in the fiscal year.

Overview of Differential Response in Illinois

The information in this section was obtained from the document review that occurred as part of the site visit, primarily from DCFS Rule and Procedures 300.45 (“Five Year Demonstration of the Differential Response Program,” attached as Appendix D) and the FY12 Differential Response Services Program Plan (attached as Appendix F). Thus, this section describes the Illinois DR program *as it is intended to be*, according to official procedures and policy. The subsequent section of the report, titled “Site Visit Results: Program Fidelity” provides information on the DR program that was actually implemented, as described by workers, supervisors, and administrators in the focus groups and interviews.

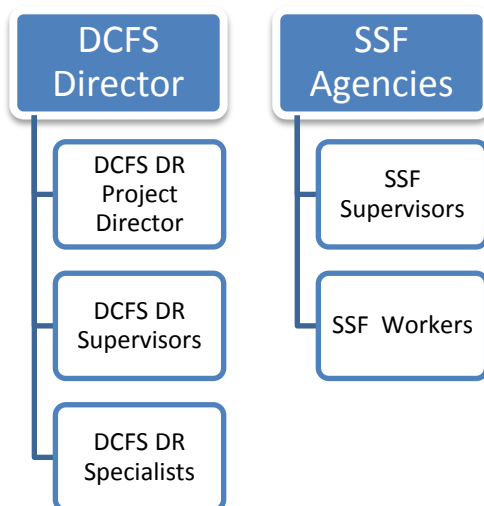
Organizational Structure and Staffing

Differential Response occupies a unique position within the organizational structure of the Illinois Department of Children and Family Services. Unlike many other States or jurisdictions, the State of Illinois did not locate DR within its Division of Child Protection or within an in-home services unit or prevention unit (in Illinois, Intact Family caseworkers are located within DCP). Instead, Illinois created a separate DR unit within the Department.

Differential Response is led by a Project Director (Womazetta Jones) who reports directly to the DCFS Director (see Figure 3r the DR organizational chart). Differential Response is staffed by

supervisors and workers employed by both the public sector (i.e., the Department) and the private sector (i.e., community-based social service agencies), who work together in paired teams. On the public side, DCFS DR supervisors are located regionally throughout the state; these supervisors report to the DR Project Director. At the time of the site visit, DCFS employed five DR supervisors in Illinois: one each in Cook County and the Northern, and Southern regions, and two in the Central region. Each DR supervisor supervises several frontline staff known as DR specialists. The DCFS DR specialists are responsible for assessing the safety of the children through completion of the CERAP following assignment of a case to DR. After completing this assessment, they must consult with their DR supervisor who then makes the final decision about whether the case is appropriate for DR or if it should be reprocessed to the investigative pathway due to the presence of safety concerns.

Figure 3: Illinois Differential Response Organizational Structure



The Department maintains contracts with several private agencies responsible for providing DR services in each of its regions. The number of agencies contracted to provide DR services in each region varies, and was established based on projected caseloads using FY09 investigation data. Within each agency, a Strengthening and Supporting Families supervisor and several caseworkers were hired. SSF caseworkers are responsible for completing a family assessment, developing a voluntary family enhancement plan, and providing direct services to eligible families.

Screening and Eligibility

The State Central Register call floor workers are responsible for processing alleged reports of neglect in accordance with Illinois Department of Children and Family Services Rules and Procedures. Reports that meet the criteria for DR are randomly assigned to DR or to an investigation and forwarded to the appropriate regional DCFS DR supervisor for review and

assignment. According to Rules and Procedures 300.45, reports that meet all of the following criteria may be assigned to the DR pathway:

1. Identifying information for the family members and their current address is known at the time of the report;
2. The alleged perpetrators are birth or adoptive parents, legal guardians or responsible relatives;
3. The family has no pending or prior indicated reports of abuse and/or neglect or prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations;
4. The alleged victims, or other siblings or household members, are not currently in the care and custody of the Department or wards of the court;
5. Protective custody of the children has not been taken or required in the current or any previous case; and
6. Allegations
 - a. The reported allegation or allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect. The following circumstances involving the allegations of Mental and Emotional Impairment, Inadequate Supervision, and Medical Neglect prohibit the report from being assigned to DR.
 - i) Mental and Emotional Impairment reports taken as abuse (Allegation #17) will be assigned an investigation pathway.
 - ii) Inadequate Supervision reports involving a child or children under the age of eight, or a child older than eight years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety will be assigned an investigation pathway.
 - iii) Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated will be assigned an investigation pathway.
 - b. All other allegations are considered to involve substantial child abuse and neglect, and are ineligible for assignment to DR.

Reassignment of Cases from DR to Investigation

Several means exist through which cases that have been randomly assigned to the DR pathway can get reassigned (also known as reprocessed in Illinois) to an investigation. A case assigned to the investigation pathway may not be reassigned to the DR pathway.

1. DCFS DR supervisors have the ability to reassign a case that has been assigned to DR into an investigation if the case does not fit the criteria for DR. Prior to assigning reports to DCFS DR specialists, DCFS DR supervisors will review all reports assigned to their teams within 2 hours of receipt in the team's electronic mailbox, excluding evenings, weekends, and holidays, to determine their appropriateness for DR. DCFS DR supervisors also will contact reporters of medical neglect allegations and may contact reporters of other allegations to confirm the information reported to the State Central Register and to obtain any additional information that will enable them to determine the appropriateness of the report for DR. The DCFS DR supervisor will redirect reports determined to be inappropriate for DR to the State Central Register for investigation.
2. If a DCFS DR specialist determines during a safety assessment that a child is unsafe, that there is an immediate need for intervention, or that maltreatment allegations are not within the scope of DR, the DCFS DR specialist shall contact the DR supervisor within 1 hour of completing the initial assessment with the family to discuss case information. If the DR supervisor determines that the report should be reassigned to an investigation due to safety concerns, the DR supervisor will contact the SCR Supervisor without delay to have the report transferred.
3. If no contact is made with the family by the sixth business day after case assignment, the DCFS DR supervisor will ensure that information in SACWIS is updated and will contact the SCR Supervisor without delay, no later than the seventh day after case assignment, to have the report transferred to investigations.
4. If the SSF caseworker (or supervisor) has reasonable cause to believe that a child has been or is being abused or neglected and at risk of harm at any time during the DR service delivery period, the SSF supervisor will contact the State Central Register Supervisor without delay to make a report of abuse or neglect and have the case reassigned to investigations.

Initial Contact with Families

The DCFS DR specialist is responsible for contacting the family by telephone within 24 hours of case assignment to explain DR, schedule an initial in-home family visit, and verify the names and dates of all family members and other persons living in the household. The initial visit is to occur in the family's home within 3 business days of the time the report is received at the State Central Register, excluding weekends and holidays. The visit shall involve the DCFS DR specialist, an SSF caseworker, adult family members, and all children.

During the initial in-home meeting, the DCFS DR specialist assesses the safety of the child(ren) in the home using a structured safety assessment instrument (the Child Endangerment Risk Assessment Protocol). If there are no safety concerns, the DCFS DR specialist, with the assistance of the SSF worker, shall explain DR to family members, including the fact that participation is voluntary. The team shall further explain that if the family declines to participate in the program the case may either be closed (if no safety issues are found) or referred for investigation based on assessed risk and/or safety issues. In addition, the DCFS DR specialist must do the following at the initial meeting with the family:

- Verify identifying information and legal relationships of all household members
- Obtain the names and addresses of any noncustodial parents
- Complete a home safety checklist
- Complete a Domestic Violence Screen
- Obtain consent for release of information signed by a family member with the authority to give consent.

Safety Assessment

In both the DR and investigation pathways, child safety is assessed during the initial visit using the Child Endangerment Risk Assessment Protocol, or CERAP. In the DR pathway, the DCFS DR specialist is responsible for conducting the initial safety assessment. To complete the CERAP, the DCFS DR specialist gathers information from family members and through other means to assess the presence (Yes) or absence (No) of 14 safety threats that may be present in the home, such as "caretaker has not, will not, or is unable to provide sufficient supervision to protect child from potentially moderate to severe harm." If the DR specialist marks a "Yes" response to a threat, the response may be mitigated by family strengths or other circumstances, which the DR specialist describes on the assessment form. The DCFS DR specialist then makes a safety decision—safe or unsafe—and obtains DR supervisor approval. If a DR case is opened for services, the SSF worker completes a second CERAP safety assessment prior to case closure.

Voluntary Services

As stated earlier, a family may refuse to accept DR services. In that situation, the following steps will be taken:

1. The DR specialist will contact the DCFS DR supervisor within 1 hour of completing the initial visit with the family to discuss case information, including the intake summary, information obtained from the reporter, observations made during the initial family visit, CERAP, information obtained from the family, and other pertinent information.
2. The DCFS DR supervisor will evaluate the case to determine whether safety issues exist and if the report should be redirected to an investigation.
 - a. If safety is a concern, the supervisor will contact the SCR Supervisor without delay to have the report transferred to investigations.
 - b. If the DCFS DR specialist and DCFS DR supervisor determine that there are no safety concerns, the case is closed without a CPS investigation.
3. In the event that the DCFS DR supervisor is not available and there are assessed safety issues, the DCFS DR specialist will contact the SCR Supervisor to complete the transfer of the report to the investigation pathway.

Case Opening and Services

If the family agrees to participate in services, the SSF worker will complete a Family Assessment (Form CFS 613-1) as part of the development of a Voluntary Family Enhancement Plan (Form CFS 613-2). The SSF worker will provide intensive strength-based, family-focused services during the service period, which will include the following:

- A comprehensive and collaborative evaluation of the family's strengths and needs that will include the family's financial status; basic educational screening for the children; and physical health, mental health, and behavioral health screening for all family members. Information obtained will be used to construct a Genogram and Ecomap for use with the family.
- Services to meet any immediate needs of the family, including food, shelter and clothing.
- A minimum of twice weekly contacts with the family, which will include the children in the household.
- Service planning.
- Services to mitigate or control the causes of neglect.
- Completion of a CERAP safety assessment in accordance with the requirements for intact families established by the Child Endangerment Risk Assessment Protocol.

- Assessment of the family's reasonable progress in resolving the issues that brought them to the attention of the Department.
- Advocacy services.
- Discharge planning.

The SSF worker will provide comprehensive case management through a mix of services tailored to meet the needs of the family. The SSF caseworker's role is expected to be that of a change agent. The SSF worker will act as a family coach or advocate, and in that role will provide crisis intervention and short-term interventions; refer to and broker for needed services, if approved by the DCFS DR Project Director or designee; identify services available in the community; transport clients to critical appointments; apprise the family of available federal, state, and local benefits; provide cash assistance and in-kind assistance; link families to community support groups; assist with proper infant care and parent education; and assist the family in creating and maintaining a safe home environment. Twice weekly in-home visits are required unless a family requests fewer contacts. If fewer weekly visits are requested by the family, the SSF supervisor must discuss the request with the family and must document the discussion in SACWIS. A minimum of one visit per week is required. The SSF agencies must deliver most, if not all, of the direct services in the client home.

SSF supervisors will provide management services including review and approval of: assessments, service plans, CERAP safety assessments, cash assistance requests, appropriateness of service referrals, case file documentation, requests for assessment service extensions, and requests to close family assessment cases.

The service period will average 60 days and will last no more than 90 days without an approved extension. Three 1-month service extensions can be approved by the DCFS DR Project Director or designee. Approval of service extensions shall be based on the child's safety and well-being, the family's needs, and progress made in mitigating those conditions that contributed to the family's involvement with the Department.

DR Cash Assistance Program

The DR Cash Assistance Program is available to families facing environmental issues (i.e., inadequate food, shelter, or clothing, or environmental neglect) to address an immediate need. Cash assistance requests are granted based on the identified need of the family. SSF workers are responsible for submitting a completed DR cash assistance form to their SSF supervisor, who forwards the form to the regional DCFS DR supervisor. Regional DCFS DR supervisors are authorized to approve requests up to \$400. Requests for more than \$400 must be approved by

the DCFS DR Project Director. Requests will be approved within 24 hours of application, excluding holidays and weekends.

Case Closure

Before formalizing a DR case closing, the SSF supervisor must receive the following documents:

1. Case Closing Summary
2. Child and Family Service Aftercare Plan
3. Case note documentation of required child interviews and documentation
4. Provider treatment reports
5. CERAP Safety Determination Form
6. Law Enforcement Agency Data Systems (LEADS) and SACWIS checks for all adult members of the household and all adults who are frequently in the home

Caseloads and Staffing

On the private-sector side, SSF workers have a maximum caseload of 12 cases per worker. The SSF worker can be assigned to work only on DR cases (i.e., they may not work in any other programs within the contracted agency). The SSF worker cannot supervise any staff.

On the public-sector side, a Memorandum of Understanding (MOU) between the Department and the union that governs Illinois State agency workers (AFSCME [American Federation of State, County, and Municipal Employees]) outlines the staffing parameters for the newly created DCFS DR specialist and DR supervisor positions, including the minimum job requirements and caseload considerations (see Appendix E for a copy of the MOU). DR team positions are considered temporary “details” that are filled for 12- or 18-month periods for DR specialists and 24-month periods for DR supervisors. The MOU does not specify a maximum caseload for DR specialists but states that “the Department may set monthly case assignment goals...consider an employee’s availability, as well as the geographic locations of the case assignments...and will adjust the number of monthly case assignments accordingly.”

Site Visit Results: Program Fidelity

Screening and Eligibility

Eligibility for DR is based primarily on the type of alleged maltreatment being reported to the State Central Register, although other factors (e.g., the age of the child) are taken into account for allegations of inadequate supervision. After the SCR worker accepts the report and assigns the allegations, eligible cases are randomly assigned to either the DR pathway or the investigation pathway. Thus, although no case can be assigned to the DR pathway that is not eligible, SCR workers have a certain amount of discretion in deciding what allegations they assign to accepted reports, which in turn can influence whether a case is eligible for DR.

During the focus groups, participants mentioned that SCR workers were manipulating the allegations that they were assigning to reports, so that certain cases would *not* be eligible for the DR pathway. Specifically, it was reported that SCR workers were adding Allegation #60 (risk of harm due to neglect) to reports that would otherwise be eligible for DR so that the case would require an investigation. According to one SSF worker: "And the hotline worker, two different times, has said: 'Let's say it's an Allegation 82, or it's environmental neglect, or it's inadequate food. But, I added a 60 [Allegation #60] to it, so it wouldn't go to DR.' "

It should be noted that in June 2011, the time that the focus groups were conducted, the allegation of "risk of harm due to neglect" (#60 in the DCFS list of allegations) was not among the list of DR-eligible allegations. However, this allegation was added to the list in July 2011, shortly after the focus groups were completed. Although this modification to the eligibility criteria has already occurred, we report the workers' comments about the appropriateness of this allegation for DR. Since SCR workers may have been using Allegation #60 as a means to manipulate which reports were eligible for DR, the addition of this allegation to the DR-eligible list may serve to increase the number of cases that are assigned to the DR pathway.

All workers and supervisors, as well as the DCFS DR Project Director and Deputy Director of Child Protection, were asked whether they felt that the cases that were being referred to DR were appropriate and whether they felt there were additional allegations that would be appropriate to add to those that are DR-eligible. The majority of DR workers and supervisors (both the DR specialists and Supervisors and the SSF workers and supervisors) felt that the reports that were being referred to DR were appropriate. The one exception raised by several workers was the allegation of medical neglect. These workers felt that some medical neglect cases were completely appropriate for DR, while others involving chronically or seriously ill children were not appropriate for DR:

SSF worker: There are cases where it's okay. It's easy—they just need to go and get their medicine—but then there's also cases where, holy cow!, they've got a really sick baby. They're not making any [medical] appointments.

SSF worker: It's like you need two categories for it.

SSF worker: Yeah.

SSF worker: Severe and not so severe.

While medical neglect was the only allegation currently eligible for DR that raised any concerns among workers, many felt that there were additional allegations that could be safely and appropriately served in the DR pathway. The suggestion that came up most frequently was “risk of harm due to neglect” (Allegation #60). Although the majority of workers felt that reports with this allegation could be appropriate for DR, almost all expressed concerns that this allegation was very broad and somewhat of a catch-all category for risks that didn't fit into any other neglect allegation types, including “risk due to domestic violence in the home” and “parental substance misuse”:

DR specialist: It [Allegation #60] just seems to be a catch-all for like, you've got a concern that doesn't actually fit all the other allegations. Half the time when you get a risk of harm, you know, it's a situation where, I don't know, it's—the risk is low. But you know, you can go on a risk of harm and just like anything, find those underlying factors. But I think maybe expanding it to DR, letting the DR Specialist go out and kind of look into the risk of harm a little bit further, to decide whether it should go to another level or stay at the DR level, you know?

Investigation supervisor: The serious DV [domestic violence], the serious substance misuse; some of that comes in as 60. I guess I'm a little unclear as to how that's going to work, because I am concerned about the timeframes. I mean, we've talked about medical neglect, and it flipping back. And some of those are pretty serious cases that we see under 60.

A smaller segment of the workers felt that DR would be appropriate for allegations outside of the neglect classifications, such as “cuts, welts, and bruises”; and one or two workers even felt that any report might be suitable for DR, if certain conditions were met:

SSF worker: I think the concept of DR specifically states that low to moderate risk, so any cases that could fall within those guidelines are appropriate for DR. It just depends on the severity of the case.

In addition to broadening the number of allegations that are eligible for DR, almost all workers and the DCFS DR Project Director felt that restricting DR services to those families with no prior reports of abuse or neglect was unnecessary, and that many families with prior reports of neglect are exactly the type of family that would benefit the most of the type of services offered in the DR pathway:

SSF supervisor: I'm like, 'Well have they had a case?' 'Well, it was like four years ago.' I'm like, 'No, we're not going to get it.' I'm like, 'They just need somebody in there for a little bit it'd be perfect,' so I think that's the one I see the most issue with.

Reassignment of Cases from DR to Investigation

When asked about the number of cases that had been reassigned from the DR pathway to the investigation pathway, the DCFS DR Project Director indicated that a fairly large percentage (perhaps as high as 15%) had been reassigned, based on the internal numbers provided to her on a monthly basis. It was noted, however, that the vast majority of these cases were reassigned due to errors made by the SCR workers in determining the eligibility criteria during the initial screening rather than because of safety concerns with the family. More specifically, many reports in which the family had a prior history with the Department (e.g., a prior investigation or an open case) were incorrectly assigned to the DR pathway, and this error typically was not discovered until the DCFS DR specialist and SSF worker made their initial visit. Once it is discovered that a family has a prior report or open case, current policy dictates that the case must be reprocessed from the DR pathway to an investigation. Almost every group of workers that were interviewed expressed frustration with these types of errors and the disruption reassignment caused for the families:

SSF worker: I had a referral and it was a perfect DR case. I was so excited to work with her. She was so excited to work me. Did the CANS; got the voluntary family enhancement plan done; went for my first visit and was arranging to get beds for her kids, because they'd been sleeping on the floor on one little, thin blanket; and then found out that it was an inappropriate referral. That I never should have got it, and I lost the case.

SSF worker: I was so sad, because she had an older child who was being raised by her mother who had gone into residential care and therefore had an open case; and because of that open case I wasn't able to work with her.

DR specialist: The other thing that would bother me, I mean, we'd find out that somebody else there had a pending investigation. I could understand it if we didn't know that person was there at the time; but the hotline needs to do a better job of screening. I just recently reprocessed a case. We had the appointment set up and she's like, 'Well, I already talked to so and so.' When they take a report, if at least one of the household member's names are the same with the same birthday and everything, it would show up and they ought to know.

DR specialist: One of the first things I always do is I spend a couple hours on every case just about doing the history. One example was when I looked up the public aid screens and find out who all is listed as active in the household; it's not uncommon to find more kids than what's on the report. So then you run the kids' prior history, and you find out that, that kid was a victim of a report and the mom, who is not Sally Jones but Sally Brown, at that time, was indicated for abuse less than five years ago, and so it gets flipped.

SSF supervisor: There was one case where we called back to investigations, because we found out, after working with the family for a week or two, that they had had an indicated report under a different name. She had gotten married or something; so then that got yanked from us, but ours get processed because somebody else makes another call in the family. Sometimes, it's for the exact same reason why they're in there working with it, but then it still gets taken away from us.

SSF workers also expressed frustration with the requirement that a family assigned to a DR pathway must be reassigned to an investigation if the SCR receives a second call on that family (known as a Subsequent Oral Report or SOR), regardless of whether the SOR pertains to the same allegations and issues that the family is currently working with the SSF worker to alleviate. SSF workers reported that mandated reporters will occasionally call the SCR to re-report the same incident several times, if the reporter believes that nothing has happened with the family. Even after the SSF worker has had the initial meeting and started working with the family, if a second report is accepted, the case must be reassigned. SCR workers have the discretion of taking subsequent calls as "related information" rather than an SOR, but workers report that screeners do not always use this discretion consistently throughout the State.

DR specialist: It was assigned to me, but then another report came in, medical neglect. Instead of making it a "related information," the [SCR] made it a new

report because they didn't check everything completely; and so I had to, sorry, reprocess it even though we'd already been out there. It's kind of shameful when we've already been out there and given hope to the family and said we're going to be giving you services only for us to be made into, in their eyes, liars. I mean, we weren't lying.

SSF worker: I just had one like that; which is really annoying, because I was almost done with her and she was fine. It was just like someone didn't like her or whatever that called and so they called and it had to be done. I had maybe a week left. I don't know and it was unfounded. There was no reason for it. I just think that's—I don't know—they need to figure something out about that, because a lot of the calls, the hotline calls, are bogus; so we're working with them and we're doing what we're supposed to be doing and then they get another bogus call and then we've got to be done.

SSF supervisor: One was because the school called the hotline. We were like one or two days away from closing the case as service complete, but there were some concerns that the school had that we didn't have. So, because they opened the investigation, we had to close the case. So, that was kind of a dilemma. How we close it, service complete? No, definitely; because while they went to investigation before case closure, so that was the only case.

Investigation supervisor: I think the saddest one that I have seen was a young family that had, had a medically complex baby. They needed some supportive kinds of things and some help arranging transportation and whatever for their child. And because the hospital social worker became overzealous, after the DR worker had talked to the parents and set an appointment, was going out to the home, they took it away from DR and made it a report to us. And by that time, this family is like, well, you're just going to take our child because that other worker was going to come and now that—so we had to go back and redo that whole engagement piece and work with them to try and regain their trust. And I think that case probably upset me most of the ones that I've seen turn around.

Most of the DCFS DR specialists and SSF workers also described situations in which they had to reprocess a case due to safety concerns, but these circumstances occurred less frequently than the type of reprocessing described above.

SSF worker: At that point we just went back out to the car. The DR Specialist called the supervisor right then and there, and we made the report. Well, they made the report. That happened more quick because with the 2-month-old crying and she didn't want to get it and when we asked questions she became really angry and hostile and told us to get out.

SSF supervisor: Until finally, the SSF worker did an unannounced home visit, because he was not responding, he was not opening. The mom went to the hospital and the grandma was having concern about them drinking, using drugs in front of the kids. So, she went to the home and she saw the father under the influence, so we had to call the hotline.

There were some differences in perception between the SSF workers and the DCFS investigators about the safety threshold for reprocessing cases from DR to investigation. At least one SSF supervisor felt that if the safety concerns in a particular family rose to the level that necessitated reprocessing the case, then the investigator should take that into consideration when making a determination about whether or not to indicate the case and provide services:

SSF supervisor: I think there should be some kind of guarantee that if the DR worker and the SSF worker go out and a house is determined to be unsafe, and it's determined that this is going to get reprocessed, that DCP has to have found it. They have to do something more. In some of the cases that the SSF worker has called me and been, like, 'Oh, my God, this is bad. This is really bad,' and it's gone back to DCP. Then we've had two cases that have gone back that direction and both, we found out, were unfounded. Then when DCP went in, and I know that they do their job; and I know if it's unfounded, it's unfounded, but it's just, like, oh, my gosh.

Investigators, on the other hand, sometimes felt that SSF workers were overly cautious about reprocessing cases due to safety concerns:

Investigation supervisor: No, they put the safety plan in, and then after some discussion, the whole case came back to us. And it was nothing that we would have ever done a safety plan on. I think it's very confusing. It's confusing to us, but can you imagine to the poor family? I mean, and I think it's really a disservice to them. I really do.

Initial Contact with Families

Families assigned to DR are initially visited by a DCFS DR specialist and an SSF caseworker.²² DCFS DR specialists and SSF caseworkers were invited to describe how they initially contacted and engaged families. There was general agreement that the role of the DCFS DR specialist during an initial visit with a family is to explain that the team is responding to a report made to the DCFS hotline, that the case has been assigned to DR, and that DR can provide the family with voluntary services. The DCFS DR specialist also completes the child safety and other assessments as indicated by the circumstances of the case.

DR specialist: Well, the first thing we do is we talk about why we're there, that there was this hotline report, however your case meets the criteria for the DR. Then explain the DR. Then I tell them what is necessary for me to accomplish. That we have to do the safety assessment. We kind of do a mini-social history; we do a domestic violence screen. I tell them the protective factors that I'm looking at. This is what we're going to talk about: we're going to talk about child development and parenting knowledge. I tell them about the six protective factors and say this is what our conversations are going to be about. It's not going to be about 'you're not a good parent because you didn't do this.' It's going to be about 'what are you doing and how can we make things better.'

SSF workers emphasized that their primary goal during the initial in-home visit is to obtain the parents' consent to participate in services. Some SSF workers do not attempt to identify needs and develop service plans during the initial visit, since many parents are too overwhelmed at that point to successfully engage in service planning. Others let the family "take the lead" and go from there.

SSF Caseworker: First, I would say I'm still with the DCFS worker and they kind of go through their process of doing their paperwork and all the documents that they are required to do. Then, I'll do the formal introduction of who I am, what our program offers, what kind of support that we could offer the families, and just give them an overview of what our agency and our component is. I usually try not to stay too long after the DR Specialist has left. More so, just have them sign—if they're gonna agree to services and I'll be like, 'Hey, I'll come back tomorrow.' I have plenty of time or we can finish up what little rest of the paperwork. Kind of go over what a service plan would look like. I mean the longest I've ever been out on one is probably an hour and a half, and that was a

²² Some SSF supervisors reported accompanying the DR specialist and SSF worker on initial visits, but DR protocol only requires the presence of the DR specialist and SSF worker.

little too long for me even. I just felt like the parents were overwhelmed and, 'Hey, why don't you let me come back and let's talk about this.'

SSF worker: I think that when I go out with my DR specialist I feel like her job is to do the CERAP and explain the DR program, and my job is to make the family feel comfortable and support the family and just explain what's going to happen after the initial visit. I kind of let them take the lead on the first half of the visit and let them do all their necessary stuff and then I'll start with talking about their needs.

Public-Private Agency Paired Team

The DR program in Illinois specifies that a paired team consisting of a DCFS DR specialist and an SSF worker conduct the initial visit with the family together. During the focus groups, both the DCFS DR specialists and SSF workers were asked how the paired team approach was working in the field. Although the overall opinion of a paired team approach was generally positive, the DCFS DR specialists and SSF workers had different perspectives on whether the two-person team was necessary, or even beneficial, to the overall DR program. DCFS DR specialists felt that the paired approach was "what makes DR work" because it allowed for a seamless transition between the initial assessment phase and the service planning and provision phase. Some SSF workers appreciated having another worker's perspective to share.

DR specialist: They're part of every conversation. And it's on the table. The family sees the faces of everyone they're working with, for the most part. There's no, 'I'll be back in two days with xxx. Well, who's xxx? Well, I like her.' They get a feel. You know, they get a feel right then and there. There's no secrets or surprises. And that's a very positive piece to have that person, because the person that's going to be helping them is the person right there, you know, and you can see them and they're interacting with them right from the get-go; and I think that's very positive.

DR specialist: It's a smoother process. It is. Because when you're out there as an investigator and you're going to do a referral, you can't give them any idea when someone's going to come—

DR specialist: Or who.

DR specialist: —or who—and you can't really even tell them for sure that they're going to get a referral. Then you have to come back and write the referral up. Then, if that person's gone, then it sits on a desk for a week. And

then it might be another week before someone can go out and do the, you know, visit together. So it is a much smoother process. It is more seamless.

SSF worker: I think it's been really good—I had one DR specialist say to me was that they appreciated the fact that we had different perspectives. We really try to respect each other's primary roles. I don't usually chime in on the initial investigative sort of questions unless I think there's a possibility that maybe we might miss something if we don't; but they're always very good about it. I don't think—well, it might be a clear role differentiating in the meeting. At the end I have always met with the DR specialist outside and we have always agreed very closely, we've discovered, on whether we felt there was a safety or not a safety concern, and we've been able to go forward from there.

SSF worker: I like to go out in pairs, but it has to be distinguished that one works for DCFS and one doesn't work for DCFS. The only reason why I like it is because my DR specialist has had so much experience; and I said if she can't get them to take services then they don't have any needs, because she's been doing it for so long. She knows exactly what to say. She'll ask the same question three different times. She'll ask about those needs three different ways and it could be the littlest thing—a mattress, anything that the family mentioned. 'Do you need help getting that couch?' She's on it, so I appreciate going in with her just as long as we make sure that we tell 'em that I don't work for DCFS and that I'm going to be the worker. I'm the one that's going to be coming out; we're only coming out in pairs the first one.

Some SSF workers questioned the necessity of having two workers on every initial visit to the family and felt that it might be intimidating for families to have more than one worker in the home at a time, especially when one identifies an affiliation with DCFS.

SSF worker: I just really feel sometimes that it would be easier if I went out on my own. Wholeheartedly, I really do. I think that if we're not capable already who received the appropriate training; we could go in and do a full safety assessment to the caliber that needs to be done. I think, still, because of the stigma, there's a lot of families that in that kind of heat-of-moment type situation, oh, yes, whatever I need to do...I still think there's an intimidation level for some families, so they feel obligated to say 'yes,' because DCFS is in the room. I think if we went in there, off the top, without that DCFS counterpart and was able to explain, in the sense, and have that conversation, it may truly keep

the ones that are interested in benefiting from the program, instead of feeling they had to, for whatever reason.

SSF worker: I've noticed that during the visit, once the DR worker leaves, the attitude and the atmosphere of the visit just changes. Like, it's almost like you can relax; you can laugh, you can have fun, you can talk to the people on a more personal level just because, in my experience, that the family is just so scared when that DR [DCFS] person is there.

As with any type of paired team approach, certain workers have styles that are more compatible with each other, and others do not. Most workers reported that they meshed fairly well together, but SSF workers in two regions reported difficulties with DR Specialists that they felt did not have a family-friendly approach:

SSF worker: I think that as long as you have a good rapport with the DCFS worker and they can see that and they can see you guys are comfortable together, that makes them a little bit more at ease too.

SSF supervisor: There's one worker that she's discussing that we always have to go back in and do what I like to do what I call 'damage control.' She comes in with an investigator hat, even after we've been doing this for multiple months now, and it's counterproductive to what we're trying to do as the POS. She's trying to make sure that it's safe and I get that, but her approach, and her verbal tone, and her questioning demeanor all say the opposite. That has been very hard to overcome in a few cases.

Safety Assessment

The DR specialists, SSF workers, and their supervisors were asked if they felt that the safety assessment protocol used in DR cases was adequate. There was consensus among all DR staff that the CERAP was a useful tool for assessing the safety in the home. One DR specialist who used to be a DCFS investigator felt that even though the tool was the same, it was being used in a more strengths-based way, by incorporating the six protective factors into the assessment:

DR specialist: I'm basically doing the CERAP in the same way that I did as an investigator because I was on a priority one team; but in addition to the way I did it before, now we have the six protective factors and we didn't have that in DCP. They might have it now, but they just started incorporating the six protective factors in terms of considering those for your CERAPS as well. I mean, not that

you are actually writing them into the CERAP, but you are assessing the six protective factors as you speak to the family and assessing the safety of the children.

Voluntary Services

Workers in each focus group were asked whether families assigned to the DR pathway were ever reassigned to an investigation on the basis of refusing services alone (absent any safety concerns). The answer from every group was that this had never occurred. However, SSF workers in several regions reported pressure from the DCFS DR Project Director and the DCFS DR supervisors to keep services refusals to a minimum. Some reported being asked to go back to a family that had refused services and work with them to think of some kind of services that they could benefit from, so that a DR case could be opened.

SSF worker: If a family declines, I have heard her on the phone with her DCFS workers saying, 'Well then you didn't say it right; you didn't present it correctly...You need to go back in there and make them take services,' because it makes them look bad if their numbers don't look good.

SSF worker: Well, I think that there is an expectation that there would be a certain percentage of those cases that we will see in service. And I think that that has been said, that you know, the expectations that they want to make sure that we're extending every effort to offer that. But I also think that, you know, you can't say to somebody, 'It's a voluntary program,' and then in any way try to pressure them.

SSF worker: Because that's going to defeat the purpose. So, it's been kind of a fine dance, and so what I say to the staff is, 'You offer them what we can help them with, whatever they need help with. But, if they say no, they say no.' And you know, and no family should have to feel that they're going to get in trouble if they don't say yes. Because I think there's enough people out there who need help, and so if that family doesn't want it this time, at least we've also created a positive experience for them to say that, 'Oh, the Department of Children and Family Services—they're not just about taking children, they do want to help people.' So, I think in some ways, we still have the ability to create that shift, and how they think about the department.

SSF supervisor: There's totally pressure for that. In fact, I thought I was going to lose my job, because we'd had 30% of our cases say no in the first few months. I

thought we were pretty good, because I thought if we got 50% of people to agree to do a voluntary program, I would consider that a success. I got told verbatim the decline rate should be about 5%. So there was a strict fear and a hurried frenzy. I was already trying to go out on the initial calls anyway, but sometimes other things would come up. Now, I will clear my schedule to make sure I go out to the initial, so there are three brains there trying to figure out what the heck we can open a case for, which I think is going to mess all the research up, because I thought part of it was whether or not people would voluntarily accept it. I feel like we open a lot of cases—I don't want to say against the families, but we really push, 'Just try it over the weekend so we can say that we opened and you at least gave it a shot.'

SSF supervisor: We had a few declines at the very beginning, because we were—long story short, I went out to make sure we were not having so many declines. First, we were being told it was voluntary, so if a family didn't want services, we thought, 'Okay, we can just walk away.' It turns out you have to not just do that, so that's a whole other segment.

Service Provision

When discussing the service needs of families, DCFS DR specialists and SSF workers and supervisors mentioned providing three primary types of support: instrumental, informational, and emotional. For example, one DR specialist described how she and the SSF worker assisted an overwhelmed young mother by providing a mix of supportive services.

DR specialist: We had one case where we...ended up doing 19 loads of laundry with this mom...We were able to be in the laundromat with the mom and really talk to her about her situation. When we were sitting there at assessment, she had 19 loads of urine-soaked laundry because she had no cash assistance. She had a kid that got sent home from school almost every day because of ADHD, because she had no consistent medical provider. And she had a bed-wetter, and she had no transportation and no support system. So while we're talking to her, this laundry kept coming up. And I said to the SSF worker, 'Looks like we need to do some laundry tomorrow.' And so, we did 19 big-boy loads of laundry, and she cried in the laundromat.

Similarly, an SSF worker reported that she often provides instrumental support for families with "dirty houses":

SSF worker: I get a lot of messy houses with my cases, too. I have had developmentally disabled parents where I actually taught them how to pop the top of the Clorox antibacterial wipes and fish out the end and put it through the little thing and pull it and tear it off. Showed them the other side of the sponge that has the scratchy Scotch-Brite and look how good it works. Show them because they never cleaned the entire eight years they lived there. That's why they're getting evicted . . .

Information about and transportation to community resources were also commonly cited by SSF supervisors as being a large part of their effort in responding to family needs. Advocating on behalf of families to secure services or accommodations from complex systems was another role often played by SSF workers.

DR specialist: A young mom with a special-needs child really felt the need for somebody to sort of back her up, help her get a better understanding of what her child's condition is, how to take care of her child, what the medical needs are. She felt that she was really being put down, though she was trying real hard. She felt that the medical community where she was taking the child was really sort of putting her down, so she just felt the need for somebody to be in her corner.

DR Cash Assistance Program

DR policy makes \$400 cash available for assisting each family participating in DR, if it is needed. This cash assistance element of DR is widely viewed by DR specialists and SSF supervisors and workers as being potentially beneficial to families served by DR. However, they noted that in practice the full benefit of those funds has been diminished, in part because the length of time it has taken to process workers' requests for the funds has been problematic and inconsistent with what they were taught in training. SSF workers and supervisors also expressed their concerns about the lack of clarity about what cash assistance funds could be used to pay for, and the need for more flexibility to meet the needs of families.

DR specialist: The way it was described to us is there is enough cash for each and every family to get the full \$400. Each and every family will have access to it within 24 hours. Yeah, to help out with the need; let's say, it's eyeglasses. They came in on medical neglect, they need some eyeglasses. Well, the SSF worker will try to get that money and first of all, they weren't properly trained on the

steps of doing the budgeting. They asked for money for this kid for glasses. 'No, he's got public aid. He'll get it in six weeks.'

SSF worker: I think there are a couple things that are wrong with the process. I knew when we were sitting in training and they said 'You'll have the money the same day,' I knew that was just a pie in the sky. I do think that sometimes it takes a hell of a lot longer. ... It's never been clear what's covered and what's not.

SSF worker: With my first one, all I needed was \$33 for a smoke detector. All I needed was a check that said the \$33. I got to the point where I was like, 'If I don't get it this week, I'm gonna out and buy it.' I actually did that, because I knew the process was still being ironed out and the family needed some lice spray for the home. I'm like, 'Well, I can do this and wait a month, or I can just go to Walgreens and out of my pocket spend \$11 or \$12 and get this family taken care of right now.'

SSF worker: Well, that's just it. Most of our families need to get this, because it's an emergency situation. So, we need it sometimes immediately. When you're having to wait, even if it's a day. Sometimes for some families, even if it's a couple days, it's 2 days too long. We haven't found the way to expedite.

SSF worker: I know they have that whole stress about immediate need stuff, but yet when we have something that is immediate need there's no money there for us to immediately access it. Also, when you tell somebody that you think you're gonna help 'em out, help them with their deposit or whatever and then it gets denied, you lose their trust.

SSF supervisor: I would really like to see there being more fluidness and flexibility in cash assistance. I understand that it's a limited pile of money, you know, like for each family. But even if we could have some negotiating points on you know, because in some things like my agency, I've developed a clothing pantry. Right there, on-site, because if a kid needs underwear, we can't wait until we process the request. If the kid needs shoes, we can't wait. So, we try to keep those things on hand. Other stuff like cleaning supplies. My staff is really good. They have found resources for almost everything. Like free baby clothes, but cleaning supplies was one of the things, and especially if it's a case for environmental neglect. The household needs to be clean. We've had to figure

out ways to get cleaning supplies. It's not time-efficient using the cash assistance process.

SSF supervisor: She didn't give us any sort of specifications on what the money could be used for from the very beginning. In fact, told us in the middle of training, 'I'm not going to tell you what is or is not going to be approved.' I'm like, 'No guidelines whatsoever ahead of time?' So we would just submit things that we thought were relevant expenses and then get denied or get told we needed to do it differently. So the list ahead of time, in training, would be great so you know what is a relevant DR expense.

Caseloads and Staffing

Caseloads for SSF workers are capped at 12 cases per worker. There are no maximum caseloads specified for DR specialists. Focus group discussions with the DCFS DR specialists revealed that from the time the DR program was implemented on November 1, 2010, their caseloads had been much lower than expected, and most of them rarely had more than one or two cases at any one time. SSF workers, who stay involved with the DR cases for longer than the DCFS DR specialists, report higher caseloads. SSF worker caseloads ranged from 1 to 9 cases, with an average around 4 per worker, although there was a considerable regional variability in caseloads.

DCFS DR specialists, investigators, and investigation supervisors reported that the unexpectedly low number of cases referred to DR has had a negative impact on staff in two ways. First, investigation supervisors and investigators said that they had understood from the beginning that one benefit of DR to them would be a caseload reduction. This benefit has not yet materialized, according to investigation supervisors, not only because so few cases have been diverted to DR but also because positions vacated by investigators who transferred to DR have not been filled. In short, some investigation supervisors reported managing the same caseload size as before the implementation of DR, but with fewer staff.

Investigation supervisor: Well, one of the things that they said about DR is it was supposed to help lower our investigations intake, which absolutely has not occurred. When they first introduced it to us in the supervisor meeting, they were saying that was one of the outcomes. They hoped that they would be able to reduce the number of people coming into the system and then to reduce the number of investigations that would come to us.

Investigation supervisor: In the process of getting staff for that [DR] program, a decision was made that workers who are already employed by the Department would go to these positions. They were guaranteed their positions to return. So, those positions were not filled in several offices.

Investigation supervisor: I think we heard that at the beginning this will reduce your caseload. I don't think that anyone's felt any sort of appreciable decrease. And in some cases they've seen an increase, because they've lost a worker; they've lost an investigator who's gone over [to DR].

Investigator: Actually, my caseload is actually higher. The impact [of DR] initially was negative. And it was negative because it took that one team of one that I talked about, used to be a team of two. One of them went to DR. So the immediate impact, to us, was negative.

Both DCFS DR specialists and investigators were unequivocal in their opinions that the relatively low caseload of the DCFS DR specialists was highly visible within DCFS offices and had become a source of resentment among investigators, whose caseloads in some regions were well over 30 or even 40 cases. The impact of the caseload discrepancies between DCFS DR specialists and investigators is discussed in more detail in a later section of this report. It should be noted that DCFS DR specialists are aware of the negative feelings their low caseloads have caused but do not have any way to rectify the problem.

DR specialist: I think I had 12 reports in 6 months, and I was, like—and I would say to <name>—‘What are you doing?’ ‘Nothing, reading a book.’ And it's almost embarrassing. No, it isn't almost embarrassing. It is embarrassing with your co-workers. You see them scurrying around and they're stressed out. I would keep my door shut every day, because I did not want people to see what I was or was not doing.

Investigation supervisor: . . . [the DR specialist] only had five cases in how-many-ever months. Now, [she] doesn't have anything to do and is bored. We used to have 17 investigators and 3 supervisors. Through people leaving, or through positions just not getting filled, there are only 2 supervisors and 12 investigators. We'll never go back up to 17. We see less staff in our area, and then new programs and new staff, and of course that's a morale issue. And it's a numbers issue, too. When it gets to people who are able to see what those numbers are, that's kind of difficult, too. When they were all excited for it, to take maybe four

or five cases a month off our caseloads, and then we have the DR workers say, 'Well, I got four for the month of May.' That just goes through [the office] like wildfire.

Investigator: We have a DR supervisor in our office who will walk around all day saying, 'I am so bored. I am so bored. My supervisor says I can't do any QI stuff, I can't do anything with intake, I can't do any community things. I'm so bored. We haven't got any cases today. I'm just going to go home.' And I'm thinking, you know, you don't have to be stupid enough to make this, you know, announcement to everyone. And you know, she's a nice person. I don't have anything personal—have a personal issue with her, you know. But we also have the DR worker, you know, sitting in our office who is at her desk either reading novels, you know, or she's on her iPhone, you know, surfing the Net and texting people. She's got nothing to do. And she was not allowed to...do any QI, QA, community stuff, nothing. That gets dumped on Investigations and Placement and Intact, because apparently, we're the only three divisions, you know, that can do anything.

In contrast to DCFS DR specialists, SSF workers and their supervisors felt strongly that their caseloads, if anything, were about right, and an increasing number of cases would be difficult to manage. SSF workers claimed that to fulfill DR mandates, they were working a large number of hours on a relatively small number of cases:

SSF worker: I have almost a full caseload. I am so busy and booked that I almost don't have time in my schedule to go out on those new referrals; but you have to make time so you have to cancel appointments. I'm putting in 50 hours a week. I'm still behind, and my supervisor's still disappointed in me that I'm not getting the Voluntary Family Enhancement Plan done in 5 days. And I'm not getting that CANS done in 5 days. Geez the family doesn't even want me back in their home yet for a week. I can't get it done in 5 days unless I can actually get through the CANS that first appointment. But I never have time to get through the CANS 'cuz I've got appointments scheduled for the whole rest of the day.

SSF worker: I'm at nine right now and I'm dying. I'm absolutely dying and I'm feeling the pressure to be in there two times a week. There was an email that came down the pike and I'm thinking 'holy smokes!' I've got nine cases you want me in their home two times a week. That's 18 home visits a week in 5 work days, plus I travel in 3 counties. My southernmost client and my northernmost

client are 2 hours apart from each other; plus getting the case notes in 24 hours; plus going in and putting in the CANS, getting it approved, printing it out; going in, putting in a voluntary family enhancement plan, getting it approved, printing it out; plus I'm supposed to do all this casework for them.

SSF supervisor: Those twice-per-week visits on 10 cases is 20 in-home visits. Do the math on that one. With the travel time, you are working 90-hour weeks. There are some families that need it, and we can do it just fine. But to mandate or expect that all need to have two; that's unnecessary. We've got some cases that are so low risk and so not really needing our help, that to be in their twice a week, they're like, 'Why are you here again? I thought I wasn't being investigated.' It's like, 'Yeah, I know. You're not in any trouble and we don't need to do anything right now, because you're just waiting for this application to come back; but I have to be out here this second time this week or I'm going to get in trouble. So here I am.' So, we'll do a lot of those.

Site Visit Results: Competency Drivers

Staff Selection

A pivotal question that must be asked at the start of any planning process when implementing a new program is "Who is qualified to do this job?" Beyond academic qualifications and experience in the field, what practitioner characteristics are best suited for the type of work they will be called upon to do? Selection of practitioners is essential, since it is at this level that evidence-based practices and programs are actually carried out. Clear descriptions of inclusion/exclusion criteria and specific skills required of frontline, supervisory, and managerial staff should be developed. A meta-analysis on staff selection studies found that the use of behavioral vignettes in interviewing allowed both the interviewer and the job candidate the opportunity to assess the skills required and was related to later work outcomes for employees.²³ Staff selection is also dependent on contextual variables, such as the overall economy, organizational financing, salaries and benefits, and the demands of the practice in terms of time and skill required.

Selection of DCFS DR Specialists and Supervisors

Child protective services in Illinois are conducted by unionized DCFS employees. Some members of the initial DR task group, which included members of the State employee union, strongly believed that the determination of child safety in alleged child abuse and neglect cases

²³ McDaniel, M.A., Whetzel, D.L. Schmidet, F.L. & Maurer, S.D. (1994). The validity of employment interviews: A comprehensive review and meta-analysis. *Journal of Applied Psychology, 79*, 599-616.

is a critical function of government and should rest in the hands of a public-sector employee. Once the DCFS DR specialist position was created, a Memorandum of Understanding was negotiated between the Department and the union that specified which DCFS staff would be able to apply for the DCFS DR specialist positions as well as the criteria that would be used to select the final candidates (see Appendix E). Only DCFS staff are allowed to “bid” on the DCFS DR specialists positions, which are considered voluntary temporary assignments, after which the DCFS employees will return to their prior work assignments. Child welfare specialists, child protection service workers, and day-care licensing representatives were eligible to apply for temporary assignment as a DCFS DR specialist to ensure the necessary credentials to serve in this capacity. In keeping with the master contract between the Department and the employees union, length of service of the employee is the prevailing factor in determining who is selected into these positions. During her interview, the DCFS DR Project Director reported that there are no differences in criteria for selection of DCFS DR specialists as compared to child protective investigators and no differences in criteria for selection of DCFS DR supervisors when compared to investigation supervisors.

Selection of SSF Caseworkers and Supervisors

Illinois also has a longstanding tradition of privatizing child welfare services through contracting with local community-based organizations. Community-based agencies were recruited and selected across the State at the regional level to select and hire caseworkers and supervisors responsible for providing DR services. The program plans (i.e., contracts) with the provider agencies include a requirement that they must operate with a family-support approach committed to providing programs and practices as well as supervision of staff consistent with a strengths-based, family-supportive approach and relationship-based practice (see Appendix F for a copy of the FY12 Program Plan). Providers also are required to demonstrate meaningful collaboration and community linkages. The contracts further require that SSF caseworkers have a bachelor’s degree acceptable by Council on Accreditation (COA) standards and must be certified to use the CERAP. SSF caseworkers must also have documented experience working with youth and families, and knowledge of the child welfare system. SSF supervisors must have a master’s degree or higher and extensive experience in working with families at risk.

While seniority was the primary method of selecting DCFS DR specialists, the method of selection used by the private agencies was less clear. Beyond the requirements outlined above, the contracted private agencies were given a great amount of latitude in determining their selection criteria for SSF caseworkers and supervisors. During her interview, Project Director Womazetta Jones confirmed that the private agencies are responsible for hiring their own staff within Council on Accreditation standards. Focus group discussion with the SSF supervisors revealed little consistency across agencies in staff selection and hiring criteria. One SSF agency

received more than 200 applications for an SSF caseworker position. When asked how the agency determined selection criteria for the job description used for this position, the SSF supervisor responded as follows:

SSF supervisor: We took bits and pieces of it, what we could glean from the contract and had to make it up. Then you couldn't promise too much, because you didn't really know what you would be able to offer them. Just good thing they just had a heart and willing—we just emphasized it was a new program. If you are a person that likes a lot of structure, then this might not be the job for you. If you're not a grassroots, ground-up person, this might not be what you're looking for, if you're expecting a lot of structure.

Another SSF supervisor was asked how the agency selected the DR worker when setting up a new program rather than transitioning existing staff into the SSF worker role:

SSF supervisor: I looked at, I was looking for someone who had experience in doing work with families and community work, because you know, you really have to not be a person who's rooted to a 9-to-5, who likes to sit in the office. It's not office work. It's out there work. And so, I looked for people who had that background and experience.

A primary means of recruiting SSF staff in several private agencies was filling these positions with individuals from other programs that had lost funding.²⁴ This practice allowed these individuals to remain with the private agencies, as long as they were willing to work in DR.

SSF worker: Our [Adoption-Preservation Assessment and Linkage, or APAL] contract actually expired, and so we were told we had this opportunity to keep our jobs, so it sounded good to me.

SSF worker: The way I heard about DR is when the contract with APAL was being canceled or whatever, then they said they were starting a new program, which is going to be DR. They were going to take the same staff that worked with APAL and put us all into DR. So I figured, okay, change and this, and they were telling us how this was—you'll be on the front end.

Interviewer: How were staff selected for the DR positions?

²⁴ The two primary programs mentioned were the Adoption-Preservation Assessment and Linkage (APAL) and System of Care (SOC) programs. The APAL program was discontinued and the SOC program substantially cut.

SSF supervisor: Well actually, we had a program, an APAL program. And so, that program was eliminated. And also we had some cuts in our SOC (System of Care) program. So, we shifted those staff into DR. And initially you know, they were not very happy, because they were like, you know, it's a powerless kind of thing. They felt like they didn't have any control. But I think that they have all come to really like this work. You know? Because you know, there's much more of an immediate gratification in this work. Because you get to help people right away, and you get to see it, and it's not these long, drawn out processes that they have to go through.

A few individuals reported being recruited specifically for DR, usually for a specific skill set that was needed—most notably the ability to speak another language.

SSF worker: I'm in the process of attaining my master's in school counseling, and for me it was a little different process. I mean, I was sort of asked to, but I guess the Differential Response program needed two bilingual staff. And since at that point I was the only bilingual person...then I was pretty much like, asked to do it. But it's cool.

Training

Practitioners must learn when, where, how, and with whom to use new approaches and new skills. Even though pre-service and in-service training are ineffective implementation strategies when used alone, they offer efficient ways to provide background information about a selected intervention and its underlying theory, philosophy, and values; introduce its components and rationales of key practices; and provide opportunities to practice new skills and receive feedback in a safe training environment.²⁵ Content will vary depending on the evidence-based or informed practice being implemented, but it must be useful and ultimately beneficial to consumers.²⁶ Delivery methods can also vary. Lecture and discussion formats are effective to convey history, theory, philosophy, and rationales for program components. Skills and the ability to carry out program components are best taught through a demonstration followed by behavior rehearsal to practice the skills and receive feedback on them.²⁷ As to the trainers themselves, top-down “train the trainer” approaches have been found to be less effective than

²⁵ Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540.

²⁶ Joyce, B., & Showers, B. (2002). *Student Achievement Through Staff Development (3rd ed.)* Alexandria, VA: Association for Supervision and Curriculum Development.

²⁷ Ibid.

those with a bottom-up approach, where trainers are chosen from the ranks of practitioners who learned the program firsthand.²⁸

Effective training appears to consist of presenting information (knowledge), providing demonstrations (live or taped) of the important components of the practice or program, and providing opportunities to practice key skills (behavior rehearsal). To impart the critical skills necessary for the delivery of human services, best practice encourages the use of behavior rehearsal— “You are in your position as a DR specialist and you are confronted with the following...” —rather than role playing (pretend you are someone else and try this), because the behavior rehearsal is a direct preparation for scenarios that the practitioner will confront in the real world environment.²⁹ Because practice itself is multidimensional, it is important to use practice sessions to help trainees integrate thinking and doing.³⁰ Movement from initial exposure to the practice, to adoption and long-term practice fidelity depends on the trainee’s confidence in executing new skills properly and integrating them into the daily activities on the job.

The Department has a centralized training division that it used to train both public and private agency DR staff. During her interview, the DCFS DR Project Director was asked to describe the training curriculum development in detail. She reported that the training division selected the trainers, but she was given final approval after having the opportunity to meet and observe them. She praised the training division for its selection of trainers. She acknowledged that none of the trainers had prior experience with DR; therefore she conducted a “train the trainer” session to prepare them to teach the DR curriculum.

The curriculum was developed by the training division under the guidance of the DCFS DR Project Director, who had full subject matter approval. The Project Director reported that she consulted American Humane Association to make sure that the core training used in the other two demonstration sites (Ohio and Colorado) was incorporated into the Illinois training curriculum. Experts from American Humane Association also reviewed the curriculum and provided comments on drafts. Areas covered by the training included:

- Differential Response overview and philosophy
- Illinois-specific DR procedures
- Family engagement
- Child Endangerment Risk Assessment Protocol (CERAP)

²⁸ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

²⁹ Ibid.

³⁰ Dansereau, D.F., & Dees, S.M. (2002). Mapping training: The transfer of a cognitive technology for improving counseling. *Journal of Substance Abuse Treatment*, 22, 219-230.

- Tools supporting DR (e.g., Family Assessment Protocol, Voluntary Family Assessment Plan, Domestic Violence Screen, Home Safety Checklists, Ecomaps, Genograms, Statewide Provider Database)
- Conflict resolution
- Community advocacy
- Evaluation of DR and data collection

The inaugural group of DCFS DR specialists (and supervisors) and SSF workers (and supervisors) attended an in-person 4-week joint training in their region, followed by a week of web-based training modules when they returned to their offices, for a total of 5 weeks of training. The first 4-week joint training sessions were held in August-September 2010 concurrently throughout the State.³¹ It should be noted that the training curriculum for DR workers *has been revised* since the time that most of the workers who participated in the focus groups were trained. Many of the issues that were consistently mentioned in the focus groups have already been addressed.³² However, all major issues reported by the workers regarding their training are included in this report. Worker training is an important implementation driver and has effects on later stages of implementation. Thus, even though the training has since been revised, it is important to document any issues that arose during the training so that they can either be addressed or acknowledged.

In the focus groups, the DR specialists and SSF workers (and supervisors) were asked to provide feedback on the training (both the in-person training and the web-based training that followed) and whether they believed the learning objectives were achieved. There was a tremendous amount of agreement from all groups of workers—both across worker types and across all regions of the State. All respondents felt that the joint training sessions—with both DCFS DR specialists and SSF workers present—were beneficial because they allowed the workers to get to know each other and bond before they had to go out and work together on a case.

DR specialist: And I think it was good for establishing relationships. And it was nice because I think our training class was—we were very close, I thought. We had a really good group who really meshed well and stuff.

SSF worker: Well, I think it did bring—the 4 weeks did bring cohesiveness to our group. I mean we got to know each other. We got to understand how we were working together as people. I mean when you invest 40 hours a week for 4

³¹ Because of the rotation of the DCFS DR specialists, who will be returning to their original assignments after their voluntary detail is over, and because turnover is expected in both the public and private agencies, additional training sessions were scheduled and will continue throughout the demonstration period.

³² See the Conclusions and Recommendations section of this report for a discussion of changes DCFS has made to the DR training and the evaluators' suggestions for additional revisions.

weeks, you kind of get that. That was nice. I mean, by the time it was over, we kind of left as a family, because that's just so much time together. So, I think that became nice because when it did—because at the beginning, we all were uncertain how to do anything, so we had each other. We had a relationship well enough that we could call and say, 'hey, <name>, do you know—we're working with this.' We had that relationship at that point so I think it achieved that greatly; but walking out of that training, I couldn't of told you how to do DR any better than the minute I walked in the door.

Other than the opportunities that it allowed for the workers to get to know each other, none of the workers had very positive things to say about the 4-week training that took place in August-September 2010. Although they had numerous complaints about the training, the majority of the issues can be grouped into a small number of themes. The primary complaint was that the training was both *too long* and *not specific enough* on the actual activities and practices that would be required of the workers when they left training and got their first case assignment.

SSF worker: I just felt it was way too long for the information that we covered. I think it could have been covered in maybe a week.

SSF worker: Yeah, especially if you've been in the field for 13 years it's insulting to sit through an entire day of how to do an initial phone call to a family and role playing and having every single person in the class take a turn role playing. It seems like there should be an accelerated training for people who already have experience as workers where you only focus on the DR specific information.

SSF worker: I'd never done this before ever, and I would be fine with a week. I didn't need all that.

SSF worker: We never did get, this is what you do. First step, second step; that we're still left with questions about how DR's going to work.

SSF worker: I think last day we got the short list of these of things you need to do. We're like, what the hell is this?

SSF worker: Yeah.

SSF worker: We had never seen a voluntary family enhancement plan.

SSF worker: We couldn't even find it on SACWIS [laughter].

SSF worker: We couldn't find our clients. I mean we really—we never saw it, what it looked like.

SSF worker: Not even a paper version. We never even saw a paper version.

SSF worker: I think it'd be beneficial if they went through and actually did that, and say okay, this is what you do when you open a case. This is the steps you have to go through; and every step, they need to break it down.

Most workers wanted more hands-on training that included practice using the forms that would be required of them, such as the family assessment form and the cash assistance form. Several noted that the actual forms were not even complete when the training occurred, so they were being trained with the draft versions of the forms.

DR specialist: Absolutely. I think doing the hands-on, this is what you're going to be doing, like the SSF workers--they're never doing a family assessment plan. That never was covered in our training. I mean, you know, I wanted the nuts and bolts of what I was doing when I went to my first house, and I didn't feel like I got that in training.

SSF worker: My thing was that I already had my Child Welfare Certification License, what have you, so I'd gone through two and half weeks up in Springfield to do foster care before. So much of it was somewhat similar but not even as intense as that was. This 4 weeks kept just going and we didn't get anything concrete. I felt like, as I was in there, I just got more and more frustrated, and I think some other people could quite possibly have been frustrated. You know if we would of asked the lady doing the training, we'd say when do we get to the meat of this. We're floating around in the clouds here.

SSF worker: You know, what's available but now that they have the forms identified and the process is more identified. This is how you apply for Cash Assistance. This is how you do this. Now that they have that a little more structure, then that information needs to be conveyed in training.

SSF supervisor: We begged the trainer to say can we all just collectively put our heads together then and come up with four main things you need to say in this initial call. Because they were told to stick to their scripts, they would not accommodate us. I can't blame our trainer for that, she's doing what she was told, and she was very nice and I'm not trying to say anything bad about her at all; but we all were just very adamant about should we identify DCFS? Should we identify? Should say exactly what this is? Should we be more ambiguous? Should we be very specific? What are we supposed to say in this phone call?

The changes to SACWIS needed to accommodate DR were not entirely completed by the time the first group of workers went through training, so they were unable to be trained on how to navigate the complex SACWIS system. Most workers felt this was an important component of training, and its absence hampered their ability to use the system when they received their first cases.

SSF worker: Some of us, and I will admit to the last 18 to 20 years having not any direct case work responsibilities. I did a lot of administrative stuff, QA stuff, training stuff, almost anything but direct case work at that point, some supervision, was that I had not seen or been familiar with or knew the ins and outs of the SACWIS screens. We got very little if anything, I think a half a day or a day, and it was all on paper. No hands-on training related to that at all.

SSF supervisor: Yeah. I would really have the paperwork piece and the SACWIS piece be more expanded, because a lot of the private agencies had not used SACWIS before, and so I think that there was this idea that you know, they would naturally know how to do it, and how to navigate through it. And really, we had to—we had to do a lot of quick learning. Yeah. So. Definitely more expansion of how to use SACWIS and exactly what documentation is expected.

Several workers suggested that new workers may need a different kind of training than those who had either already been working in the child welfare field for a long time, or recently been through other child welfare trainings or certifications.

DR specialist: And maybe it should have been a separate training from the department for the SSF workers.

DR specialist: Well, we should have come in, like, at the end or something.

DR Specialist: I mean, they didn't know what anything meant. I mean, you're talking people who did not have a child welfare background was a good chunk of our training. So I mean, we literally had to start out by acronyms and stuff, because you're throwing them around.

DR specialist: But again, back again to what they all said, you know, I think a lot of those SSF workers--that's still hard to say--were brand new and they needed that total core training community. But they could have had them for 4 weeks or whatever and brought us in, maybe, for the last week and had some activities where we could meet them and, you know.

DR specialists were particularly dissatisfied with the week of training on the Child Endangerment Risk Assessment Protocol (CERAP). Most of them were already CERAP trained and certified. Moreover, the information presented in the CERAP component of the DR training conflicted with these workers' prior training.

DR specialist: The training part for CERAP was horrible. Everything we thought we knew we were doing, they changed it. And I think--honestly, I do think the training was not right. And the sad part of that was all the SSF workers--because this was the first go-around and they were all brand new so they hadn't--none of them were CERAP-certified.

DR specialist: And, like, there was a whole week of CERAP training and we were required to be there every day except during the test. We got to sit in a different area or we got a take-home or whatever. But we had to be there, even though we were all CERAP-certified, for an entire week. ...We got confused because all the information they gave us was different than any of us knew. We were so-- that was probably the most stressful week, because we were, like, so confused.

Finally, workers were very resistant to the week-long web-based training as well, and felt that this training was redundant with earlier learning.

SSF supervisors also mentioned wanting some specific instructions on things that they would be required to do in their supervisory capacity, which was not covered in their initial training.

SSF supervisor: I think, as supervisors, it would've helped. There was a piece where the DCFS supervisors were gone for a while for some additional training. I wish that there would have been some of that for us as supervisors as well, only because there are pieces of things, even in our SACWIS training, like doing a case extension. It's a little highlighted blue thing in the middle of the screen.

SSF supervisor: I mean, it was good because we all got to know each other. I mean, there were good parts of it I don't want you to think I'm super negative, but the aspect of the program it lacked a lot of things. A couple days could've been broken into training for supervisors, this is what your expectation, this is what we're wanting, these are the reports, what reports are we supposed to be sending? Just a lot of things like that, that would've made it run a lot smoother and been a lot helpful instead of us all running around with our heads cut off.

Control Group (Investigation) Training

DCFS investigators and their supervisors all were required to attend an hour and a half web-based, instructor-led training on DR, which covered the purpose and rationale of the program, an overview of the evaluation and randomized control trial, and an explanation of each of the data collection activities required when they received a report that was randomly assigned to the control group. This “control group” training was conducted by trainers from the Department’s training division and was held several times in September and October 2010 to allow all investigative staff to attend. The control group training has also been incorporated into the core curriculum given to all new investigators when they begin their employment with the Department.

In the focus groups, investigators and their supervisors were asked what they learned from the control group training. Many reported that the format of the web-based training was not conducive to learning; that the trainers did not have accurate information when they were asked questions; and that many times, they didn’t pay any attention during the training because they were doing other tasks while the training was being conducted:

Investigation supervisor: Telephone conference.

Investigation supervisor: With slides on the screen.

Investigation supervisor: Our slides didn't work. So we just had to listen.

Investigation supervisor: It was terrible.

Investigation supervisor: Large groups of people on there, the training was done where you just followed along. A lot of people didn't have the right materials to begin with. It took—there was a huge delay trying to get people up on the computers. And then, once we got on there, because all they could do—and it is important to do the overview, the philosophy. But when you do it with such a large group, not face to face, people were hostile. So people who wanted to listen didn't get the message.

Investigator: To be honest, it was training at my desk and we’re short-staffed, so I’m like doing—I’m doing investigations, what I can, and kind of half listening at the same time to make sure that—but I didn’t even understand the piece of it, that when we got an investigation that it was the control group, it took me awhile to figure out that there was another one somewhere that was diverted from us. I thought if it’s being diverted from us, how come I still have to do stuff on it?

Investigator: I remember from the training I listened to that there was a lot of people that were pretty argumentative, not meaning to be argumentative, but there was some stuff that—like so many times the department institute stuff that I don't see what the rationale is, I don't understand it in my level, and really all I wanna know is how it's gonna impact me, because I don't have time to figure it out. If it doesn't make sense, then it's gonna get challenged. I think in that training there was a lot of people saying, "Why are we even doing this? I don't understand what the purpose of it is."

Moderator: Can you tell me what you learned in that training?

Investigator: Absolutely nothing.

Investigator: I'm gonna be honest with you because when we get those things through the web you know, and this and that.

Investigator: We do them because it says 'mandatory.'

Investigator: Because first they say it's mandatory. And then you sitting up there and I'm really working on something else while I'm listening, and you know, I'm working on something else. So that's the basically, that's what—I'm working on something else.

Supervision and Coaching

The next step to successful training is ensuring that what is learned in the training curriculum is transferred into skills that DR staff can use daily in their work. Recent studies have shown that support and training reinforcement from supervisors enhances the transfer of learning to skills following child welfare training.³³ Because innovations such as DR require behavior change at the practitioner, supervisor, and administrative support levels, all levels will benefit from both formal supervision and coaching to enhance this transfer of knowledge. The distinction can be explained as follows: Formal supervision is more compliance-driven and determines practitioner fidelity to the practice model; coaching is more skills-based and helps to develop sound judgment grounded in best practices. Both are necessary for successful implementation of DR.

As part of her formal supervision of DCFS DR supervisors, the DCFS Project Director prepared a list of specific performance expectations. Supervisors are expected to speak immediately to the assigned DR specialist at the time of case assignment to review and discuss case information. Supervision may be held by telephone in those cases where the supervisor may not be working

³³ Antle, B.F., Barbee, A.P., Sullivan, D.J., & Christensen, D.N. (2009). The effects of training reinforcement on training transfer in child welfare. *Child Welfare, 88*, 5-26. Antle, B.F., Barbee, A.P., & van Zyl, M.A. (2008). A comprehensive model for child welfare training evaluation. *Child and Youth Services Review, 30*, 1063-1080.

in the same location as the DR specialist. A supervisory conference is to be held within 24 hours of the DR specialist's initial in-person contact with the family for the purpose of reviewing contact notes, CERAP, and to ensure procedural compliance. DCFS DR supervisors are expected to meet with their staff members individually twice per month for face-to-face supervision and hold monthly team meetings in person with all unit members.

In the private agencies, the contractual program plan requires significant supervisory review and oversight of the SSF caseworkers' tasks and duties. According to the DCFS contract, SSF supervisors must review and approve family assessment and service plans, and must review family service plan progress weekly. SSF supervisors must approve all safety plans and ensure both weekly review of all unsafe CERAPs and weekly monitoring of children who are the subjects of safety plans. Supervisors must also approve all terminations of safety plans, all case-closing CERAPs, and case closures. In addition, supervisors must review and approve cash assistance requests and worker requests for extension of DR services, which are then forwarded to the Project Director for final review and approval. Specific contract language requires supervisors to make diligent efforts to contact and engage birth fathers and paternal family members.

There is no mention of coaching in the SSF program plan or in the DR supervisor responsibilities. In her interview, DR Project Director Womazetta Jones reported that the DR supervisors who are not performing up to par will be part of the new Supervisory Training to Enhance Practice (STEP) program, which is designed to provide coaching to the supervisors to improve their skills. According to the DR Project Director, she conducts weekly teleconferences with DCFS DR supervisors and monthly teleconferences with the private agency PSSF supervisors. Quarterly meetings are held for both DCFS and private agency DR staff.

Data obtained during the June 2011 site visit focus groups indicate that the DR specialists and SSF caseworkers are uniformly satisfied with their supervision. DCFS DR specialists point to a variety of reasons for their satisfaction with their regional DR supervisors, including the following:

- The supervisor's fostering of a good working relationship between them, which led to a cohesive team approach:
 - "We have a very good working relationship, team working relationship. I feel very comfortable working with her."
 - "I am the kind of person that I'm honest and straight. I'm going to tell you how I feel. I have established that with my supervisor. I let them know I cannot function if I can't be pointed, frank, and honest with you. When I'm having trouble, I'll tell her. When I'm struggling, I'll tell her."

- The flexibility of the supervisor to mold supervision to fit the needs of the individual DR specialists and motivate them accordingly:
 - “I need sometimes to be pushed a little bit more, but that’s okay. She does it in such a manner where I don’t feel like she’s beating me with a stick. She’s encouraging me and I get results done. I don’t know if she’s supervised everybody else the way she does me. It’s based on need. Sometimes she doesn’t supervise all of us in the same way.”
 - “It’s a case by case basis. She’s able to adjust.”

- The ability of the supervisor to coach and provide constructive feedback on a variety of issues:
 - “He helps me a lot with SACWIS and the different, the different you know, doing checks and all that stuff, and he also when I write my notes, I always ask for his input on my notes.”
 - “Help with time management. Whatever it is.”

- The availability of the supervisor, even if only by phone because they are located in different offices or are geographically separated:
 - “We talk on the phone; we do a lot of email....I mean he’s accessible, you can call him, you can email him; he’s there.”
 - “I think our supervisor is about as available as a supervisor gets.”
 - “She has an open-door policy, which means that any time there’s an issue with a family and stuff we can go in and discuss it right then and there. We don’t have to wait for a set date and set time because things come up, and quite often we need her available that we can go in and say, ‘Hey, this is what’s going on; what do you suggest?’ She’s very good. She’s very good.”

- The supervisor’s ability to recognize the needs of the DCFS DR specialist:
 - “She can read us. She’ll know when we’re feeling down or we’re overwhelmed, whatever, or she’ll know if we’ve gotten stressed out. At least for me she can tell.”

- The subject matter expertise of the supervisor and a willingness to share knowledge:
 - “She’s very knowledgeable about community services and about in-home services. She’s been doing it forever and she’s really, really good.”
 - “Our supervisor, she’s great. I can call her after a visit, something I didn’t feel comfortable with. She’ll help me brainstorm, help me process it. If I’m

in a rush, I can't find this resource, she'll find it, print it out, put it on my desk for me, and it's been there when I come in."

One problem was noted by the DCFS DR specialists related to remote supervision and the ability of the DR specialist to obtain required supervisory signatures:

DR specialist: I think like one little hassle that we've encountered, I mean, I know it's kind of more our [inaudible] away from <location deleted>, is the backlog of stuff that we need signatures on. I mean, we have so little in-person contact with her, you know, some of the—the SSF workers' files, need those things in the file. But they can't go in there without a signature, and some of those things sit around and get, you know, wait for a signature.

DR specialist: Timekeeping issues, you know, those types of things there where, you know, before you just walked down the hall and get a signature. Now, it's 'When am I going to see this person again, to have her sign this here for us here,' so I mean, I know that's a little bit of a hassle for us.

Some of the SSF supervisors discussed their supervision styles and what they do to support the SSF workers:

SSF supervisor: I think in my part, I have a structure. Having supervision every week. I have an open-door policy, too. So, whenever they have any questions, any concerns, we talk about that. So, I'm going to be more conscious and careful to document whatever I'm talking to them about, each case. Because yes, we talk about cases like maybe every day, or I'm doing this, or what I think about that, or this family needs these services. So, I think that's something that I have to prove myself as supervisor, but I'm doing supervision every week. Sometimes twice a week. It depends on the situation.

SSF supervisor: So, I also create DR guidelines for them. And they help me too, I mean, we have been kind of working in collaboration. Like, I'm setting up a lot of different things for the program, and for them to know and understand about the services, about the program, and about everything. So, there's a guideline that what are things for them to know and to do, during the initial home visit. What kind of documentation, SACWIS notes and everything, and also the bad ways about case closure, what are the requirements for case closure, and everything. So, I think that's part of my responsibility, and I have been guiding

them, supporting them, educating them, in that part. So, I think I've provided a lot of supervision and now it's going to be like every week, until we close the case.

There is a diversity of thought among SSF supervisors about whether or not an SSF supervisor should accompany those they supervise in the field when caseworkers are visiting families.

SSF supervisor: I've gone out on probably, I would say, 90% of every initial call. Then a couple of the—I've gone out on a few other. We had a case that was really, really bad. Not really bad. We called it the saddest case ever. They just had a lot of stuff, so I just tag-teamed it with the worker and we went out. Any time we held a family meeting, I was there, because I think we're supposed to be there anyway during big family meetings. It was absolutely necessary to get through all the litany of things that needed to happen for that family. When they have school meetings, I go to those. When there's family meetings or if there's something big going on, I make sure to go to those. I like that approach.

SSF supervisor: I haven't gone out on an initial meeting, because I just think it would be overwhelming for the family. The three people involved, plus the worker and the specialist have such a great team. They do a great job. I first started just going out on the [initial in-home visit]. Now, I'm going out to meet every family on the third or fourth meetings, after the worker establishes a rapport with the family, just so I can get a better idea of what he's working with. Not seeing or meeting the family and him just coming back, and me giving him supervision on a family I don't know anything about except for what he's told me, I don't feel like I'm giving him what I need to give. I think it's important to meet every family.

SSF supervisor: I've gone out with a couple just because I wanted to go see—and I can if I want. I mean, my agency does not care in whatever I want to do. I don't do it on a regular basis, no.

SSF supervisor: I have not. We've kinda had some issues with the DCFS worker, so I wanted to allow them to work that out themselves. Now, going into the second year, I think I will go out more on the side. I was trying to see how the program was going to be. We debrief a lot, we talk a lot.

Although the DCFS DR supervisors and SSF supervisors were not directly asked about the supervision and direction they receive from the DR Project Director, this subject came up in many focus groups. According to the interview with the DCFS DR Project Director, she holds monthly conference calls for both DCFS DR supervisors and SSF supervisors. She also holds quarterly one- or two-day meetings with the DCFS DR supervisors where they work collaboratively on programmatic issues. In their focus group, the DCFS DR supervisors confirm that there is a mutually supportive relationship with the DR Project Director:

DR supervisor: And she [the Project Director] has the energy for it and the passion for it and she's good to us and she listens and she provides guidance and she handles her business and takes care of things.

DR supervisor: We're able to talk to her and, okay, we might not see things certain ways. She may not—she may say, 'Well I understand where you're going, but let's look at it this way'; and I appreciate that. I think that's good.

The SSF supervisors felt less able to ask the DR Project Director questions and give feedback to her on project-related issues:

SSF supervisor: To make the program work how it's supposed to be, you need to be able to ask those questions, because it's taking off, right. So to get those questions answered to help the families is going to make the program work. If you can't ask the questions, don't feel comfortable asking the questions, then the program's not going to run the way it should run.

SSF supervisor: It's a wonderful program. We've seen, just by my worker doing little things, it has changed the family, the dynamic. It's so nice to see. We just would like questions answered. A little bit more of a teamwork approach from above would be awesome.

Performance Evaluation

According to Fixsen et al. (2009) there is strong consensus in the implementation literature that staff performance evaluations should be designed to assess the use and outcomes of the skills that are reflected in the selection criteria, taught in training, and reinforced and expanded upon through supervision and coaching.³⁴ They should be used as part of a sequence of supports that integrates performance assessment with what was taught in training, coupled with supervision protocols and the provision of meaningful feedback through observation of the

³⁴ Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

practitioner's skills through job coaching. Staff evaluations should first and foremost be used as a means to help the individual practitioner continue to improve in effectively providing services to children and families.³⁵

Staff performance evaluations are a critical tool in determining fidelity to the program and should be developed by program administrators to reliably assess both the practitioner's *compliance* and *competence*.³⁶ Compliance measures should be used to determine fidelity to the core intervention components (e.g., timely completion of the CERAP, face-to-face contact with the family for the prescribed number of times per week). Competence measures are essential for determining the extent to which the core intervention components are delivered with skill and attention to best practices when interacting with families (e.g., engaging the family using strengths-based language, tailoring the family-service plan to meet the specific needs of the individual family). The development of effective performance measures is hampered if the practice model is not clearly defined, making identification of core components difficult, or if these core components have not been operationally defined with agreed-upon criteria for implementation.³⁷

DCFS DR specialists' performance evaluations are governed by the master contract with the union. Any changes to reflect DR-specific performance indicators must be negotiated with the union. The MOU indicates that since an employee's assignment to DR is strictly voluntary on the employee's part, and the DR program is new, the Department will not use progressive and corrective discipline to address work performance or case related/case outcome issues and problems. Counseling and corrective action plans will be used to address performance deficiencies. The MOU also states that the master union contract controls employee evaluations. Although it encourages "periodic informal evaluation conferences" between the DCFS DR specialists and their supervisors, and the DCFS DR supervisors and the DR Project Director, it restricts written employee evaluation to DR work performance only and must acknowledge that this assignment is voluntary and the performance evaluated is not reflective of the employee's permanent job assignment. The DCFS Project Director reports that she had the DR supervisors and the DR specialists develop the DR performance objectives. The performance objectives for the supervisors are set annually by the supervisors themselves in partnership with the DR Project Director. According to the Project Director, if performance is

³⁵ Ibid.

³⁶ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

³⁷ McGrew, J.H., Bond, G.R., Dietzen, L., & Salyers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting & Clinical Psychology, 62*, 670-678.

deemed not acceptable, they will jointly identify training needs and develop a corrective action plan.

Since the DCFS DR specialists and SSF workers had not yet had a performance evaluation when the focus groups were conducted in June 2011, feedback on this implementation component is limited. One DR specialist described wanting to know how he was doing on the job and how he actively sought out this type of information:

DR specialist: I ask questions. I'm constantly asking for feedback from my clients. And I'm just that kind of a person. Even my SSF workers, right after we get out of a meeting, I'm saying, 'How did I do? What did you think, is there anything I can do better?' And I get some great feedback on that, and I do my own self-assessment.

Those SSF workers who were aware of the performance evaluation process described the evaluations as being general in nature and not targeted to specific DR-related compliance or competencies.

SSF worker: I don't think it's this program specific. It's just an agency-based performance evaluation. So I would expect it's pretty similar for every program within the agency. Yeah, just general but not specific to DR.

SSF worker: We have annual reviews, but it's a real cookie cutter. Personally I don't take a lot out of it, because there's not much put into it; but we do in the formal supervision. There's a lot of emphasis on the productivity for how many hours we spend per family, and so that's really what the focus is. I mean, there's the clinical aspect of what we're doing with families and what not, but not to the extent that you guys experience it, but there is still fee for service. There's a lot of emphasis on getting our hours in and documenting everything.

One SSF supervisor reported that the agency's performance evaluation "was a hybrid, but for the most part it's DR specific."

Site Visit Results: Organization Drivers

The competency drivers discussed previously are essential core components to changing the behaviors of practitioners within an organization: They must be present for implementation to occur with fidelity, thereby leading to good outcomes. These core components do not exist in a

vacuum; they are contained within and supported by an organization that establishes facilitative administration structures and processes to select, train, supervise/coach, and evaluate the performance of practitioners; carries out program evaluation functions to provide guidance for decision making; and intervenes in external systems to assure ongoing resources and support for the intervention.³⁸ Organization drivers include decision data support systems, facilitative administration, and external systems intervention. These must be present to enable and support the intervention over the long term. Contextually, both competency and organization drivers must be considered when facing potential changes in leadership, funding priorities, economic downturns, and shifting social priorities. The desired outcomes of sustainable high-fidelity practices are best achieved when strong core competency drivers are well supported by strong organization structures and cultures in an enabling mix of external influences.³⁹

Decision Support Data Systems

Programmatic evaluation assesses the effectiveness of the intervention at the organizational level by analyzing the relationship of model fidelity to expected outcomes. Reliable programmatic data are critical to quality assurance and continuous quality improvement efforts, to assure successful implementation of the practice change over time. A frequent and user-friendly feedback loop that provides process and outcome data for decision making at both the policy and practice levels is helpful in assuring organizational fidelity and assessing future program development needs.⁴⁰

One of the first decisions made by the initial task group assigned to project design was to determine that the State's existing Statewide Automated Child Welfare Information System (SACWIS) would be used for the collection and management of DR data. To streamline data collection and reporting for the DR project, an interface was developed between SACWIS and the Child and Youth Centered Information System (CYCIS), the database used by private providers responsible for delivering child welfare services under contract with the Department. The interface would allow the private agencies to enter case-specific information into SACWIS.

In addition to the interface with CYCIS, other significant modifications were made to the existing SACWIS to support the DR program. Operational protocols related to intake and investigation assignment had to be developed and a randomizer had to be built into SACWIS to

³⁸ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. (FMHI#231)Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

³⁹ Ibid.

⁴⁰ Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice*, 19(5), 531-540.

allow for reports accepted by the hotline screeners as DR-eligible to be assigned to either an investigation or DR pathway. Access to the SACWIS system, which is limited to personnel serving in clearly defined roles/assignment, had to be expanded to include the roles of those individuals performing DR-related services and tasks. The DR process and DR-specific timeframes had to be built into the system for DR users and added to the entries that SACWIS automatically requires in accordance with statute, rule, and procedure. Additionally, issues related to case closure and retention of records had to be resolved, since those cases assigned to the DR pathway are not formally substantiated and maintained on the State Central Register.

DCFS has extensive programmatic monitoring capability both internally (for programs housed within DCFS) and externally (for contracted services provided by other entities). The Department's Division of Quality Assurance is responsible for determining fidelity to programs and services delivered directly by DCFS. The Division of Monitoring is responsible for programmatic oversight of private agencies under contract with the Department. Fiscal monitoring is conducted by the Division of Budget and Finance to ensure contractual compliance. Contractual goals are specified in the private agency contracts (e.g., the percentage of children served that remain safely in their home during the intervention period, and the percentage of clients receiving DR services that were satisfied with the services provided).

The Project Director reports that the system has the ability to monitor intakes, declines, case reassignment, re-reports, case closures, requests for extension, and cash assistance requests. She reports that she monitors some of these directly, but she has to rely on the SACWIS staff to prepare reports for her on others. Project Director Jones indicates that the Department is building the reporting capacity to allow her to run and access these reports herself whenever she wants.

The focus groups did not produce much data related to the use of data to drive practice improvement or to help support frontline staff. One SSF supervisor reported "that it would be good if we had, like, a general structure for private agencies in terms of documentation." Her agency had just had its first contract review by DCFS and the agency was questioned about missing documentation.

The following discussion between SSF supervisors illustrates how one private agency has integrated staff compliance performance measurement with its quality improvement processes. It appears there is clear alignment between both staff and programmatic fidelity measures. It is also a good illustration of how supervisors can use data to help them manage more effectively.

SSF supervisor: In my agency we have a QI [quality improvement] process. First of all, everyone is, the first year you work in a new program or you start something new, position, you're evaluated at the 6-month period. But, monthly, we have a QI process where there isn't, because this is a fee for service kind of program, it's laid out where I—and it's on a public file, so anybody can look at it within—well, the administrator and the worker can. What the worker is doing, how many contacts they've had, what paperwork is due, the timelines of when it's turned in, it counts down, how many days you have to work a case, and even at the bottom it's embedded, based on if we were purely a fee-for-service, how much would have been expended. And so, that way, they can --

Facilitator: That's for each case that they have?

SSF supervisor: It's for each worker. It's for each worker's caseload. So, all of their cases are, you know, each worker has a sheet. And so, and it's a wonderful tool because it's at a glance, you can see, okay. So, they've been visiting consistently, what paperwork is outstanding, you know, how much time do they have left on the case, how much have they expended for the budgetary projection.

Facilitator: And so how is that related, then, to their performance evaluation? Is that the criteria?

SSF supervisor: Well, that's part of it. We have, it's called Performance Now, where it basically evaluates basic things about their performance. Their work ethic, their contact with their clients, with their—percentages, it's also broken down to compliance and percentages, each month. How much have you complied with, if it's 80%, 100%. So, that's all part of it. And then, there's a standard evaluation where we look at their performance in terms of their timeliness, and, you know, all of that stuff. About their overall performance.

Facilitator: Who is it that feeds the information into the summary sheet that you described?

SSF supervisor: Our QI person. All of the documentation goes to our QI person. She logs in everything. She's amazing. She logs it all in, and then updates it weekly.

SSF supervisor: I think for my staff of course there is a 90-day evaluation period, and everything counts. Thorough supervision. Professional trainings. We also have, like, a weekly planner, so we always follow that for everybody. It's not to know what they're doing, I don't like that; but it's just in case of an emergency. I mean, they know, and the work schedule and everything, and also when they pass the 90-day evaluation we go into the yearly evaluation. And also, we have the program quality improvement, so who review their caseload randomly, so they do it every month to see how they're doing in terms of meeting the

program expectations and meeting the guidelines, and everything that is required.

Facilitative Administration

Facilitative administration provides leadership and makes use of a range of data inputs to inform decision making, support the overall processes, and keep staff focused on the desired intervention outcomes.⁴¹ It uses administrative supports to facilitate movement through the stages of implementation. Closely aligned with external systems interventions, it looks for ways to make the work of frontline practitioners easier and more effective. The elements most often described⁴² as important to organizational change include:

- Commitment of leadership to the implementation process, such as to
 - Initiate and shepherd the organization through the complex change process;
 - Set explicit goals, communicate them clearly throughout the organization, resolve conflicts with other goals, and reinforce persistence;
 - Help create the details of activities, processes, and tasks in order to operationalize implementation policies;
 - Inspire, guide and provide direction;
 - Recruit, select, train, locate, advance, promote, or dismiss employees to further the aims of implementation policies.
- Involvement of stakeholders in the planning and selection of programs to implement or encourage buy-in and ownership during implementation and continuing operations.
- Creation of an implementation task force made up of consumers, stakeholders, unions, and community leaders to oversee the implementation process.
- Suggestions to “unfreeze” current organizational practices, changing them and integrating them to be functional, and then reinforcing new levels of management within the organization.
- Resources for extra costs, effort, equipment, manuals, materials, recruiting, access to expertise, and retraining for new organizational roles.
- Alignment of organizational structures to integrate staff selection, training, performance evaluation, and ongoing training.
- Alignment of organizational structures to achieve horizontal and vertical integration (including training for managers and executive staff) and liaisons with resources and partners.

⁴¹ Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

⁴² Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

- Commitment of ongoing resources and support for providing time and scheduling for coaching, participatory planning, exercise of leadership, and evolution of teamwork, and for generating and using data locally.

Interviews with DCFS Director McEwen and DCFS DR Project Director Jones, and the focus group with the CWAC DR Project Steering Committee included the following questions related to facilitative administration (see Appendix A):

- 1) Who is responsible for the ongoing development and/or modifications of DR? What is their role in implementation?
- 2) What adjustments, if any, have been made to DR since the initial implementation? Why were these adjustments made?
- 3) What changes or additions, if any, have been made to DR policies and procedures since initial implementation? Why were these changes made?
- 4) In what ways are administrative and other data sources used to inform changes to DR policy and practice?

In her interview, DR Project Director Womazetta Jones reported that she is solely responsible for ongoing development and modifications made to DR program goals and the practice model. She says that “all of it falls on” her and she cannot delegate this responsibility to anyone else. She says that she talks frequently with Director McEwen, who is “very involved” in the project but “does not micromanage.” The Project Director stated in her interview that she asked for workers’ opinions frequently and that they helped her in her decision making. As previously discussed, DCFS DR specialists and supervisors confirmed that their input was often sought, but the SSF supervisors reported that they were not comfortable with speaking up in meetings to provide input on the DR program to the DCFS DR Project Director.

Although a Project Steering Committee had been established under the auspices of the Illinois Child Welfare Advisory Committee, members of this group were unclear on its role in implementation and project oversight. Director McEwen met with the DR Project Steering Committee at its initial meeting on January 20, 2010, to share his vision for the DR program and to set forth his expectations. He described essential components of the DR program, which included the provision of direct services to families. He was asked specifically about the role of the steering committee and told the group that because DR was only a “skeletal model” they needed to flesh out its policies and procedures. He asked them to look at what tools would be needed to support DR workers. He also told them to look at which families should be served by DR and to consider if the program should be expanded, although he recognized that there was

risk in doing so if an adverse event occurred during early implementation and a public awareness campaign was not in place.

During their focus group, members of the steering committee expressed some confusion and frustration about the lack of clarity in their role over time despite the Director's initial guidance:

Steering Committee member: I was on the initial steering committee, before the CWAC committee was formed. There, I think we were very involved in actually forming the details of what it should look like. There was a lot of work. I mean, our meetings were a day long and a lot of work put into what it should look like. I kind of feel more like I listen now.

Steering Committee member: I think one of my concerns is that I was under the impression that originally we were to steer the process and something got lost amidst that, then, that changed our role into more of supporting the process. When I look back at some of the subgroups that were formed that were designed to help steer some of the elements of the process and bring it together, and then all of the sudden some—I felt as if some decisions had already been made and we were just, in a sense, supporting them, being a sounding board, attempts challenging it, but not as involved in driving it as we had—or as I had originally—been under the assumption that we were going to be.

Steering Committee member: Then we would come, and announcements were made. Then we were thinking, well, we're coming to hear announcements rather than, again, to steer the process. That was my frustration.

Some members of the steering committee expressed legitimate concern about not interfering with the Department's right to select its contractors, while still maintaining the ability of the committee to do its work.

Steering Committee member: Once it shifts to implementation, then I think the role of the advisory committee is pretty much kind of the role of an advisory committee in any project that's going on, which is offering advice and support for the program from the vantage point that you represent, so that having stakeholders at the table saying this works, this doesn't work, this is where we're encountering problems is really valuable, then, assisting, brainstorming, assisting with resolving any issues that occur, as well as bringing potential things to the

table, resources to the table.

When asked about what the role of the steering committee should be going forward, the members expressed great interest in the findings of the evaluation and its ability to inform their work.

Steering Committee member: I think that this is a 5-year project, and the main product of the department is the safety and well-being of children and families. I want to know whether this has enhanced anything or not. I think people lose sight, from my perspective, since I do not have a contract and I have no financial interest in this at all, I want to know what the outcome is for the families and children.

Steering Committee member: I'm also interested in a cost-benefit analysis, which people are—I think if we establish each family as a cost center in the system, that we would be horrified at the amount of money that we actually spend on each family, if we really counted it right, including the rent, the pencils, the overhead, and all that other stuff. I want to know what this costs and are we getting any more bang for the buck with this than we are with nothing, or with what we were doing before. Is it worth the incremental amount of investment, as opposed to giving it to gifted children, or building roads, or feeding people?

Steering Committee member: I'd like to see the committee really looking at what some of the data is as it comes out and helping with what some of those implications are, and thinking about how you adjust or change the program for better results. I mean, even if it's doing well, you can always do a little better. Also, if they're promising practices that are merging, how do you then integrate that into the way practice is done within the system more generally? How do we plan for the ongoing work that DR would be on the project, that issue of sustainability that—? I have a pretty good feeling that we're gonna see some pretty good results—or at least equitable if not better than how we are currently serving. I think it will need to be playful if we want to sustain it beyond the project. I think that that's something we could be doing.

External Systems Intervention

Child welfare practice does not occur in a vacuum; it is part of a larger systems framework that can either inhibit or support its success. Systems interventions are strategies to work with external systems and stakeholders to ensure the availability of the financial, organizational, and

human resources required to support the work of practitioners.⁴³ The Department made the strategic decision to fund the roll-out of DR within existing resources by realigning departmental priorities to support this initiative, which in turn generated support from the governor's office and the state legislature. Director McEwen actively sought input from opponents of DR during the exploration and adoption phases in early 2009.

Other than the CWAC DR Project Steering Committee, external stakeholder groups and community members were not invited to participate in focus groups or interviews during the 2011 site visit. Thus, the information that is available about systems intervention related to DR in Illinois is very limited at this time and reflects only the views of those steering committee members who participated in the focus group. The next DR site visit, set to occur in late 2012, will collect more detailed information about the influence of external systems on the implementation of DR.

Director McEwen was asked by a steering committee member during the initial Project Steering Committee meeting of January 20, 2010, whether one of the roles of the steering committee included outreach to other community stakeholders. Director McEwen agreed that it was and said that he thinks their outreach should be even broader. "I see this group as impacting those families who haven't had a hotline referral but are on the same block as a family who has and received DR services."

When asked specifically about how they have engaged other external stakeholders in DR, the members indicated that they talked to other providers about DR and educated them on its principles. One member reported actively working at the local level to encourage referrals of DR participants to the *Strengthening Families Illinois* Parent Cafés.⁴⁴ Steering committee members expressed a desire to be more actively involved in outreach to external stakeholders: "Because when you say engaging other stakeholders in DR, there are people who really love the idea, but they don't know how they can get involved...what are the roles or the ways that people who want to be supportive of DR can engage? I'm just not completely clear on how that would work, how that could work."

All focus group participants and interviewees were asked about who they thought the champions of DR were in Illinois. The majority of respondents from both the public and private

⁴³ Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540. Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

⁴⁴ For more information about Parent Cafés, please see the Strengthening Families website at <http://www.strengtheningfamiliesillinois.org/>

sectors indicated that the frontline workers were the primary champions of the program. Many also cited Director McEwen and Project Director Jones and their strong support of the program. No one mentioned an external champion, such as the original sponsors of the DR legislation or other political figures who could ensure the project is sustained in the future.

DCFS Organizational Culture and Resistance to Differential Response

During the site visit, it became clear that a certain amount of friction or resistance existed between the Division of Child Protection (DCP) and DR. This friction exists at all levels—from administration, to supervisors, to workers. In his site visit interview, DCFS Director Erwin McEwen spoke about his surprise at the level of resistance among DCP senior staff toward DR:

The sustained opposition has really amazed me. At first that silence I think was not want to do it—and it feels like to me the greatest opposition—I think we penetrated the investigative front end level staff. The greatest opposition seems to come from child protective services management staff. I mean senior managers. That just really amazed me.

What I really understand now is that I did make one unilateral decision—that [DR] would be a separate entity. That it wouldn't be housed in operations, nor would it be housed in DCP. I think that those managers thought 'these (cases) are coming off the hotline, this should be in DCP.'

That's what they're struggling with. Three quarters of [DCFS] staff is Child Protective Services. DR is a little speck. They [DCP] really didn't want those people to bid on DR. The people who bid on DR have been real pioneers. They've had to deal with being ostracized and intimidated.

Director McEwen also reports opposition to DR from the State Central Register:

Director McEwen: I think it's a level of control for them, the fact that they control the hotline, and they control the SCR. Those staff report up through the Child Protective Services, to the deputy of Child Protective Services. That's still there.

When reflecting on why he did not place DR under Child Protective Services, he responds that it would not have resulted in the changes he wanted in the current organizational practices.

Director McEwen: I understood that if I would have put Differential Response under CPS, they would have adjusted DR to fit their system and what they were doing. It was a real deliberate intent to change that system to fit DR. I think that's what a lot of the push back from trying to understand that...it was a new player in the system. Those old guards in the system couldn't control it. They tried to control with the resources they had....People try to protect themselves against change, and DR is a dramatic change.

In spite of this perceived opposition from DCP senior management, Director McEwen believes that the right staff was recruited and selected for the "pioneer" positions in DR. He believes that this has helped to advance and promote DR statewide and points to the second round of bidding for DCFS DR specialist and supervisor positions, which has attracted widespread interest. In particular, he points to the hiring of the Cook County union president as a DR specialist as helpful in resolving issues with the union, thereby paving the way for implementation.

Director McEwen: Some very respected people came to DR. For instance in Cook County we had zero issues with the union, because the union president bid on DR. He was one of the few investigators that came over. He was just like, this is really the right thing to do. He really got it. That helped. Also the senior staff and their experience with DR.

Some conflicts do remain with the union. Some investigators have challenged the decision of Director McEwen and the DCFS DR Project Director to deny them the opportunity to serve as on-call investigators while they are on temporary detail to the DR program.

Director McEwen: Still dealing with grievances because the investigators want to do—but they want to be able to get paid on call. They want to still do investigations on call, but then come and do DR in another way. That's a challenge.

In her interview, Project Director Womazetta Jones also spoke of continued resistance from DCP, including from Deputy Director Vennikandam and the supervisors and workers at the SCR, which is housed under DCP. However, in his site visit interview, Deputy Director Vennikandam was quite supportive of the DR program and felt that it should be expanded to include additional allegations.

At the worker and supervisor levels, one source of resentment from investigators and their supervisors is the perceived difference in workload between the two jobs. (Caseload

differences between DR and investigations are described earlier.) Investigators in many regions described very high current caseloads, which also contributed to a stressful work environment. Vacant investigator and investigation supervisor positions in many DCFS field offices have gone unfilled for months. Some of these already short-staffed field offices lost even more workers who transferred to become DR specialists. These positions cannot be filled; they must be held until the DR specialists rotate back to their original position after a 12- or 18-month detail in DR. The Department attempted to add needed help to these field offices by assigning “floaters” to come and help, but investigators suggest that it isn’t enough help to fill the need.

DR specialist: The one thing that I would add is, that I think that the biggest negative to the DR program has been that it has taken very, very scarce staff and put them in the DR program and left these holes statewide, within these teams that the caseloads have not been covered. And the department came up with this you know, extended detailing, where you could send people from other offices to cover these holes, and it has created a very negative backlash for DR staff who, you know, I mean, we're not telling them what our caseloads are. But the reality is, people are knowing that you're not getting the numbers that they're getting, over there in the holes that are left behind.

Facilitator: Sure.

DR specialist: And those holes are there for 12 or 18 months, and like for me, I'm going to placement when I get done in September. They have been dying for a placement worker over there for two years. And they have to sit and watch me over there get DR cases, and they're dying. So, there was really nothing built in, in an agency that was already very, very low staffed. And then you want people to buy into the DR program while they're sitting over there, carrying you know, 22 placement cases.

DR specialist: But they [investigators] don't believe we're doing anything. Like, people in my office say, ‘DR workers aren't doing anything, you're just sitting there.’ I'm like, okay, but.

DR specialist: Well, compared to what they got I probably would agree.

DR specialist: I would agree too, with—with what they're—

DR specialist: Relativity, now.

DR specialist: What they're getting, and what I'm getting, yeah. I would agree that if I was sitting in their shoes, I would probably feel the exact same way.

Moderator: You think the DR workload is less?

DR specialist: Oh, yes.

Unfortunately, part of the early communication from the Department to investigators was that the introduction of DR would decrease their current caseload of investigations. The investigators who were interviewed seemed surprised that they were still getting reports that they felt should have been assigned to the DR pathway. They were resentful that they were still working these type of cases and seemed unaware that they would continue to have DR-eligible cases on their caseload during the duration of the evaluation, due to the random assignment of treatment and control group cases.

DR specialist: So, when DR first started, I was still working as an investigator. A lot of times, the investigators in my office, they didn't have any understanding of DR. They, they you know, even though they went to the training because everyone had to do the training, they still didn't understand what DR was all about. A lot of people thought that it was going to drastically reduce all their caseload. When it did not do that, they were like, angry, and they said, 'What's the purpose of it?' They think the purpose of DR is just to reduce their caseload.

In addition, many DCFS DR specialists (when describing their former positions in the Department), investigators, and investigation supervisors described the prevailing organizational culture within the Department as one that is punitive toward workers, filled with burdensome and overwhelming levels of paperwork, not supportive of workers, and overly concerned with potential negative outcomes, to the point that workers must check with supervisors before making any decisions at all.

DR specialist: During [Intact Family Services], it was just always boom, boom, boom, boom, boom, and it was never enough. Don't let anything happen to anything where it becomes a case with the media or you go to OIG [Office of the Inspector General]. It's just very punitive. It's very threatening. You have the fear that you could be losing your job. It's just all of those emotions, negative emotions that would prevent you from doing the job that could be your very best, but you always have to have in the back of your mind that if the OIG gets involved no matter what you've done, it would never be enough. I could flip off of a building, break my leg, and it would still never be enough. They would have been asking, 'well, why didn't you do this, why didn't you do that.' Well, in hindsight I could have done that at the time, but at the time these things were not a concern. I can leave a house and 5 hours later something can happen, but they would be looking at me. They're looking back and dissecting everything that you did, I mean, just scrutinizing. It's just awful.

Investigation supervisor: Well, and I think, you know—and I think that’s the big issue, is just, like, we just are not well-supported. We’re not well-supported. And DR was supposed to help be a support and it really hasn’t turned out that way, you know. And so it’s just—you know, it’s just the lack of respect that upper management gives the managers and the investigators and the supervisors. That’s just how I see it, you know. So it’s just more than this whole DR situation.

Investigation supervisor: I'm not gonna sit here and just complain about how bad it is around the region. I do have suggestions, but we were never asked. This was presented to us like here it is and this is what we're gonna do. Right off the bat, you're gonna get attitude when people treat you in that manner. We're somebody; between us, we have years of experience. We've been doing this. We may have a thought about how we can run easier. I think the resentment starts, then when you're not asked for your opinion. You're told this going to benefit you and then your area is suffering.

Many of the DCFS DR specialists recognized the cultural differences between Child Protection and DR, and all appreciated the greater level of autonomy that was given to them as a worker in the DR program and the lesser reliance on paperwork.

DR specialist: I'm going to have a lot of hard time getting back to the, switching philosophies again back to creating service plans, where you need to do X, Y, and Z because I identified it through this really big, integrated assessment, in order to kind of resolve all the things in your life. It's not going to be so much of like <name> said, 'What do you feel you need?' Where being in DR, I have a little bit more autonomy and just kind of being able to kind of, I don't know, I'm not micromanaged as much. It's not that many—so many levels of like, management, when you're in Intact, so it's—it's going to be a hard adjustment going back.

DR specialist: So, while you have this highly educated, people with so much experience, that went to school to do social work, they spend the majority of their time doing paperwork. Which is the sad part about it. In DR, it's exactly the opposite.

DR specialist: Here's my perspective. You can call it DR, you can call it best practice, you can call it whatever you want to, but over 29 years I've seen these

programs come and go. And the reality is, if you give people a reasonable caseload, access to resources, less paperwork, you can call it whatever you want to, but they can do a better job, and they can do what they went to school to do.

SSF worker: I feel like I'm doing exactly what I went into social work for now versus what I—I mean Intact was great, that's why I wanted to do it, but there was so much paperwork. Like I literally felt like every time I was going to see the families, I could say please don't let this go above an hour because I have so much to do and the timeframe. Right now, I feel like, 'hey, I have the time to work with these families.'

SSF worker: Yeah, and I agree with that completely, because that's why I got out of the foster care, because it was just so paper heavy. This is the kind of work that I always wanted to do with kids and family. Go in and do exactly this. But in foster care, I mean, you got 25 pieces of paper for one action. So, you're just—so you spend your time with the family but then you're rushing back. With this, you can truly invest the time with the family because it's not so involved heavy with paper. It's just not and I love it. I absolutely love it.

Another huge source of contention between the DR specialists/SSF workers and the investigators was the lack of information about DR cases that is available to investigators when a DR case is either reprocessed or re-reported to the SCR hotline. Current policy requires that all information related to DR cases is sealed and cannot be shared with investigators or other Department workers following case closure. Although the Deputy Director of Child Protection was fully supportive of this policy mandate, frontline staff felt that it inhibited their ability to do their investigations in the most informed way possible.

DR specialist: I think us not being able to share our DR work with investigations.

DR specialist: After, you know, if they get a subsequent report, I think that's really difficult. Because they're very angry about that.

Moderator: They are? That they are not able to access?

DR specialist: Or even ask us questions.

DR specialist: And we can't share the information about what we've done.

DR specialist: One thing is, they cannot—this, it's sealed.

DR specialist: It's like it's a brand new report.

DR specialist: And all the rich information we have they cannot access.

Moderator: Okay.

DR specialist: Very angry about that.

DR specialist: Like we're in the CIA or something.

DR specialist: I think it does create some hostility within the office, because you know, they—they're—they have to re-create the information that we already have. And one of mine unfortunately was a family that could not speak any English, and so we had to have an interpreter, and we had access to phone numbers. Mom was in North Carolina. It got flipped back to investigations because we couldn't find her. She wasn't going to be back, and all that had to be re-created through people who couldn't speak English, and interpreters, and it was really just such a waste of time.

DR specialist: You know, given what I'm hearing them saying, I definitely, I have a problem with that. Because even if they talk to us, we can hone them in. Whatever that little thing that caused it to have to go, we can even have conversation and brainstorm together to figure a way how we can get over that, so they can take it to the next level. But, why should they have to use all the energy and effort to get a lot of information that we already have? That makes no sense to me.

DR specialist: Well, I had a situation where a worker emailed me and said—because I work in that particular office as an investigator. She said, 'Well, <name>, this is a DR case, it got sent back to me in investigations, I want to know about this family.' And so when I spoke to her I said, 'I'm sorry, I can't give you any information about anything.' And she was upset, because she felt—because we're still colleagues with these people.

Conclusions and Recommendations

Differential Response was implemented statewide in Illinois on November 1, 2010. A tremendous amount of effort by a large variety of stakeholders has been put into the development and implementation of the program. The true scope of this effort cannot adequately be captured in this report, although we attempt to document the significant amount of work that went into the early implementation stages. The DCFS DR specialists and SSF caseworkers and their supervisors expressed a considerable amount of commitment to the program—both the overall philosophy for working with families and the specific DR program as implemented in Illinois. This is evidenced in the ways that workers answered the question, “Who are the champions of DR in Illinois?” The DR workers see *themselves* as the champions of DR—the advocates for systems change:

Interviewer: Who are the champions of DR in Illinois?

Respondent: We are.

Respondent: All of us, all of us.

Respondent: You bet.

Respondent: And our director, Womazetta, as well as the director of DCFS, had the guts to put it together and present it to the legislature. I mean, there was a lot of work that had to be done to get it approved by law, down to the people that are actually out there doing it and are partners with the private agencies. And hopefully, someday, the champions or cheerleaders of this program will be the people that it's really designed to serve, that we've actually done what we were set out to do, and they will be our champions for spreading the word.

And as some of the DCFS DR specialists come to the end of their temporary detail positions in DR and go back to their permanent positions as investigators, Intact Family caseworkers, and placement caseworkers, we may see this change in philosophy infuse through the prevailing Department culture.

This site visit report provides a snapshot of how the DR program looked as of June 2011, approximately 8 months into the implementation process. Program implementation is a dynamic process and the DR program model in Illinois has already changed in several significant ways since the data for this report were collected:

1. The DR case eligibility criteria have been expanded to include the additional allegation of risk of harm due to neglect (Allegation #60). Although it is too soon to know how big of an impact this will have on the number of cases assigned to the DR pathway, this change will most likely increase the caseloads of both DR specialists and SSF caseworkers.
2. The 4-week training curriculum for DR specialists and SSF workers and their supervisors has been updated to include additional hands-on instruction related to SACWIS and the specifics of DR policy.
3. As of July 1, 2012, the requirement of twice weekly in-home visits from SSF workers may be reduce to once a week at the family's request. This request must be discussed between the family and the SSF supervisor, and this discussion must be documented in SACWIS. It should be noted that this request must come from the family rather than the SSF worker.

These changes will strengthen DR practice and indicate a willingness on the part of the Department administration to listen to worker and supervisor feedback to institute changes. Based on the data collected during the site visit and the growing empirical literature on the factors that affect successful implementation of human services programs, some additional recommendations can be made regarding both the Illinois DR program and the competency and organizational components that support DR practice.

1. Some of the cases that are being randomly assigned to the DR pathway are actually ineligible (under the current eligibility criteria) to receive DR services, because they have prior reports that the SCR is not identifying at the time of the initial acceptance of the call. SSF workers report a tremendous amount of frustration when these cases get flipped back to investigations because a prior report is discovered after the case is opened. Two potential solutions exist to this problem. The first would be to improve the screening process employed by SCR workers so that fewer ineligible reports are put into the randomizer and sent to the DR pathway. A second solution would be to expand the DR eligibility criteria to include those families with prior maltreatment reports related to neglect, which tends to be a chronic condition. Ruling out all families with prior neglect reports excludes a significant number of the families that could potentially benefit from DR.
2. There seems to be some inconsistency at the SCR about how additional calls that come in on a family assigned to the DR pathway are handled: whether they are taken as “information only” or as an SOR, a subsequent oral report, which automatically causes the DR case to be reassigned to an investigation. Unless the information from the reporter involves new allegations, it seems less disruptive for the family if additional calls (while the case is open) are taken as information only.
3. Simplify the cash assistance process by giving SSF workers and supervisors clearer guidance on the types of family needs that will be approved and speeding up the process for getting the cash to the family.
4. Create more opportunities for meaningful dialogue between the DR workers. DCFS DR specialists and SSF workers expressed a desire to meet more often with their colleagues to exchange ideas and information. Geographic barriers may impede the ability to get together often—even within a region—but this is important, especially since new workers will not have the benefit of spending 4 weeks together in training like the inaugural group of workers did.

5. Increase the flow of information about DR to DCFS investigators, supervisors, and managers. Many of the investigation staff expressed an interest in learning more about how the implementation of DR is proceeding but had no informal or formal venues for obtaining current information. A webpage on the DCFS intranet with brief updates from the DR Project Director would be one method for communicating about DR implementation with all DCFS employees in an efficient manner. Another possible method of increasing the flow of information to the investigation staff would be to have the regional DR supervisors attend the regional supervisory forum that are attended by investigation supervisors and give period updates on DR implementation. Investigation supervisors can then pass the information along to the investigators that they supervise.
6. Review the “control group” training module on DR that is now part of the new employee training for DCFS employees. The widespread confusion among investigators about DR practice and the DR evaluation indicates that the current module may not be effective. It seems important to emphasize to investigators that they will still get DR-eligible cases (in the control group) until the evaluation is over, and that DR will not affect their caseload immediately.
7. Although there are benefits to having one 4-week training curriculum that both DCFS DR specialists and private agency SSF workers and supervisors attend together, there are also disadvantages to a “one size fits all” training. Because of their seniority within the Department, the DCFS DR specialists may not need to receive ALL of the modules currently included in the 4-week training, especially those that could be considered introductory. Since they are also CERAP-certified, they may not need to attend the week of training devoted to CERAP certification. Less experienced SSF workers or supervisors, however, may benefit from the more extensive training. Finally, separate modules dealing with supervision and coaching may be useful for DR and SSF supervisors.
8. The role of the CWAC Project Steering Committee should be clarified. A facilitator should lead a discussion on the role of the steering committee going forward, and develop shared goals for the DR project once their role has been clearly established. A long-range strategic plan should be developed with particular attention paid to how external stakeholders will be engaged to support and champion the DR project. In addition, task-related workgroups within the steering committee should be structured to examine each of the implementation drivers as they relate to DR.

Appendix A: Focus Group and Interview Protocols

Interview with Project Director Womazetta Jones

Topic Area	Question
DR Eligibility	Please describe the criteria for DR eligibility/ineligibility
	Beyond formal eligibility criteria, what are the guidelines and procedures for determining whether a case is eligible for DR?
	Are eligibility criteria applied consistently? <ul style="list-style-type: none"> ▪ If not, why not? Please give examples.
	Are cases assigned to the DR changed to investigations? <ul style="list-style-type: none"> ▪ If yes, how often? ▪ By whom?
	Are there any aspects of the eligibility process that you would like to see change?
	Do you expect the percentage of screened-in reports determined eligible for DR to change over time? <ul style="list-style-type: none"> ▪ If yes, why?
	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Random Assignment	Have there been any problems resulting from random assignment (the randomizer)? Give examples. <ul style="list-style-type: none"> ▪ If yes, how were these resolved?
Assessment	How, if at all, do safety assessments differ between DR cases and Investigative cases?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Reassignment	What percentage of DR cases are reassigned to the investigative track after the initial track assignment? <ul style="list-style-type: none"> ▪ For what reasons are they reassigned?
	Are these reassigned cases tracked over time? How?
	Are DR families that refuse services ever reassigned to investigations for that reason alone?
	Have you ever had a family request to change from the DR track to CPS investigations? <ul style="list-style-type: none"> ▪ If yes, did the family give a reason? ▪ What happened as a result of the family's request?
Case Closure	What are the guidelines for how long DR and investigative cases should be open? <ul style="list-style-type: none"> ▪ Is there a procedure for extending that time? ▪ If yes, what is it? ▪ If yes, how many times have DR cases been extended since the inception of DR? ▪ For what reasons have they been extended?
Re-Report	What quality assurance protocols are in place to assure proper tracking of re-reported cases? <ul style="list-style-type: none"> ▪ If there are protocols, how consistently are these protocols followed?
DR Model	Please describe the process used to develop the DR model and practice guidance for Illinois.

DR Model	Since initial implementation, have there been any formal changes to the DR model? <ul style="list-style-type: none"> ▪ If yes, what were they? ▪ How did they come about?
Training	Who was involved in developing and reviewing the DR Training?
Training	What sources and/or experts did you rely upon in developing the DR Training?
Data Development	From your perspective, what changes to CPS administrative data systems were needed to support DR?
Data Development	How were those changes identified?
Data Development	Who implemented those changes?
Data Development	What were the major challenges in making those changes?
Data Development	What, if anything, remains to be done to make the data system fully supportive of DR?
Community “Buy In”	What key community stakeholders did you identify for DR?
Community “Buy In”	What outreach, if any was done to key community stakeholders? <ul style="list-style-type: none"> ▪ If done, what was the purpose of that outreach? ▪ What groups were specifically targeted? ▪ Why were they targeted?
Community “Buy In”	What has worked well in the community outreach process?
Community “Buy In”	Were there any groups not brought into the process initially that should have been? <ul style="list-style-type: none"> ▪ If yes, which groups? ▪ Why?
Community “Buy In”	What has not worked well in the community outreach efforts?
Community “Buy In”	Have suggestions from community stakeholders been incorporated into the DR model? Please provide examples
Staff Selection	What are the criteria for selecting caseworkers for DR?
Staff Selection	Are there different criteria for selection of DCFS DR Specialists as compared to CPS investigators? <ul style="list-style-type: none"> ▪ If yes, what are they? ▪ How are those criteria related to the practice of DR?
Staff Selection	Are there different criteria for the selection of DCFS DR Supervisors as compared to CPS supervisors? <ul style="list-style-type: none"> ▪ If yes, what are they? ▪ How are those criteria related to the practice of DR?
Staff Selection	Are there different criteria for selection of POS PSSF workers as compared to other child welfare positions within your agency? <ul style="list-style-type: none"> ▪ If yes, what are they? ▪ How are those criteria related to the practice of DR?
Staff Selection	What was the process for selecting DCFS DR Specialists?
Staff Selection	What was the process for selecting DCFS DR Supervisors?
Training	Are there specific job requirements for DCFS trainers?
Training	How were trainers assigned to train on DR?

Training	What experts, if any, did you consult with regarding the DR curriculum content?
Training	What are the trainers' levels of prior experience with DR?
Training	After the initial implementation of DR, how are new DCFS and POS DR staff trained?
Training	What, if any, changes have been made to the DR training curriculum since the first time it was given: <ul style="list-style-type: none"> ▪ For the control group (investigators)? ▪ For the experimental group (DR workers)?
Performance Assessment	How is caseworker performance evaluated for DR? <ul style="list-style-type: none"> ▪ DR Specialists ▪ CPS Investigators ▪ POS DR Workers
Performance Assessment	Who evaluates caseworker performance? How often is it evaluated? If performance is not acceptable what, if anything, happens?
Coaching	Please describe the process used to coach caseworkers and supervisors to improve practice.
Supervision	How are DR workers supervised?
Supervision	Is there a specific supervision model? <ul style="list-style-type: none"> ▪ If so, which one? ▪ Is there a specific supervision protocol utilized?
Supervision	How often does formal supervision take place?
Monitoring	What outcomes are monitored to assess DR performance at the system level? <ul style="list-style-type: none"> ▪ How are they monitored? ▪ How frequently are these outcomes monitored?
Monitoring	Are these infused into existing quality assurance protocols? <ul style="list-style-type: none"> ▪ If so, in what way?
Facilitative Administration	Who is responsible for the ongoing development and/or modifications of DR? <ul style="list-style-type: none"> ▪ What is their role in implementation?
Facilitative Administration	What adjustments, if any, have been made to DR since the initial implementation? <ul style="list-style-type: none"> ▪ Why were these adjustments made?
Facilitative Administration	What changes or additions, if any, have been made to DR policies and procedures since initial implementation? <ul style="list-style-type: none"> ▪ Why were these changes/additions made?
Facilitative Administration	In what ways are administrative and other data sources used to inform changes to DR policy and practice?
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Have you engaged external stakeholders in DR? <ul style="list-style-type: none"> ▪ If so, who are they? ▪ How did you engage them? ▪ Why did you engage them?
Systems Intervention	Who are the DR champions in Illinois?
Community Involvement	Are other community agencies and businesses being used in DR? <ul style="list-style-type: none"> ▪ If so, in what way?

Interview with DCFS Director Erwin McEwen

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessments	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Exploration and Adoption	What led you to consider DR for Illinois?
Exploration and Adoption	Who were the primary leaders in the exploration process to consider DR?
Exploration and Adoption	What key stakeholders were involved in the exploration stages to consider DR?
Exploration and Adoption	Were there dissenting voices heard during the exploration process? <ul style="list-style-type: none"> ▪ If yes, were their concerns addressed? ▪ How were their concerns addressed?
Exploration and Adoption	What implementation factors, if any, were considered during the exploration stages?
Exploration and Adoption	Where there any other child protection or child welfare reform efforts being initiated at the same time? <ul style="list-style-type: none"> ▪ If yes, did this influence the consideration of the adoption of DR?
Exploration and Adoption	Would DR have been adopted without the Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR)?
DR Model	Please describe the process used to develop the DR model and practice guidance for Illinois.
DR Model	Since initial implementation, have there been any formal changes to the DR model? <ul style="list-style-type: none"> ▪ If yes, what were they? ▪ How did they come about?
Data Development	From your perspective, what changes to CPS administrative data systems were needed to support DR?
Data Development	How were those changes identified?
Data Development	Who implemented those changes?
Data Development	What were the major challenges in making those changes?
Data Development	What, if anything, remains to be done to make the data system fully supportive of DR?
Community “Buy In”	What key community stakeholders did you identify for DR?
Community “Buy In”	What outreach, if any was done to key community stakeholders? <ul style="list-style-type: none"> ▪ If done, what was the purpose of that outreach? ▪ What groups were specifically targeted? ▪ Why were they targeted?

Community “Buy In”	What has worked well in the community outreach process?
Community “Buy In”	Were there any groups not brought into the process initially that should have been? <ul style="list-style-type: none"> ▪ If yes, which groups? ▪ Why?
Community “Buy In”	What has not worked well in the community outreach efforts?
Community “Buy In”	Have suggestions from community stakeholders been incorporated into the DR model? Please provide examples
Facilitative Administration	Who is responsible for the ongoing development and/or modifications of DR? <ul style="list-style-type: none"> ▪ What is their role in implementation?
Facilitative Administration	What adjustments, if any, have been made to DR since the initial implementation? <ul style="list-style-type: none"> ▪ Why were these adjustments made?
Facilitative Administration	What changes or additions, if any, have been made to DR policies and procedures since initial implementation? <ul style="list-style-type: none"> ▪ Why were these changes/additions made?
Facilitative Administration	In what ways are administrative and other data sources used to inform changes to DR policy and practice?
Systems Intervention	Have you engaged external stakeholders in DR? <ul style="list-style-type: none"> ▪ If so, who are they? ▪ How did you engage them? ▪ Why did you engage them?
Systems Intervention	Who are the DR champions in Illinois?
Community Involvement	Are other community agencies and businesses being used in DR? <ul style="list-style-type: none"> ▪ If so, in what way?

Interview with DCFS Deputy Director George Vennikandam

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessments	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Exploration and Adoption	What led you to consider DR for Illinois?
Exploration and Adoption	Who were the primary leaders in the exploration process to consider DR?
Exploration and Adoption	What key stakeholders were involved in the exploration stages to consider DR?
Exploration and Adoption	Were there dissenting voices heard during the exploration process? <ul style="list-style-type: none"> ▪ If yes, were their concerns addressed? ▪ How were their concerns addressed?

Exploration and Adoption	What implementation factors, if any, were considered during the exploration stages?
Exploration and Adoption	Where there any other child protection or child welfare reform efforts being initiated at the same time? <ul style="list-style-type: none"> ▪ If yes, did this influence the consideration of the adoption of DR?
Exploration and Adoption	Would DR have been adopted without the Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR)?
DR Model	Please describe the process used to develop the DR model and practice guidance for Illinois.
DR Model	Since initial implementation, have there been any formal changes to the DR model? <ul style="list-style-type: none"> ▪ If yes, what were they? ▪ How did they come about?
Performance Assessment	How is performance evaluated for CPS Investigators?
Performance Assessment	Who evaluates caseworker performance? How often is it evaluated? If performance is not acceptable what, if anything, happens?
Coaching	Please describe the process used to coach caseworkers and supervisors to improve practice.
Systems Intervention	Who are the DR champions in Illinois?

Focus Group with CWAC DR Steering Committee

Topic Area	Question
DR Model	Please describe the process used to develop the DR model and practice guidance for Illinois.
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessments	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
DR Model	Since initial implementation, have there been any formal changes to the DR model? <ul style="list-style-type: none"> ▪ If yes, what were they? ▪ How did they come about?
Community “Buy In”	What key community stakeholders did you identify for DR?
Community “Buy In”	What outreach, if any was done to key community stakeholders? <ul style="list-style-type: none"> ▪ If done, what was the purpose of that outreach? ▪ What groups were specifically targeted? ▪ Why were they targeted?
Community “Buy In”	What has worked well in the community outreach process?
Community “Buy In”	Were there any groups not brought into the process initially that should have been? <ul style="list-style-type: none"> ▪ If yes, which groups? ▪ Why?
Community “Buy In”	What has not worked well in the community outreach efforts?

In”	
Community “Buy In”	Have suggestions from community stakeholders been incorporated into the DR model? Please provide examples
Facilitative Administration	Who is responsible for the ongoing development and/or modifications of DR? <ul style="list-style-type: none"> ▪ What is their role in implementation?
Facilitative Administration	What adjustments, if any, have been made to DR since the initial implementation? <ul style="list-style-type: none"> ▪ Why were these adjustments made?
Facilitative Administration	What changes or additions, if any, have been made to DR policies and procedures since initial implementation? <ul style="list-style-type: none"> ▪ Why were these changes/additions made?
Facilitative Administration	In what ways are administrative and other data sources used to inform changes to DR policy and practice?
Systems Intervention	Have you engaged external stakeholders in DR? <ul style="list-style-type: none"> ▪ If so, who are they? ▪ How did you engage them? ▪ Why did you engage them?
Systems Intervention	Who are the DR champions in Illinois?
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?

Focus Group with DCFS Investigators

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How are you using the CERAP in your work?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Service Delivery	Please describe what happens during your first visit with a family. <ul style="list-style-type: none"> ▪ If you had follow-up visits with the family, what did you do?
Service Delivery	What strategies do you use to engage families when you work with them? Are they successful?
Service Delivery	What types of services do families you work with need the most? <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	Are there services that should be provided that are not? <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do you see families face-to-face?
Service Delivery	What aspects of your practice, if any would you like to change?
Case Closure	On average, how long are your cases open?
Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Supervision	Are you satisfied with the amount and type of supervision you currently receive? If not,

	what would you like to have change?
Performance evaluation	How do you know if you are doing a good job?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
Systems Intervention	Has the implementation of DR affected practice in CPS? <ul style="list-style-type: none"> ▪ If so, how? ▪ Give an example ▪ Is practice with families better or worse because of DR?
Systems Intervention	Has the implementation of DR affected YOUR practice with families in any way? <ul style="list-style-type: none"> • If so, how?
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	Since DR has started, have there been changes to the relationship between CPS and other community service groups/agencies? What type of change?

Focus Group with DCFS Investigation Supervisors

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How is safety assessed in the cases you supervise?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Service Delivery	Please describe what happens during the first visit with a family. <ul style="list-style-type: none"> ▪ What about follow up visits?
Service Delivery	What types of services do families need the most? <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	Are there services that should be provided that are not? <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do workers see families face-to-face?
Service Delivery	What aspects of CPS practice, if any would you like to change?
Case Closure	On average, how long are your cases open?
Staff Selection	What are the criteria for selecting CPS workers?
Performance	How is worker performance evaluated?

Assessment	
Performance Assessment	Who evaluates caseworker performance? How often is it evaluated? If performance is not acceptable what, if anything, happens?
Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Supervision	How are your workers supervised?
Supervision	Is there a specific supervision model? <ul style="list-style-type: none"> ▪ If so, which one? ▪ Is there a specific supervision protocol utilized?
Supervision	How often does formal supervision take place?
Decision Support System	What outcomes are monitored to assess CPS performance at the unit level? <ul style="list-style-type: none"> ▪ How are they monitored? ▪ How frequently are they monitored?
Decision Support System	Do you use data in your supervision? <ul style="list-style-type: none"> ▪ How do you do so? ▪ Give an example
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
Systems Intervention	Has the implementation of DR affected practice in CPS? <ul style="list-style-type: none"> ▪ If so, how? ▪ Give an example
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	Since DR has started, have there been any changes to the relationship between CPS and other community service groups/agencies? <ul style="list-style-type: none"> ▪ If yes, what type of change? Please give an example

Focus Group with DCFS DR Specialists

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How are you using the CERAP in your work?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?

Reassignment	Have you ever had a DR case reassigned to investigations? <ul style="list-style-type: none"> ▪ For what reasons?
Reassignment	Are DR families that refuse services ever reassigned to investigations for that reason alone?
Reassignment	Have you ever had a family request to change from the DR track to CPS investigations? <ul style="list-style-type: none"> ▪ If yes, did the family give a reason? ▪ What happened as a result of the family's request?
Service Delivery	For those of you temporarily assigned as DCFS DR Specialists who were CPS Investigators prior to this assignment, what if anything are you doing differently now as a DR Specialist than you were doing as an investigator?
Service Delivery	Please describe what happens during your first visit with a family. <ul style="list-style-type: none"> ▪ If you had follow-up visits with the family, what did you do?
Service Delivery	What strategies do you use to engage families when you work with them? Are they successful?
Service Delivery	What types of services do families you work with need the most? <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	Are there services that should be provided that are not? <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do you see families face-to-face?
Service Delivery	What aspects of your practice, if any would you like to change?
Case Closure	On average, how long are your cases open?
Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Supervision	Are you satisfied with the amount and type of supervision you currently receive? If not, what would you like to have change?
Performance evaluation	How do you know if you are doing a good job?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
Systems Intervention	Has the implementation of DR affected practice in CPS? <ul style="list-style-type: none"> ▪ If so, how? ▪ Give an example ▪ Is practice with families better or worse because of DR?
Systems	How has the implementation of DR affected YOUR practice with families?

Intervention	
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	<p>Since DR has started, have there been any changes to the relationship between CPS and other community service groups/agencies?</p> <ul style="list-style-type: none"> ▪ If yes, what type of change? ▪ Please give an example

Focus Group with DCFS DR Supervisors

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How is safety assessed in the cases you supervise?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Reassignment	<p>Have you ever had a DR case reassigned to investigations?</p> <ul style="list-style-type: none"> ▪ For what reasons?
Reassignment	Are DR families that refuse services ever reassigned to investigations for that reason alone?
Reassignment	<p>Have you ever had a family request to change from the DR track to CPS investigations?</p> <ul style="list-style-type: none"> ▪ If yes, did the family give a reason? ▪ What happened as a result of the family's request?
Service Delivery	For those of you temporarily assigned as DCFS DR Specialists who were CPS Investigators prior to this assignment, what if anything are you doing differently now as a DR Specialist than you were doing as an investigator?
Service Delivery	<p>Please describe what happens during your first visit with a family.</p> <ul style="list-style-type: none"> ▪ What about follow-up visits?
Service Delivery	<p>What types of services do families need the most?</p> <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	<p>Are there services that should be provided that are not?</p> <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do workers see families face-to-face?
Service Delivery	What aspects of practice, if any would you like to change?
Case Closure	On average, how long are your cases open?
Staff Selection	What are the criteria for selecting DR workers?
Performance	How is caseworker performance evaluated for DR workers?

Assessment	
Performance Assessment	Who evaluates caseworker performance? How often is it evaluated? If performance is not acceptable what, if anything, happens?
Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Supervision	How are your workers supervised?
Supervision	Is there a specific supervision model? <ul style="list-style-type: none"> ▪ If so, which one? ▪ Is there a specific supervision protocol utilized?
Supervision	How often does formal supervision take place?
Decision Support System	What outcomes are monitored to assess DR performance at the unit level? <ul style="list-style-type: none"> ▪ How are they monitored? ▪ How frequently are they monitored?
Decision Support System	Do you use data in your supervision? <ul style="list-style-type: none"> ▪ How do you do so? ▪ Give an example
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	Since DR has started, have there been any changes to the relationship between CPS and other community service groups/agencies? <ul style="list-style-type: none"> ▪ If yes, what type of change? ▪ Please give an example

Focus Group with SSF Supervisors

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How is safety assessed in the cases you supervise?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?

Reassignment	Have you ever had a DR case reassigned to investigations? <ul style="list-style-type: none"> ▪ For what reasons?
Reassignment	Are DR families that refuse services ever reassigned to investigations for that reason alone?
Reassignment	Have you ever had a family request to change from the DR track to CPS investigations? <ul style="list-style-type: none"> ▪ If yes, did the family give a reason? ▪ What happened as a result of the family's request?
Service Delivery	Please describe what happens during your first visit with a family. <ul style="list-style-type: none"> ▪ What about follow-up visits?
Service Delivery	Do you try to engage families when you work with them? What strategies do you use? Are they successful?
Service Delivery	What types of services do families need the most? <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	Are there services that should be provided that are not? <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do workers see families face-to-face?
Service Delivery	What aspects of practice, if any would you like to change?
Case Closure	On average, how long are your cases open?
Staff Selection	What are the criteria for selecting caseworkers for DR?
Supervision	How are DR workers supervised?
Supervision	Is there a specific supervision model? <ul style="list-style-type: none"> ▪ If so, which one? ▪ Is there a specific supervision protocol utilized?
Supervision	How often does formal supervision take place?
Performance Assessment	How is caseworker performance evaluated for DR?
Performance Assessment	Who evaluates caseworker performance? How often is it evaluated? If performance is not acceptable what, if anything, happens?
Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Decision Support System	What outcomes are monitored to assess DR performance at the unit level? <ul style="list-style-type: none"> ▪ How are they monitored? ▪ How frequently are they monitored?
Decision Support	Do you use data in your supervision?

System	<ul style="list-style-type: none"> ▪ How do you do so? ▪ Give an example
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	<p>Since DR has started, have there been any changes to the relationship between CPS and other community service groups/agencies?</p> <ul style="list-style-type: none"> ▪ If yes, what type of change? ▪ Please give an example

Focus Group with SSF Caseworkers

Topic Area	Question
DR Eligibility	Do you think there are cases being assigned to DR that should <u>not</u> be? Please give examples.
	Do you think that area cares which are currently not eligible for DR that should be? Please give examples
Assessment	How are you using the CERAP in your work?
	Do you feel that the safety assessments for DR cases are adequate?
	Do you feel that the safety assessments for CPS investigations are adequate?
Reassignment	Have you ever had a DR case reassigned to investigations? <ul style="list-style-type: none"> ▪ For what reasons?
Reassignment	Are DR families that refuse services ever reassigned to investigations for that reason alone?
Reassignment	Have you ever had a family request to change from the DR track to CPS investigations? <ul style="list-style-type: none"> ▪ If yes, did the family give a reason? ▪ What happened as a result of the family's request?
Service Delivery	Please describe what happens during your first visit with a family. <ul style="list-style-type: none"> ▪ If you had follow-up visits with the family, what did you do?
Service Delivery	What strategies do you use to engage families when you work with them? Are they successful?
Service Delivery	What types of services do families you work with need the most? <ul style="list-style-type: none"> ▪ Who provides these services? ▪ Are these services available in your community? ▪ If yes, how quickly can you get them in place for the family?
Service Delivery	Are there services that should be provided that are not? <ul style="list-style-type: none"> ▪ If yes, what are they?
Service Delivery	On average, how many times do you see families face-to-face?
Service Delivery	What aspects of your practice, if any would you like to change?
Case Closure	On average, how long are your cases open?

Training	What were the learning objectives for DR training?
Training	How successful was the DR training in accomplishing these learning objectives?
Training	How would you improve DR training?
Supervision	Are you satisfied with the amount and type of supervision you currently receive? If not, what would you like to have change?
Performance evaluation	How do you know if you are doing a good job?
Coaching	Do you receive any coaching on your job skills? <ul style="list-style-type: none"> ▪ If so, from whom? ▪ Give an example of the type of coaching you have received.
Systems Intervention	How did you first hear about DR? What did you think when you first heard about it?
Systems Intervention	Who are the DR champions in Illinois?
Systems Intervention	How has the implementation of DR affected YOUR practice with families?
	Do you think that children are safer since DR has been implemented? Why or why not?
	In your opinion, was the implementation of DR in Illinois a success? Why or why not?
Community Role in DR	Since DR has started, have there been any changes to the relationship between CPS and other community service groups/agencies? <ul style="list-style-type: none"> ▪ If yes, what type of change? ▪ Please give an example

Appendix B: Focus Group Recruitment Letter



Children and Family Research Center
School of Social Work
1010 W. Nevada Street
Suite 2080, Mail Code 082
Urbana IL 61801

Dear :

You are being invited to participate in an important national study about the use of Differential Response (DR) in child protective services. This study is being conducted by Dr. Tamara Fuller of the Children and Family Research Center at the University of Illinois at Urbana-Champaign. Illinois is one of three national demonstration sites selected by the National Quality Improvement Center on Differential Response (QIC-DR) to conduct a rigorous evaluation of DR that will advance our knowledge about this approach to working with families. Your opinion as someone who works in child protective investigations or child welfare services is vital to our understanding of this issue.

The Differential Response evaluation is very comprehensive, and you may have already completed an online survey regarding your opinions and experiences about Differential Response. Over the next several weeks, we will be holding numerous focus groups to ask more detailed questions about how DR has been implemented in Illinois and how it has affected both workers and families. We are gathering information from both DCFS investigators and private agency DR workers (in separate groups) in each region of the state to get a variety of opinions and information.

We would like to invite you to attend a focus group that will be held on XXX at the following location: XXX. The groups will be facilitated by a researcher from the Children and Family Research Center (University of Illinois) and will take about 1½-2 hours. The groups will be small, and will consist of others with similar job titles (supervisors, managers, or other administrators will not be present). Each group will be audio-taped and transcribed for analysis. Participant names will not appear in the transcript, and identifiable responses will not appear in any report. If quotes from focus groups are featured in reports, we will use pseudonyms. The facilitator will ask that focus group participants respect the privacy of the sessions, but we cannot guarantee that one or more group members won't relate information learned from the session to others once the session is over.

This study involves minimal risk to you. You are under no obligation to participate in this focus group and your decision will not impact your employment. The attached "Informed Consent" explains your rights as a participant in this focus group. It is important for you to read this form carefully. If you agree to participate, you will be asked to sign this form when you attend the focus group and give it to the facilitator (we will have copies available at the group). The

consent form, which contains your signature, will be kept separate from the transcript so your privacy can be assured.

Your assistance is greatly appreciated. Please indicate whether or not you are willing to participate in the focus group by responding to this email and simply replying “yes” or “no.” If you agree to participate, a reminder email will be sent to you with the details related to the group. To expedite scheduling, we would appreciate your decision by **June 6, 2011**.

If you have any questions about the study, please do not hesitate to contact Dr. Tamara Fuller at (217)333-5837 or by e-mail at t-fuller@illinois.edu. Thank you in advance for your help with this important national study.

Very truly yours,

Dr. Tamara Fuller
Lead Evaluator
Director, Children and Family Research Center

Appendix C: DR Legislation

Public Act 096-0760

SB0807 Enrolled

AN ACT concerning children.

**Be it enacted by the People of the State of Illinois,
represented in the General Assembly:**

Section 5. The Children and Family Services Act is amended
by changing Sections 5, 5a, and 9.9 as follows:

(20 ILCS 505/5) (from Ch. 23, par. 5005)

Sec. 5. Direct child welfare services; Department of
Children and Family Services. To provide direct child welfare
services when not available through other public or private
child care or program facilities.

(a) For purposes of this Section:

(1) "Children" means persons found within the State who
are under the age of 18 years. The term also includes
persons under age 19 who:

(A) were committed to the Department pursuant to
the Juvenile Court Act or the Juvenile Court Act of
1987, as amended, prior to the age of 18 and who
continue under the jurisdiction of the court; or

(B) were accepted for care, service and training by
the Department prior to the age of 18 and whose best
interest in the discretion of the Department would be
served by continuing that care, service and training
because of severe emotional disturbances, physical

disability, social adjustment or any combination thereof, or because of the need to complete an educational or vocational training program.

(2) "Homeless youth" means persons found within the State who are under the age of 19, are not in a safe and stable living situation and cannot be reunited with their families.

(3) "Child welfare services" means public social services which are directed toward the accomplishment of the following purposes:

(A) protecting and promoting the health, safety and welfare of children, including homeless, dependent or neglected children;

(B) remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation or delinquency of children;

(C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing the breakup of the family where the prevention of child removal is desirable and possible when the child can be cared for at home without endangering the child's health and safety;

(D) restoring to their families children who have been removed, by the provision of services to the child and the families when the child can be cared for at

home without endangering the child's health and safety;

(E) placing children in suitable adoptive homes, in cases where restoration to the biological family is not safe, possible or appropriate;

(F) assuring safe and adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption. At the time of placement, the Department shall consider concurrent planning, as described in subsection (1-1) of this Section so that permanency may occur at the earliest opportunity. Consideration should be given so that if reunification fails or is delayed, the placement made is the best available placement to provide permanency for the child;

(G) (blank);

(H) (blank); and

(I) placing and maintaining children in facilities that provide separate living quarters for children under the age of 18 and for children 18 years of age and older, unless a child 18 years of age is in the last year of high school education or vocational training, in an approved individual or group treatment program, in a licensed shelter facility, or secure child care facility. The Department is not required to place or maintain children:

- (i) who are in a foster home, or
- (ii) who are persons with a developmental disability, as defined in the Mental Health and Developmental Disabilities Code, or
- (iii) who are female children who are pregnant, pregnant and parenting or parenting, or
- (iv) who are siblings, in facilities that provide separate living quarters for children 18 years of age and older and for children under 18 years of age.

(b) Nothing in this Section shall be construed to authorize the expenditure of public funds for the purpose of performing abortions.

(c) The Department shall establish and maintain tax-supported child welfare services and extend and seek to improve voluntary services throughout the State, to the end that services and care shall be available on an equal basis throughout the State to children requiring such services.

(d) The Director may authorize advance disbursements for any new program initiative to any agency contracting with the Department. As a prerequisite for an advance disbursement, the contractor must post a surety bond in the amount of the advance disbursement and have a purchase of service contract approved by the Department. The Department may pay up to 2 months operational expenses in advance. The amount of the advance disbursement shall be prorated over the life of the contract or

the remaining months of the fiscal year, whichever is less, and the installment amount shall then be deducted from future bills. Advance disbursement authorizations for new initiatives shall not be made to any agency after that agency has operated during 2 consecutive fiscal years. The requirements of this Section concerning advance disbursements shall not apply with respect to the following: payments to local public agencies for child day care services as authorized by Section 5a of this Act; and youth service programs receiving grant funds under Section 17a-4.

(e) (Blank).

(f) (Blank).

(g) The Department shall establish rules and regulations concerning its operation of programs designed to meet the goals of child safety and protection, family preservation, family reunification, and adoption, including but not limited to:

- (1) adoption;
- (2) foster care;
- (3) family counseling;
- (4) protective services;
- (5) (blank);
- (6) homemaker service;
- (7) return of runaway children;
- (8) (blank);
- (9) placement under Section 5-7 of the Juvenile Court Act or Section 2-27, 3-28, 4-25 or 5-740 of the Juvenile

Court Act of 1987 in accordance with the federal Adoption Assistance and Child Welfare Act of 1980; and

(10) interstate services.

Rules and regulations established by the Department shall include provisions for training Department staff and the staff of Department grantees, through contracts with other agencies or resources, in alcohol and drug abuse screening techniques approved by the Department of Human Services, as a successor to the Department of Alcoholism and Substance Abuse, for the purpose of identifying children and adults who should be referred to an alcohol and drug abuse treatment program for professional evaluation.

(h) If the Department finds that there is no appropriate program or facility within or available to the Department for a ward and that no licensed private facility has an adequate and appropriate program or none agrees to accept the ward, the Department shall create an appropriate individualized, program-oriented plan for such ward. The plan may be developed within the Department or through purchase of services by the Department to the extent that it is within its statutory authority to do.

(i) Service programs shall be available throughout the State and shall include but not be limited to the following services:

- (1) case management;
- (2) homemakers;

- (3) counseling;
- (4) parent education;
- (5) day care; and
- (6) emergency assistance and advocacy.

In addition, the following services may be made available to assess and meet the needs of children and families:

- (1) comprehensive family-based services;
- (2) assessments;
- (3) respite care; and
- (4) in-home health services.

The Department shall provide transportation for any of the services it makes available to children or families or for which it refers children or families.

(j) The Department may provide categories of financial assistance and education assistance grants, and shall establish rules and regulations concerning the assistance and grants, to persons who adopt physically or mentally handicapped, older and other hard-to-place children who (i) immediately prior to their adoption were legal wards of the Department or (ii) were determined eligible for financial assistance with respect to a prior adoption and who become available for adoption because the prior adoption has been dissolved and the parental rights of the adoptive parents have been terminated or because the child's adoptive parents have died. The Department may continue to provide financial assistance and education assistance grants for a child who was

determined eligible for financial assistance under this subsection (j) in the interim period beginning when the child's adoptive parents died and ending with the finalization of the new adoption of the child by another adoptive parent or parents. The Department may also provide categories of financial assistance and education assistance grants, and shall establish rules and regulations for the assistance and grants, to persons appointed guardian of the person under Section 5-7 of the Juvenile Court Act or Section 2-27, 3-28, 4-25 or 5-740 of the Juvenile Court Act of 1987 for children who were wards of the Department for 12 months immediately prior to the appointment of the guardian.

The amount of assistance may vary, depending upon the needs of the child and the adoptive parents, as set forth in the annual assistance agreement. Special purpose grants are allowed where the child requires special service but such costs may not exceed the amounts which similar services would cost the Department if it were to provide or secure them as guardian of the child.

Any financial assistance provided under this subsection is inalienable by assignment, sale, execution, attachment, garnishment, or any other remedy for recovery or collection of a judgment or debt.

(j-5) The Department shall not deny or delay the placement of a child for adoption if an approved family is available either outside of the Department region handling the case, or

outside of the State of Illinois.

(k) The Department shall accept for care and training any child who has been adjudicated neglected or abused, or dependent committed to it pursuant to the Juvenile Court Act or the Juvenile Court Act of 1987.

(l) Before July 1, 2000, the Department may provide, and beginning July 1, 2000, the Department shall offer family preservation services, as defined in Section 8.2 of the Abused and Neglected Child Reporting Act, to help families, including adoptive and extended families. Family preservation services shall be offered (i) to prevent the placement of children in substitute care when the children can be cared for at home or in the custody of the person responsible for the children's welfare, (ii) to reunite children with their families, or (iii) to maintain an adoptive placement. Family preservation services shall only be offered when doing so will not endanger the children's health or safety. With respect to children who are in substitute care pursuant to the Juvenile Court Act of 1987, family preservation services shall not be offered if a goal other than those of subdivisions (A), (B), or (B-1) of subsection (2) of Section 2-28 of that Act has been set. Nothing in this paragraph shall be construed to create a private right of action or claim on the part of any individual or child welfare agency.

The Department shall notify the child and his family of the Department's responsibility to offer and provide family

preservation services as identified in the service plan. The child and his family shall be eligible for services as soon as the report is determined to be "indicated". The Department may offer services to any child or family with respect to whom a report of suspected child abuse or neglect has been filed, prior to concluding its investigation under Section 7.12 of the Abused and Neglected Child Reporting Act. However, the child's or family's willingness to accept services shall not be considered in the investigation. The Department may also provide services to any child or family who is the subject of any report of suspected child abuse or neglect or may refer such child or family to services available from other agencies in the community, even if the report is determined to be unfounded, if the conditions in the child's or family's home are reasonably likely to subject the child or family to future reports of suspected child abuse or neglect. Acceptance of such services shall be voluntary. The Department may also provide services to any child or family after completion of a family assessment, as an alternative to an investigation, as provided under the "differential response program" provided for in subsection (a-5) of Section 7.4 of the Abused and Neglected Child Reporting Act.

The Department may, at its discretion except for those children also adjudicated neglected or dependent, accept for care and training any child who has been adjudicated addicted, as a truant minor in need of supervision or as a minor

requiring authoritative intervention, under the Juvenile Court Act or the Juvenile Court Act of 1987, but no such child shall be committed to the Department by any court without the approval of the Department. A minor charged with a criminal offense under the Criminal Code of 1961 or adjudicated delinquent shall not be placed in the custody of or committed to the Department by any court, except a minor less than 15 years of age committed to the Department under Section 5-710 of the Juvenile Court Act of 1987 or a minor for whom an independent basis of abuse, neglect, or dependency exists, which must be defined by departmental rule. An independent basis exists when the allegations or adjudication of abuse, neglect, or dependency do not arise from the same facts, incident, or circumstances which give rise to a charge or adjudication of delinquency.

(1-1) The legislature recognizes that the best interests of the child require that the child be placed in the most permanent living arrangement as soon as is practically possible. To achieve this goal, the legislature directs the Department of Children and Family Services to conduct concurrent planning so that permanency may occur at the earliest opportunity. Permanent living arrangements may include prevention of placement of a child outside the home of the family when the child can be cared for at home without endangering the child's health or safety; reunification with the family, when safe and appropriate, if temporary placement

is necessary; or movement of the child toward the most permanent living arrangement and permanent legal status.

When determining reasonable efforts to be made with respect to a child, as described in this subsection, and in making such reasonable efforts, the child's health and safety shall be the paramount concern.

When a child is placed in foster care, the Department shall ensure and document that reasonable efforts were made to prevent or eliminate the need to remove the child from the child's home. The Department must make reasonable efforts to reunify the family when temporary placement of the child occurs unless otherwise required, pursuant to the Juvenile Court Act of 1987. At any time after the dispositional hearing where the Department believes that further reunification services would be ineffective, it may request a finding from the court that reasonable efforts are no longer appropriate. The Department is not required to provide further reunification services after such a finding.

A decision to place a child in substitute care shall be made with considerations of the child's health, safety, and best interests. At the time of placement, consideration should also be given so that if reunification fails or is delayed, the placement made is the best available placement to provide permanency for the child.

The Department shall adopt rules addressing concurrent planning for reunification and permanency. The Department

shall consider the following factors when determining appropriateness of concurrent planning:

- (1) the likelihood of prompt reunification;
- (2) the past history of the family;
- (3) the barriers to reunification being addressed by the family;
- (4) the level of cooperation of the family;
- (5) the foster parents' willingness to work with the family to reunite;
- (6) the willingness and ability of the foster family to provide an adoptive home or long-term placement;
- (7) the age of the child;
- (8) placement of siblings.

(m) The Department may assume temporary custody of any child if:

- (1) it has received a written consent to such temporary custody signed by the parents of the child or by the parent having custody of the child if the parents are not living together or by the guardian or custodian of the child if the child is not in the custody of either parent, or

- (2) the child is found in the State and neither a parent, guardian nor custodian of the child can be located.

If the child is found in his or her residence without a parent, guardian, custodian or responsible caretaker, the Department may, instead of removing the child and assuming temporary custody, place an authorized representative of the Department

in that residence until such time as a parent, guardian or custodian enters the home and expresses a willingness and apparent ability to ensure the child's health and safety and resume permanent charge of the child, or until a relative enters the home and is willing and able to ensure the child's health and safety and assume charge of the child until a parent, guardian or custodian enters the home and expresses such willingness and ability to ensure the child's safety and resume permanent charge. After a caretaker has remained in the home for a period not to exceed 12 hours, the Department must follow those procedures outlined in Section 2-9, 3-11, 4-8, or 5-415 of the Juvenile Court Act of 1987.

The Department shall have the authority, responsibilities and duties that a legal custodian of the child would have pursuant to subsection (9) of Section 1-3 of the Juvenile Court Act of 1987. Whenever a child is taken into temporary custody pursuant to an investigation under the Abused and Neglected Child Reporting Act, or pursuant to a referral and acceptance under the Juvenile Court Act of 1987 of a minor in limited custody, the Department, during the period of temporary custody and before the child is brought before a judicial officer as required by Section 2-9, 3-11, 4-8, or 5-415 of the Juvenile Court Act of 1987, shall have the authority, responsibilities and duties that a legal custodian of the child would have under subsection (9) of Section 1-3 of the Juvenile Court Act of 1987.

The Department shall ensure that any child taken into custody is scheduled for an appointment for a medical examination.

A parent, guardian or custodian of a child in the temporary custody of the Department who would have custody of the child if he were not in the temporary custody of the Department may deliver to the Department a signed request that the Department surrender the temporary custody of the child. The Department may retain temporary custody of the child for 10 days after the receipt of the request, during which period the Department may cause to be filed a petition pursuant to the Juvenile Court Act of 1987. If a petition is so filed, the Department shall retain temporary custody of the child until the court orders otherwise. If a petition is not filed within the 10 day period, the child shall be surrendered to the custody of the requesting parent, guardian or custodian not later than the expiration of the 10 day period, at which time the authority and duties of the Department with respect to the temporary custody of the child shall terminate.

(m-1) The Department may place children under 18 years of age in a secure child care facility licensed by the Department that cares for children who are in need of secure living arrangements for their health, safety, and well-being after a determination is made by the facility director and the Director or the Director's designate prior to admission to the facility subject to Section 2-27.1 of the Juvenile Court Act of 1987.

This subsection (m-1) does not apply to a child who is subject to placement in a correctional facility operated pursuant to Section 3-15-2 of the Unified Code of Corrections, unless the child is a ward who was placed under the care of the Department before being subject to placement in a correctional facility and a court of competent jurisdiction has ordered placement of the child in a secure care facility.

(n) The Department may place children under 18 years of age in licensed child care facilities when in the opinion of the Department, appropriate services aimed at family preservation have been unsuccessful and cannot ensure the child's health and safety or are unavailable and such placement would be for their best interest. Payment for board, clothing, care, training and supervision of any child placed in a licensed child care facility may be made by the Department, by the parents or guardians of the estates of those children, or by both the Department and the parents or guardians, except that no payments shall be made by the Department for any child placed in a licensed child care facility for board, clothing, care, training and supervision of such a child that exceed the average per capita cost of maintaining and of caring for a child in institutions for dependent or neglected children operated by the Department. However, such restriction on payments does not apply in cases where children require specialized care and treatment for problems of severe emotional disturbance, physical disability, social adjustment, or any

combination thereof and suitable facilities for the placement of such children are not available at payment rates within the limitations set forth in this Section. All reimbursements for services delivered shall be absolutely inalienable by assignment, sale, attachment, garnishment or otherwise.

(o) The Department shall establish an administrative review and appeal process for children and families who request or receive child welfare services from the Department. Children who are wards of the Department and are placed by private child welfare agencies, and foster families with whom those children are placed, shall be afforded the same procedural and appeal rights as children and families in the case of placement by the Department, including the right to an initial review of a private agency decision by that agency. The Department shall insure that any private child welfare agency, which accepts wards of the Department for placement, affords those rights to children and foster families. The Department shall accept for administrative review and an appeal hearing a complaint made by (i) a child or foster family concerning a decision following an initial review by a private child welfare agency or (ii) a prospective adoptive parent who alleges a violation of subsection (j-5) of this Section. An appeal of a decision concerning a change in the placement of a child shall be conducted in an expedited manner.

(p) There is hereby created the Department of Children and Family Services Emergency Assistance Fund from which the

Department may provide special financial assistance to families which are in economic crisis when such assistance is not available through other public or private sources and the assistance is deemed necessary to prevent dissolution of the family unit or to reunite families which have been separated due to child abuse and neglect. The Department shall establish administrative rules specifying the criteria for determining eligibility for and the amount and nature of assistance to be provided. The Department may also enter into written agreements with private and public social service agencies to provide emergency financial services to families referred by the Department. Special financial assistance payments shall be available to a family no more than once during each fiscal year and the total payments to a family may not exceed \$500 during a fiscal year.

(q) The Department may receive and use, in their entirety, for the benefit of children any gift, donation or bequest of money or other property which is received on behalf of such children, or any financial benefits to which such children are or may become entitled while under the jurisdiction or care of the Department.

The Department shall set up and administer no-cost, interest-bearing accounts in appropriate financial institutions for children for whom the Department is legally responsible and who have been determined eligible for Veterans' Benefits, Social Security benefits, assistance allotments from

the armed forces, court ordered payments, parental voluntary payments, Supplemental Security Income, Railroad Retirement payments, Black Lung benefits, or other miscellaneous payments. Interest earned by each account shall be credited to the account, unless disbursed in accordance with this subsection.

In disbursing funds from children's accounts, the Department shall:

(1) Establish standards in accordance with State and federal laws for disbursing money from children's accounts. In all circumstances, the Department's "Guardianship Administrator" or his or her designee must approve disbursements from children's accounts. The Department shall be responsible for keeping complete records of all disbursements for each account for any purpose.

(2) Calculate on a monthly basis the amounts paid from State funds for the child's board and care, medical care not covered under Medicaid, and social services; and utilize funds from the child's account, as covered by regulation, to reimburse those costs. Monthly, disbursements from all children's accounts, up to 1/12 of \$13,000,000, shall be deposited by the Department into the General Revenue Fund and the balance over 1/12 of \$13,000,000 into the DCFS Children's Services Fund.

(3) Maintain any balance remaining after reimbursing

for the child's costs of care, as specified in item (2).

The balance shall accumulate in accordance with relevant State and federal laws and shall be disbursed to the child or his or her guardian, or to the issuing agency.

(r) The Department shall promulgate regulations encouraging all adoption agencies to voluntarily forward to the Department or its agent names and addresses of all persons who have applied for and have been approved for adoption of a hard-to-place or handicapped child and the names of such children who have not been placed for adoption. A list of such names and addresses shall be maintained by the Department or its agent, and coded lists which maintain the confidentiality of the person seeking to adopt the child and of the child shall be made available, without charge, to every adoption agency in the State to assist the agencies in placing such children for adoption. The Department may delegate to an agent its duty to maintain and make available such lists. The Department shall ensure that such agent maintains the confidentiality of the person seeking to adopt the child and of the child.

(s) The Department of Children and Family Services may establish and implement a program to reimburse Department and private child welfare agency foster parents licensed by the Department of Children and Family Services for damages sustained by the foster parents as a result of the malicious or negligent acts of foster children, as well as providing third party coverage for such foster parents with regard to actions

of foster children to other individuals. Such coverage will be secondary to the foster parent liability insurance policy, if applicable. The program shall be funded through appropriations from the General Revenue Fund, specifically designated for such purposes.

(t) The Department shall perform home studies and investigations and shall exercise supervision over visitation as ordered by a court pursuant to the Illinois Marriage and Dissolution of Marriage Act or the Adoption Act only if:

(1) an order entered by an Illinois court specifically directs the Department to perform such services; and

(2) the court has ordered one or both of the parties to the proceeding to reimburse the Department for its reasonable costs for providing such services in accordance with Department rules, or has determined that neither party is financially able to pay.

The Department shall provide written notification to the court of the specific arrangements for supervised visitation and projected monthly costs within 60 days of the court order. The Department shall send to the court information related to the costs incurred except in cases where the court has determined the parties are financially unable to pay. The court may order additional periodic reports as appropriate.

(u) In addition to other information that must be provided, whenever the Department places a child with a prospective adoptive parent or parents or in a licensed foster home, group

home, child care institution, or in a relative home, the Department shall provide to the prospective adoptive parent or parents or other caretaker:

(1) available detailed information concerning the child's educational and health history, copies of immunization records (including insurance and medical card information), a history of the child's previous placements, if any, and reasons for placement changes excluding any information that identifies or reveals the location of any previous caretaker;

(2) a copy of the child's portion of the client service plan, including any visitation arrangement, and all amendments or revisions to it as related to the child; and

(3) information containing details of the child's individualized educational plan when the child is receiving special education services.

The caretaker shall be informed of any known social or behavioral information (including, but not limited to, criminal background, fire setting, perpetuation of sexual abuse, destructive behavior, and substance abuse) necessary to care for and safeguard the children to be placed or currently in the home. The Department may prepare a written summary of the information required by this paragraph, which may be provided to the foster or prospective adoptive parent in advance of a placement. The foster or prospective adoptive parent may review the supporting documents in the child's file

in the presence of casework staff. In the case of an emergency placement, casework staff shall at least provide known information verbally, if necessary, and must subsequently provide the information in writing as required by this subsection.

The information described in this subsection shall be provided in writing. In the case of emergency placements when time does not allow prior review, preparation, and collection of written information, the Department shall provide such information as it becomes available. Within 10 business days after placement, the Department shall obtain from the prospective adoptive parent or parents or other caretaker a signed verification of receipt of the information provided. Within 10 business days after placement, the Department shall provide to the child's guardian ad litem a copy of the information provided to the prospective adoptive parent or parents or other caretaker. The information provided to the prospective adoptive parent or parents or other caretaker shall be reviewed and approved regarding accuracy at the supervisory level.

(u-5) Effective July 1, 1995, only foster care placements licensed as foster family homes pursuant to the Child Care Act of 1969 shall be eligible to receive foster care payments from the Department. Relative caregivers who, as of July 1, 1995, were approved pursuant to approved relative placement rules previously promulgated by the Department at 89 Ill. Adm. Code

335 and had submitted an application for licensure as a foster family home may continue to receive foster care payments only until the Department determines that they may be licensed as a foster family home or that their application for licensure is denied or until September 30, 1995, whichever occurs first.

(v) The Department shall access criminal history record information as defined in the Illinois Uniform Conviction Information Act and information maintained in the adjudicatory and dispositional record system as defined in Section 2605-355 of the Department of State Police Law (20 ILCS 2605/2605-355) if the Department determines the information is necessary to perform its duties under the Abused and Neglected Child Reporting Act, the Child Care Act of 1969, and the Children and Family Services Act. The Department shall provide for interactive computerized communication and processing equipment that permits direct on-line communication with the Department of State Police's central criminal history data repository. The Department shall comply with all certification requirements and provide certified operators who have been trained by personnel from the Department of State Police. In addition, one Office of the Inspector General investigator shall have training in the use of the criminal history information access system and have access to the terminal. The Department of Children and Family Services and its employees shall abide by rules and regulations established by the Department of State Police relating to the access and

dissemination of this information.

(v-1) Prior to final approval for placement of a child, the Department shall conduct a criminal records background check of the prospective foster or adoptive parent, including fingerprint-based checks of national crime information databases. Final approval for placement shall not be granted if the record check reveals a felony conviction for child abuse or neglect, for spousal abuse, for a crime against children, or for a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery, or if there is a felony conviction for physical assault, battery, or a drug-related offense committed within the past 5 years.

(v-2) Prior to final approval for placement of a child, the Department shall check its child abuse and neglect registry for information concerning prospective foster and adoptive parents, and any adult living in the home. If any prospective foster or adoptive parent or other adult living in the home has resided in another state in the preceding 5 years, the Department shall request a check of that other state's child abuse and neglect registry.

(w) Within 120 days of August 20, 1995 (the effective date of Public Act 89-392), the Department shall prepare and submit to the Governor and the General Assembly, a written plan for the development of in-state licensed secure child care facilities that care for children who are in need of secure

living arrangements for their health, safety, and well-being. For purposes of this subsection, secure care facility shall mean a facility that is designed and operated to ensure that all entrances and exits from the facility, a building or a distinct part of the building, are under the exclusive control of the staff of the facility, whether or not the child has the freedom of movement within the perimeter of the facility, building, or distinct part of the building. The plan shall include descriptions of the types of facilities that are needed in Illinois; the cost of developing these secure care facilities; the estimated number of placements; the potential cost savings resulting from the movement of children currently out-of-state who are projected to be returned to Illinois; the necessary geographic distribution of these facilities in Illinois; and a proposed timetable for development of such facilities.

(Source: P.A. 94-215, eff. 1-1-06; 94-1010, eff. 10-1-06; 95-10, eff. 6-30-07; 95-601, eff. 9-11-07; 95-642, eff. 6-1-08; 95-876, eff. 8-21-08.)

(20 ILCS 505/5a) (from Ch. 23, par. 5005a)

Sec. 5a. Reimbursable services for which the Department of Children and Family Services shall pay 100% of the reasonable cost pursuant to a written contract negotiated between the Department and the agency furnishing the services (which shall include but not be limited to the determination of reasonable

cost, the services being purchased and the duration of the agreement) include, but are not limited to:

SERVICE ACTIVITIES

Adjunctive Therapy;
Child Care Service, including day care;
Clinical Therapy;
Custodial Service;
Field Work Students;
Food Service;
Normal Education;
In-Service Training;
Intake or Evaluation, or both;
Medical Services;
Recreation;
Social Work or Counselling, or both;
Supportive Staff;
Volunteers.

OBJECT EXPENSES

Professional Fees and Contract Service Payments;
Supplies;
Telephone and Telegram;
Occupancy;
Local Transportation;
Equipment and Other Fixed Assets, including amortization

of same;
Miscellaneous.

ADMINISTRATIVE COSTS

Program Administration;
Supervision and Consultation;
Inspection and Monitoring for purposes of issuing
licenses;
Determination of Children who are eligible
for federal or other reimbursement;
Postage and Shipping;
Outside Printing, Artwork, etc.;
Subscriptions and Reference Publications;
Management and General Expense.

Reimbursement of administrative costs other than inspection
and monitoring for purposes of issuing licenses may not exceed
20% of the costs for other services.

The Department may offer services to any child or family
with respect to whom a report of suspected child abuse or
neglect has been called in to the hotline after completion of a
family assessment as provided under subsection (a-5) of Section
7.4 of the Abused and Neglected Child Reporting Act and the
Department has determined that services are needed to address
the safety of the child and other family members and the risk
of subsequent maltreatment. Acceptance of such services shall
be voluntary.

All Object Expenses, Service Activities and Administrative Costs are allowable.

If a survey instrument is used in the rate setting process:

(a) with respect to any day care centers, it shall be limited to those agencies which receive reimbursement from the State;

(b) the cost survey instrument shall be promulgated by rule;

(c) any requirements of the respondents shall be promulgated by rule;

(d) all screens, limits or other tests of reasonableness, allowability and reimbursability shall be promulgated by rule;

(e) adjustments may be made by the Department to rates when it determines that reported wage and salary levels are insufficient to attract capable caregivers in sufficient numbers.

The Department of Children and Family Services may pay 100% of the reasonable costs of research and valuation focused exclusively on services to wards of the Department. Such research projects must be approved, in advance, by the Director of the Department.

In addition to reimbursements otherwise provided for in this Section, the Department of Human Services shall, in accordance with annual written agreements, make advance quarterly disbursements to local public agencies for child day

care services with funds appropriated from the Local Effort Day Care Fund.

Neither the Department of Children and Family Services nor the Department of Human Services shall pay or approve reimbursement for day care in a facility which is operating without a valid license or permit, except in the case of day care homes or day care centers which are exempt from the licensing requirements of the "Child Care Act of 1969".

(Source: P.A. 89-507, eff. 7-1-97.)

(20 ILCS 505/9.9) (from Ch. 23, par. 5009.9)

Sec. 9.9. Review under Administrative Review Law. Any responsible parent or guardian affected by a final administrative decision of the Department in a hearing, conducted pursuant to this Act, may have the decision reviewed only under and in accordance with the Administrative Review Law as amended. The provisions of the Administrative Review Law, and the rules adopted pursuant thereto, shall apply to and govern all proceedings for the judicial review of such final administrative decisions of the Department. The term "administrative decision", is defined as in Section 3-101 of the Code of Civil Procedure.

Review of a final administrative decision under the Administrative Review Law is not applicable to a decision to conduct a family assessment as provided under subsection (a-5) of Section 7.4 of the Abused and Neglected Child Reporting Act

because no determination concerning child abuse or neglect is made and nothing is reported to the central register.

Appeals from all final orders and judgments entered by a court upon review of the Department's orders in any case may be taken by either party to the proceeding and shall be governed by the rules applicable to appeals in civil cases.

The remedy herein provided for appeal shall be exclusive, and no court shall have jurisdiction to review the subject matter of any order made by the Department except as herein provided.

(Source: P.A. 83-1037.)

Section 10. The Abused and Neglected Child Reporting Act is amended by changing Sections 7.4 and 11.6 as follows:

(325 ILCS 5/7.4) (from Ch. 23, par. 2057.4)

Sec. 7.4. (a) The Department shall be capable of receiving reports of suspected child abuse or neglect 24 hours a day, 7 days a week. Whenever the Department receives a report alleging that a child is a truant as defined in Section 26-2a of The School Code, as now or hereafter amended, the Department shall notify the superintendent of the school district in which the child resides and the appropriate superintendent of the educational service region. The notification to the appropriate officials by the Department shall not be considered an allegation of abuse or neglect under this Act.

(a-5) Beginning January 1, 2010, the Department of Children and Family Services may implement a 5-year demonstration of a "differential response program" in accordance with criteria, standards, and procedures prescribed by rule. The program may provide that, upon receiving a report, the Department shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child abuse or neglect.

For purposes of this subsection (a-5), "family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. "Family assessment" does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

For purposes of this subsection (a-5), "investigation" means fact-gathering related to the current safety of a child and the risk of subsequent abuse or neglect that determines whether a report of suspected child abuse or neglect should be indicated or unfounded and whether child protective services are needed.

Under the "differential response program" implemented under this subsection (a-5), the Department:

- (1) Shall conduct an investigation on reports

involving substantial child abuse or neglect.

(2) Shall begin an immediate investigation if, at any time when it is using a family assessment response, it determines that there is reason to believe that substantial child abuse or neglect or a serious threat to the child's safety exists.

(3) May conduct a family assessment for reports that do not allege substantial child endangerment. In determining that a family assessment is appropriate, the Department may consider issues including, but not limited to, child safety, parental cooperation, and the need for an immediate response.

(4) Shall promulgate criteria, standards, and procedures that shall be applied in making this determination, taking into consideration the Child Endangerment Risk Assessment Protocol of the Department.

(5) May conduct a family assessment on a report that was initially screened and assigned for an investigation.

In determining that a complete investigation is not required, the Department must document the reason for terminating the investigation and notify the local law enforcement agency or the Department of State Police if the local law enforcement agency or Department of State Police is conducting a joint investigation.

Once it is determined that a "family assessment" will be implemented, the case shall not be reported to the central

register of abuse and neglect reports.

During a family assessment, the Department shall collect any available and relevant information to determine child safety, risk of subsequent abuse or neglect, and family strengths.

Information collected includes, but is not limited to, when relevant: information with regard to the person reporting the alleged abuse or neglect, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being abused or neglected; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged abuse or neglect. Information relevant to the assessment must be asked for, and may include:

(A) The child's sex and age, prior reports of abuse or neglect, information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this paragraph (A) is consistent with other information collected during the course of the assessment or investigation.

(B) The alleged offender's age, a record check for prior reports of abuse or neglect, and criminal charges and convictions. The alleged offender may submit supporting documentation relevant to the assessment.

(C) Collateral source information regarding the

alleged abuse or neglect and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or care of the child maintained by any facility, clinic, or health care professional, and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child.

(D) Information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this subsection (a-5) precludes the Department from collecting other relevant information necessary to conduct the assessment or investigation. Nothing in this subsection (a-5) shall be construed to allow the name or identity of a reporter to be disclosed in violation of the protections afforded under Section 7.19 of this Act.

After conducting the family assessment, the Department shall determine whether services are needed to address the safety of the child and other family members and the risk of subsequent abuse or neglect.

Upon completion of the family assessment, if the Department concludes that no services shall be offered, then the case

shall be closed. If the Department concludes that services shall be offered, the Department shall develop a family preservation plan and offer or refer services to the family.

At any time during a family assessment, if the Department believes there is any reason to stop the assessment and conduct an investigation based on the information discovered, the Department shall do so.

The procedures available to the Department in conducting investigations under this Act shall be followed as appropriate during a family assessment.

The Department shall arrange for an independent evaluation of the "differential response program" authorized and implemented under this subsection (a-5) to determine whether it is meeting the goals in accordance with Section 2 of this Act. The Department may adopt administrative rules necessary for the execution of this Section, in accordance with Section 4 of the Children and Family Services Act.

The demonstration conducted under this subsection (a-5) shall become a permanent program on January 1, 2015, upon completion of the demonstration project period.

(b) (1) The following procedures shall be followed in the investigation of all reports of suspected abuse or neglect of a child, except as provided in subsection (c) of this Section.

(2) If, during a family assessment authorized by subsection (a-5) or an investigation, it appears that the

immediate safety or well-being of a child is endangered, that the family may flee or the child disappear, or that the facts otherwise so warrant, the Child Protective Service Unit shall commence an investigation immediately, regardless of the time of day or night. All other investigations In all other cases, investigation shall be commenced within 24 hours of receipt of the report. Upon receipt of a report, the Child Protective Service Unit shall conduct a family assessment authorized by subsection (a-5) or begin make an initial investigation and make an initial determination whether the report is a good faith indication of alleged child abuse or neglect.

(3) Based on an initial investigation, if If the Unit determines the report is a good faith indication of alleged child abuse or neglect, then a formal investigation shall commence and, pursuant to Section 7.12 of this Act, may or may not result in an indicated report. The formal investigation shall include: direct contact with the subject or subjects of the report as soon as possible after the report is received; an evaluation of the environment of the child named in the report and any other children in the same environment; a determination of the risk to such children if they continue to remain in the existing environments, as well as a determination of the nature, extent and cause of any condition enumerated in such report; the name, age and condition of other children in

the environment; and an evaluation as to whether there would be an immediate and urgent necessity to remove the child from the environment if appropriate family preservation services were provided. After seeing to the safety of the child or children, the Department shall forthwith notify the subjects of the report in writing, of the existence of the report and their rights existing under this Act in regard to amendment or expungement. To fulfill the requirements of this Section, the Child Protective Service Unit shall have the capability of providing or arranging for comprehensive emergency services to children and families at all times of the day or night.

(4) If (i) at the conclusion of the Unit's initial investigation of a report, the Unit determines the report to be a good faith indication of alleged child abuse or neglect that warrants a formal investigation by the Unit, the Department, any law enforcement agency or any other responsible agency and (ii) the person who is alleged to have caused the abuse or neglect is employed or otherwise engaged in an activity resulting in frequent contact with children and the alleged abuse or neglect are in the course of such employment or activity, then the Department shall, except in investigations where the Director determines that such notification would be detrimental to the Department's investigation, inform the appropriate supervisor or administrator of that employment or activity

that the Unit has commenced a formal investigation pursuant to this Act, which may or may not result in an indicated report. The Department shall also notify the person being investigated, unless the Director determines that such notification would be detrimental to the Department's investigation.

(c) In an investigation of a report of suspected abuse or neglect of a child by a school employee at a school or on school grounds, the Department shall make reasonable efforts to follow the following procedures:

(1) Investigations involving teachers shall not, to the extent possible, be conducted when the teacher is scheduled to conduct classes. Investigations involving other school employees shall be conducted so as to minimize disruption of the school day. The school employee accused of child abuse or neglect may have his superior, his association or union representative and his attorney present at any interview or meeting at which the teacher or administrator is present. The accused school employee shall be informed by a representative of the Department, at any interview or meeting, of the accused school employee's due process rights and of the steps in the investigation process. The information shall include, but need not necessarily be limited to the right, subject to the approval of the Department, of the school employee to confront the accuser, if the accuser is 14 years of age or

older, or the right to review the specific allegations which gave rise to the investigation, and the right to review all materials and evidence that have been submitted to the Department in support of the allegation. These due process rights shall also include the right of the school employee to present countervailing evidence regarding the accusations.

(2) If a report of neglect or abuse of a child by a teacher or administrator does not involve allegations of sexual abuse or extreme physical abuse, the Child Protective Service Unit shall make reasonable efforts to conduct the initial investigation in coordination with the employee's supervisor.

If the Unit determines that the report is a good faith indication of potential child abuse or neglect, it shall then commence a formal investigation under paragraph (3) of subsection (b) of this Section.

(3) If a report of neglect or abuse of a child by a teacher or administrator involves an allegation of sexual abuse or extreme physical abuse, the Child Protective Unit shall commence an investigation under paragraph (2) of subsection (b) of this Section.

(c-5) In any instance in which a report is made or caused to be made by a school district employee involving the conduct of a person employed by the school district, at the time the report was made, as required under Section 4 of this Act, the

Child Protective Service Unit shall send a copy of its final finding report to the general superintendent of that school district.

(d) If the Department has contact with an employer, or with a religious institution or religious official having supervisory or hierarchical authority over a member of the clergy accused of the abuse of a child, in the course of its investigation, the Department shall notify the employer or the religious institution or religious official, in writing, when a report is unfounded so that any record of the investigation can be expunged from the employee's or member of the clergy's personnel or other records. The Department shall also notify the employee or the member of the clergy, in writing, that notification has been sent to the employer or to the appropriate religious institution or religious official informing the employer or religious institution or religious official that the Department's investigation has resulted in an unfounded report.

(e) Upon request by the Department, the Department of State Police and law enforcement agencies are authorized to provide criminal history record information as defined in the Illinois Uniform Conviction Information Act and information maintained in the adjudicatory and dispositional record system as defined in Section 2605-355 of the Department of State Police Law (20 ILCS 2605/2605-355) to properly designated employees of the Department of Children and Family Services if the Department

determines the information is necessary to perform its duties under the Abused and Neglected Child Reporting Act, the Child Care Act of 1969, and the Children and Family Services Act. The request shall be in the form and manner required by the Department of State Police. Any information obtained by the Department of Children and Family Services under this Section is confidential and may not be transmitted outside the Department of Children and Family Services other than to a court of competent jurisdiction or unless otherwise authorized by law. Any employee of the Department of Children and Family Services who transmits confidential information in violation of this Section or causes the information to be transmitted in violation of this Section is guilty of a Class A misdemeanor unless the transmittal of the information is authorized by this Section or otherwise authorized by law.

(Source: P.A. 95-908, eff. 8-26-08.)

(325 ILCS 5/11.6) (from Ch. 23, par. 2061.6)

Sec. 11.6. All final administrative decisions of the Department under this Act are subject to judicial review under the Administrative Review Law, as now or hereafter amended, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure.

Review of a final administrative decision under the Administrative Review Law is not applicable to a decision to

Public Act 096-0760

SB0807 Enrolled

conduct a family assessment under subsection (a-5) of Section 7.4 because no determination concerning child abuse or neglect is made and nothing is reported to the central register.

(Source: P.A. 82-783.)

Appendix D: DCFS Differential Response Rule and Procedure

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY TRANSMITTAL 2011.02 DIFFERENTIAL RESPONSE

DATE: January 26, 2011

TO: Rules and Procedures Bookholders, Child Protection and Child Welfare Staff

FROM: Erwin McEwen, Director

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this policy transmittal is to issue new Rules and Procedures 300.45.

II. PRIMARY USERS

The primary users of these amended rules are the Department's State Central Register call floor workers, Differential Response Specialists and Supervisors, and purchase of agencies.

III. REVISIONS

Rules and Procedures 300.45 establish the Differential Response Five Year Demonstration Program. During the demonstration period, reports involving specific allegations of child neglect that meet a set of predetermined criteria will be randomly assigned to either an investigation or family assessment pathway. Unlike an investigation which requires gathering forensic evidence and a formal determination whether child maltreatment occurred, a family assessment is voluntary, non-adversarial, and non-accusatory. Family members are not labeled perpetrators or victims, and a record of the case is not entered in the State Central Register. After the initial assessment completed by a Differential Response Specialist, short term "Strengthening and Supporting Families" services are provided by a purchase of service agency. Cases may be referred back to the State Central Register at the initial assessment or anytime during the service delivery period when abuse or neglect issues are suspected or identified that make the case inappropriate for Differential Response. Investigation pathway cases may not be reassigned to Differential Response.

IV. NEW FORMS

The following forms are attached and may be downloaded from the SACWIS T drive:

CFS 613	Family Assessment Consent Form
CFS 613-1	Pathways to Strengthening and Supporting Families Family Assessment
CFS 613-2	Pathways to Strengthening and Supporting Families Voluntary Family Enhancement Plan

V. QUESTIONS

Questions concerning revisions may be directed to the Office of Child and Family Policy at 217/524-1983 or e-mail through Outlook at OCFP-Mailbox. Non-outlook users may submit questions to cfpolicy@idcfs.state.il.us through the Internet.

VI. FILING INSTRUCTIONS

Remove Rules 300 pages (1) - (2) and replace with the attached corresponding pages.

Remove Rules 300.20 in its entirety and replace with the attached corresponding pages.

Place new Rules 300.45 after Rules 300.40.

Remove Table of Contents from Procedures 300 and replace with attached Table of Contents.

Place new Procedures 300.45 after Procedures 300.40.

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER a: SERVICE DELIVERY

PART 300
REPORTS OF CHILD ABUSE AND NEGLECT

Section	
300.10	Purpose
300.20	Definitions
300.30	Reporting Child Abuse or Neglect to the Department
300.40	Content of Child Abuse or Neglect Reports
<u>300.45</u>	<u>Five Year Demonstration of the Differential Response Program</u>
300.50	Transmittal of Child Abuse or Neglect Reports
300.60	Special Types of Reports (Recodified)
300.70	Referrals to the Local Law Enforcement Agency and State's Attorney
300.80	Delegation of the Investigation
300.90	Time Frames for the Investigation
300.100	Initial Investigation
300.110	The Formal Investigative Process
300.120	Taking Children into Temporary Protective Custody
300.130	Notices Whether Child Abuse or Neglect Occurred
300.140	Transmittal of Information to the Illinois Department of Professional Regulation and to School Superintendents
	Referral for Other Services
	Special Types of Reports
300.150	Child Death Review Teams
300.160	Abandoned Newborn Infants
300.170	Acknowledgement of Mandated Reporter Status
300.180	Child Abuse and Neglect Allegations
	APPENDIX A
	APPENDIX B

AUTHORITY: Implementing and authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5], the Abandoned Newborn Infants Protection Act [325 ILCS 2] and Section 3 of the Consent by Minors to Medical Procedures Act [410 ILCS 210/3].

SOURCE: Adopted and codified as 89 Ill. Adm. Code 302 at 5 Ill. Reg. 13188, effective November 30, 1981; amended at 6 Ill. Reg. 15529, effective January 1, 1983; recodified at 8 Ill. Reg. 992; peremptory amendment at 8 Ill. Reg. 5373, effective April 12, 1984; amended at 8 Ill. Reg. 12143, effective July 9, 1984; amended at 9 Ill. Reg. 2467, effective March 1, 1985; amended at 9 Ill. Reg. 9104, effective June 14, 1985; amended at 9 Ill. Reg. 15820, effective November 1, 1985; amended at 10 Ill. Reg. 5915, effective April 15, 1986; amended at 11 Ill. Reg. 1390, effective January 13, 1987; amended at 11 Ill. Reg. 1151, effective January 14, 1987; amended at 11 Ill. Reg. 1829, effective January 15, 1987; recodified from 89 Ill. Adm. Code 302.20, 302.100, 302.110, 302.120, 302.130, 302.140, 302.150, 302.160, 302.170, 302.180, 302.190, and Appendix A at 11 Ill. Reg. 3492; emergency amendment at 11 Ill. Reg. 4058, effective February 20, 1987, for a maximum of

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150 days; amended at 11 Ill. Reg. 12619, effective July 20, 1987; recodified at 11 Ill. Reg. 13405; amended at 13 Ill. Reg. 2419, effective March 1, 1989; emergency amendment at 14 Ill. Reg. 11356, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 17558, effective October 15, 1990; amended at 14 Ill. Reg. 19827, effective November 28, 1990; emergency amendment at 15 Ill. Reg. 14285, effective September 25, 1991; amended at 15 Ill. Reg. 17986, effective December 1, 1991; emergency amendment at 17 Ill. Reg. 15658, effective September 10, 1993, for a maximum of 150 days; emergency expired February 7, 1994; amended at 18 Ill. Reg. 8377, effective May 31, 1994; amended at 18 Ill. Reg. 8601, effective June 1, 1994; amended at 19 Ill. Reg. 3469, effective March 15, 1995; amended at 19 Ill. Reg. 10522, effective July 1, 1995; amended at 20 Ill. Reg. 10328, effective July 19, 1996; amended at 22 Ill. Reg. 18847, effective October 1, 1998; amended at 23 Ill. Reg. 13590, effective November 15, 1999; amended at 24 Ill. Reg. 7707, effective June 1, 2000; amended at 25 Ill. Reg., 12781, effective October 1, 2001; amended at 26 Ill. Reg. 7435, effective May 15, 2002; amended at 26 Ill. Reg. 11730, effective August 1, 2002; amended at 27 Ill. Reg. 1114, effective January 15, 2003; amended at 27 Ill. Reg. 9431, effective June 9, 2003; peremptory amendment at 29 Ill. Reg. 21065, effective December 8, 2005; amended at 33 Ill. Reg. 7862, effective June 15, 2009; amended at 34 Ill. Reg. 6373, effective May 1, 2010; amended at 35 Ill. Reg. _____, effective _____.

Section 300.10 Purpose

The purpose of this Part is to describe how the Department of Children and Family Services (Department) administers and provides child protective services through a State Central Register and local child protective service units. This Part governs how child abuse and neglect is reported and how such reports are handled and investigated.

(Source: Added at 11 Ill. Reg. 12619, effective July 20, 1987)

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Section 300.20 Definitions

"Abandonment" means parental conduct that demonstrates the purpose of relinquishing all parental rights and claims to the child. Abandonment is also defined as any parental conduct that evinces a settled purpose to forego all parental duties and relinquish all parental claims to the child.

"Abused child" means a child whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent:

inflicts, causes to be inflicted, or allows to be inflicted upon such child physical or mental injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;

creates a substantial risk of physical or mental injury to such child by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health, or loss of or impairment of any bodily function;

commits or allows to be committed any sex offense against such child, as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include children under 18 years of age;

commits or allows to be committed an act or acts of torture upon such child; or

inflicts excessive corporal punishment; or

commits or allows to be committed the offense of female genital mutilation, as defined in Section 12-34 of the Criminal Code of 1961, against the child. [325 ILCS 5/3]

"Act" means the Abused and Neglected Child Reporting Act [325 ILCS5].

"CANTS/SACWIS 8" or "C/S8" means the Department's document titled Notification of a Report of Suspected Child Abuse and/or Neglect. This document explains the Department's child abuse/neglect allegation investigation process.

"CANTS/SACWIS 9" or "C/S9" means the Department's document titled Notification of Intent to Indicate Child Care Worker for Report of Child Abuse and/or Neglect. This document is used to notify a person that the Department plans to indicate that person as a perpetrator of child abuse/neglect.

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"CANTS/SACWIS 10" or "C/S10" means the Department's document titled Notice of Intent to Indicate a Child Care Worker for Report of Child Abuse and/or Neglect-Questions and Answers. This is an informational document explaining the impact of a determination of indicated child abuse/neglect and the appeal process.

"CANTS/SACWIS 11" or "C/S11" means the Department's document titled Notification of Indicated Decision in an Employment Related Report of Suspected Child Abuse and/or Neglect. This is the document by which the Department notifies a person that the Department has determined that there is credible evidence that he or she is responsible for the child abuse or neglect described in that document.

"Caregiver" means the child's parents, guardian, custodian or relative with whom the child lives and who has primary responsibility for the care and supervision of the child.

"Child" means any person under the age of 18 years, unless legally emancipated by reason of marriage or entry into a branch of the United States armed services. [325 ILCS 5/3]

"Child care facility" means any person, group of persons, agency, association or organization, whether established for gain or otherwise, who or which receives or arranges for care or placement of one or more children, unrelated to the operator of the facility, apart from the parents, with or without the transfer of the right of custody in any facility as defined in the Child Care Act of 1969, established and maintained for the care of children. Child care facility includes a relative who is licensed as a foster family home under Section 4 of the Child Care Act of 1969. [225 ILCS 10/2.05]

"Child care worker" means any person who is employed to work directly with children and any person who is an owner/operator of a child care facility, regardless of whether the facility is licensed by the Department. Child care facilities, for purposes of this definition, include child care institutions; child welfare agencies; day care/night care centers; day care/night care homes; day care/night care group day care homes; group homes; hospitals or health care facilities; schools, including school teachers and administrators, but not tenured school teachers or administrators who have other disciplinary processes available to them; and before and after school programs, recreational programs and summer camps. "Child care worker" also means persons employed as full-time nannies. A child care worker may, at his or her discretion, be subject to this Part if alleged to be responsible for child abuse or neglect outside of his or her employment. "Child care worker" includes a person: currently employed as a child care worker; currently enrolled in an academic program that leads to a position as a child care worker; or who has applied for a license required for a child care worker position. A person will be considered to be "employed as a child care worker" under this Part if, at the time of the notice of the investigation, he or she: has applied for, or will apply within 180 days for, a position as a child care worker; is enrolled in, or will commence within 180 days, an academic program that leads to a position as a child care worker; or has applied for a license as a child care worker.

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"Child-placing agency" means a licensed public or private agency that receives a child for the purpose of placing or arranging for the placement of the child in a foster family home or other facility for child care, apart from the custody of the child's parents. [325 ILCS 2/10]

"Child Protective Service Unit" or "CPS" means certain specialized State employees of the Department assigned by the Director or his or her designee to perform the duties and responsibilities described under this Part. CPS staff is also referred to as investigative staff. [325 ILCS 5/3]

"Children for whom the Department is legally responsible" means children for whom the Department has temporary protective custody, custody or guardianship via court order, or children whose parents have signed an adoptive surrender or voluntary placement agreement with the Department.

"CPSW" means a Child Protective Service Worker.

"Collateral contact" means obtaining information concerning a child, parent, or other person responsible for the child from a person who has knowledge of the family situation but was not directly involved in referring the child or family to the Department for services.

"Credible evidence of child abuse or neglect" means that the available facts when viewed in light of surrounding circumstances would cause a reasonable person to believe that a child was abused or neglected.

"Delegation of an investigation" means the investigation of a report of child abuse or neglect has been deferred to another authority. The Department maintains responsibility for determining whether the report is indicated or unfounded, entering information about the report in the State Central Register and notifying the subjects of the report and mandated reporters of the results of the investigation.

"Department" or "DCFS" means the Department of Children and Family Services.

"Determination" means a final Department decision about whether there is credible evidence that child abuse or neglect occurred. A determination must be either "indicated" or "unfounded."

"DR Specialist" means a Differential Response Specialist as described in Section 300.45 (e) (1).

"Disfigurement" means a serious or protracted blemish, scar, or deformity that spoils a person's appearance or limits bodily functions.

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“Ecomap” means a pictorial representation of family connections to different systems and community and other resources to identify significant people and/or systems around the family to illustrate the strengths, impact, and quality of each connection. (Hartman, A. Diagrammatic Assessment of Family Relationships. Social Casework, 59, 465-476. 1978)

“Emergency medical facility” means a freestanding emergency center or trauma center, as defined in the Emergency Medical Services (EMS) Systems Act. [325 ILCS 2/10]

“Emergency medical professional” includes licensed physicians, and any emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, trauma nurse specialist, and pre-hospital RN, as defined in the Emergency Medical Services (EMS) Systems Act. [325 ILCS 2/10]

“Fire station” means a fire station within the State with at least one staff person. [325 ILCS 2/10]

“Formal investigation” means those activities conducted by Department investigative staff necessary to make a determination as to whether a report of suspected child abuse or neglect is indicated or unfounded. Those activities shall include: an evaluation of the environment of the child named in the report and any other children in the same environment; a determination of the risk to such children if they continue to remain in the existing environments, as well as a determination of the nature, extent and cause of any condition enumerated in such report, the name, age and condition of other children in the environment; and an evaluation as to whether there would be an immediate and urgent necessity to remove the child from the environment if appropriate family preservation services were provided. After seeing to the safety of the child or children, the Department shall forthwith notify the subjects of the report in writing, of the existence of the report and their rights existing under the Act in regard to amendment or expungement. [325 ILCS 5/3]

“Genogram” means a pictorial representation of an individual's family relationships.

“Godparent” is a person who sponsors a child at baptism or one in whom the parents have entrusted a special duty that includes assisting in raising a child if the parent cannot raise the child. The worker shall verify the godparent/godchild relationship by contacting the parents to confirm the fact that they did, in fact, designate the person as the godparent. If the parents are unavailable, the worker should contact other close family members to verify the relationship. If the person is considered to be the child's godparent, in order for placement to occur, the same placement selection criteria as contained in 89 Ill. Adm. Code. 301.60 (Placement Selection) must be met. If the godparent is not a licensed foster parent, all the conditions currently in effect for placement with relatives in 89 Ill. Adm. Code. 301.80 must be met.

“Hospital” has the same meaning as in the Hospital Licensing Act [210 ILCS 851].

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“Indicated report” means any report of child abuse or neglect made to the Department for which it is determined, after an investigation, that credible evidence of the alleged abuse or neglect exists.

“Initial investigation” means those activities conducted by Department investigative staff to determine whether a report of suspected child abuse or neglect is a good faith indication of abuse or neglect and, therefore, requires a formal investigation. Good faith in this context means that the report was made with the honest intention to identify actual child abuse or neglect.

“Initial oral report” means a report alleging child abuse or neglect for which the State Central Register has no prior records on the family.

“Involved subject” means a child who is the alleged victim of child abuse or neglect or a person who is the alleged perpetrator of the child abuse or neglect.

“Legal custody” means the relationship created by a court order in the best interest of a newborn infant that imposes on the infant’s custodian the responsibility of physical possession of the infant, the duty to protect, train, and discipline the infant, and the duty to provide the infant with food, shelter, education, and medical care, except as these are limited by parental rights and responsibilities. [312 ILCS 2/10]

“Local law enforcement agency” means the police of a city, town, village or other incorporated area or the sheriff of an unincorporated area or any sworn officer of the Illinois Department of State Police.

“Mandated reporters” means those individuals required to report suspected child abuse or neglect to the Department. A list of these persons and their associated responsibilities is provided in Section 300.30 of this Part.

“Member of the clergy” means a clergyman or practitioner of any religious denomination accredited by the religious body to which he or she belongs. [325 ILCS 5/3]

“Neglected child” means any child who is not receiving the proper or necessary nourishment or medically indicated treatment including food or care not provided solely on the basis of present or anticipated mental or physical impairment as determined by a physician acting alone or in consultation with other physicians or otherwise is not receiving the proper or necessary support or medical or other remedial care recognized under State law as necessary for a child's well-being (including where there is harm or substantial risk of harm to the child's health or welfare), or other care necessary for a child's well-being, including adequate food, clothing and shelter; or who is abandoned by his or her parents or other person responsible for the child's welfare without a proper plan of care; or who is a newborn infant whose blood, urine or meconium contains any amount of controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in

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the newborn infant is the result of medical treatment administered to the mother or newborn infant. A child shall not be considered neglected for the sole reason that the child's parent or other person responsible for his or her welfare has left the child in the care of an adult relative for any period of time. A child shall not be considered neglected or abused for the sole reason that such child's parent or other person responsible for his or her welfare depends upon spiritual means through prayer alone for the treatment or cure of disease or remedial care under Section 4 of the Abused and Neglected Child Reporting Act. Where the circumstances indicate harm or substantial risk of harm to the child's health or welfare and necessary medical care is not being provided to treat or prevent that harm or risk of harm because the parent or other person responsible for the child's welfare depends upon spiritual means alone for treatment or cure, the child is subject to the requirements of this Act for the reporting of, investigation of, and provision of protective services with respect to the child and his or her health needs, and in such cases spiritual means through prayer alone for the treatment or cure of disease or for remedial care will not be recognized as a substitute for necessary medical care, if the Department or, as necessary, a juvenile court determines that medical care is necessary. A child shall not be considered neglected or abused solely because the child is not attending school in accordance with the requirements of Article 26 of the School Code. [325 ILCS 5/3]

“Newborn infant” means a child who a licensed physician reasonably believes is 7 days old or less at the time the child is initially relinquished to a hospital, police station, fire station, or emergency medical facility, and who is not an abused or a neglected child. [325 ILCS 2/10]

“Perpetrator” means a person who, as a result of investigation, has been determined by the Department to have caused child abuse or neglect.

“Person responsible for the child's welfare” means the child's parent, guardian, foster parent, relative caregiver, an operator, supervisor, or employee of a public or private residential agency or institution or public or private profit or not-for-profit child care facility; or any other person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust, including but not limited to health care professionals, educational personnel, recreational supervisors, members of the clergy and volunteers or support personnel in any setting where children may be subject to abuse or neglect. [325 ILCS 5/3]

“Police station” means a municipal police station or a county sheriff's office. [315 ILCS 2/10]

“Private guardianship” means an individual person appointed by the court to assume the responsibilities of the guardianship of the person as defined in Section 1-3 of the Juvenile Court Act of 1987 [705 ILCS 405/1-3] or Article XI of the Probate Act of 1975 [755 ILCS 5/Art. XI].

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“Relative,” for purposes of placement of children for whom the Department is legally responsible, means any person, 21 years of age or over, other than the parent, who:

is currently related to the child in any of the following ways by blood or adoption: grandparent, sibling, great-grandparent, uncle, aunt, nephew, niece, first cousin, first cousin once removed (children of one's first cousin to oneself), second cousin (children of first cousins are second cousins to each other), godparent (as defined in this Section), great-uncle, or great-aunt, or

is the spouse of such a relative, or

is the child's step-father, step-mother, or adult step-brother or step-sister,

Relative also includes a person related in any of the foregoing ways to a sibling of a child, even though the person is not related to the child, when the child and its sibling are placed together with that person. [20 ILCS 505/7(b)]

“Relinquish” means to bring a newborn infant, who a licensed physician reasonably believes is 30 days old or less, to a hospital, police station, fire station, or emergency medical facility and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant. In the case of a mother who gives birth to an infant in a hospital, the mother's act of leaving the new born infant at the hospital without expressing an intent to return for the infant or stating that she will not return for the infant is not a “relinquishment” under the act. [325 ILCS 2/10]

“Strengthening and Supporting Families service period” means a level of service intervention that will average 90 days, but no more than 120 days.

“State Central Register” is the record of child abuse and/or neglect reports maintained by the Department pursuant to the Act.

“Subject of a report” means any child reported to the child abuse/neglect State Central Register, and his or her parent, personal guardian or other person responsible for the child's welfare who is named in the report.

“SSF worker” means a Strengthening and Supporting Families worker.

“Temporary protective custody” means custody within a hospital or other medical facility or a place previously designated by the Department, subject to review by the Court. Temporary protective custody cannot exceed 48 hours excluding Saturdays, Sundays and holidays.

“Undetermined report” means any report of child abuse or neglect made to the Department in which it was not possible to complete an investigation within 60 days on the basis of information provided to the Department.

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“Unfounded report” means any report of child abuse or neglect for which it is determined, after an investigation, that no credible evidence of the alleged abuse or neglect exists.

(Source: amended at 35 Ill. Reg. _____, effective _____)

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Section 300.45 Five Year Demonstration of the Differential Response Program

- a) Differential Response recognizes that there are variations in the severity of reported maltreatment and allows for an investigation or family assessment response to reports of child neglect. Both responses focus on the safety and well-being of the child; promote permanency within the family whenever possible; and recognize the authority of child protection to make decisions about protective custody and court involvement when necessary.

An investigation response involves gathering forensic evidence and requires a formal determination regarding whether there is credible evidence that child maltreatment has occurred. A family assessment response involves assessing the family's strengths and needs and offering services to meet the family's needs and support positive parenting.

- b) Differential Response Criteria

During the demonstration period, reports of neglect that meet all the following criteria may be assigned to an assessment pathway:

- 1) Identifying information for the family members and their current address is known at the time of the report;
- 2) The alleged perpetrators are birth or adoptive parents, legal guardians or responsible relatives;
- 3) The family has no pending or prior indicated reports of abuse and/or neglect or prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations;
- 4) The alleged victims, or other siblings or household members, are not currently in the care and custody of the Department or wards of the court;
- 5) Protective custody of the children has not been taken or required in the current or any previous case; and
- 6) Allegations
 - A) The reported allegation or allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect. The following circumstances involving the allegations of Mental and Emotional Impairment, Inadequate Supervision, and Medical Neglect prohibit the report from being assigned to a family assessment pathway.

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- i) Mental and Emotional Impairment reports taken as abuse (Allegation #17) will be assigned an investigation pathway.
 - ii) Inadequate Supervision reports involving a child or children under the age of eight, or a child older than eight years of age with a physical or mental disability that limits his or her skills in the areas of communication, self-care, self-direction, and safety will be assigned an investigation pathway.
 - iii) Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated will be assigned an investigation pathway.
 - B) All other allegations are considered to involve substantial child abuse and neglect, and are ineligible for assignment to the assessment pathway.
- c) Differential Response Team (DRT) Supervisors

Prior to assigning reports to Differential Response (DR) Specialists, DRT Supervisors will review all reports assigned to their teams within two hours after receipt in the team's electronic mailbox, excluding evenings, weekends and holidays to determine their appropriateness for Differential Response. DRT Supervisors will also contact reporters of medical neglect reports, and may contact reporters of other allegations to confirm the information reported to the State Central Register and obtain any additional information that will enable the supervisor to determine the appropriateness of the report for Differential Response. Reports determined to be inappropriate for Differential Response will be redirected by the supervisor to the State Central Register for investigation in accordance with subsection (e).
- d) Initial and Ongoing Contacts with the Family

The initial Differential Response contact will occur in the family's home within three business days from the time the report is received at the State Central Register excluding weekends and holidays, and the contact shall involve the DR Specialist, Strengthening and Supporting Families (SSF) worker, adult family members and all children.

 - 1) If a family accepts assessment pathway services, the DR Specialist must do the following at the initial meeting with the family:
 - A) Verify identifying information and legal relationships of all household members.
 - B) Complete a Child Endangerment Risk Assessment Protocol Safety Assessment.

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- C) Obtain the names and addresses of any non-custodial parents.
- D) Complete a home safety checklist.
- E) Obtain consent for release of information signed by a family member with the authority to give consent.

AGENCY NOTE: If the family will not allow the DR Specialist access to the child or children, the family has declined family assessment services and the requirements of subsection (e) will be followed.

2) The SSF worker will provide intensive strength-based family-focused services during the Strengthening and Supporting Families service period, which will include the following:

- A) A comprehensive and collaborative evaluation of the family's strengths and needs that will include the family's financial status, basic educational screening for the children, and physical health, mental health and behavioral health screening for all family members. Information obtained will be used to construct a Genogram and Ecomap for use with the family;
- B) Services to meet any immediate needs of the family, including food, shelter and clothing;
- C) A minimum of twice weekly contacts with the family, which will include the children in the household;
- D) Service planning;
- E) Services to mitigate or control the causes of neglect;
- F) Child Endangerment Risk Assessment Protocol Safety Assessments completed in accordance with the requirements for intact families established by the Child Endangerment Risk Assessment Protocol;

AGENCY NOTE: The Child Endangerment Risk Assessment Protocol (CERAP) is used within the larger protocol of child protection practice to identify information consistent with threats to child safety; to analyze safety threats to determine how they are occurring within a particular family; and for safety planning to control identified safety threats. The major steps that are required to apply the protocol include an assessment and analysis of the safety factors using the Safety Determination Form (CFS 1441).

- G) Assessment of the family's reasonable progress in resolving the issues that brought them to the attention of the Department;

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H) Advocacy services; and

I) Discharge planning.

AGENCY NOTE: If at anytime during the service period the family denies the SSF worker access to the child or children, the SSF worker will follow the requirements of Subsection 300.45 (e).

3) Strengthening and Supporting Families supervisors will provide management services that will include review and approval of assessments, service plans, Child Endangerment Risk Assessment Protocol Safety Assessments, cash assistance requests, appropriateness of service referrals, case file documentation, requests for assessment service extensions, and requests to close family assessment cases.

A) Supervisory review and approval of Child Endangerment Risk Assessment Protocol Safety Assessments will be in accordance with the Child Endangerment Risk Assessment Protocol.

B) Families receiving Family Assessment services are eligible for cash assistance through the Differential Response Cash Assistance Program. The Differential Response Cash Assistance Program provides cash assistance to families facing environmental issues (i.e. inadequate food, shelter, or clothing, or environmental neglect) to address an immediate need due to environmental issues, which may be addressed by the delivery of some immediate cash assistance.”

The program provides cash assistance to families in the assessment pathway. Cash assistance requests are granted based upon the identified need of the applicant. An SSF worker submits a completed DR cash assistance form to his or her SSF Supervisor who forwards the form to the Regional DR Supervisor. Regional DR Supervisors are authorized to approve requests for \$400 or less. Requests over \$400 must be approved by the DCFS DR Project Director. Requests will be approved within 24 hours of application excluding holidays and weekends.

C) Supervisory monitoring of service provider reports to assess service delivery and appropriateness of services.

D) Approval of service extensions shall be based on the child’s safety and well-being, family’s needs and progress made in mitigating those conditions that contributed to their involvement with the Department.

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E) The following documents must be submitted to the SSF Supervisor before formalizing case closing with the family:

- i) Case Closing Summary
- ii) Child and Family Service Aftercare Plan
- iii) Case note documentation of required child interviews and documentation
- iv) Provider treatment reports
- v) CFS 1441, Safety Determination Form
- vi) Completed LEADS and SACWIS/CANTS checks for all adult members of the household and all adults who are frequently in the home

e) Pathway Reassignment

1) Differential Response Specialist

If a Differential Response Specialist determines that a child is unsafe, that there is an immediate need for intervention, or that maltreatment allegations are not within the scope of differential response, the Differential Response Specialist shall contact his or her supervisor within one hour after completion of the initial contact with the family to discuss case information and possible referral to the investigation pathway. If the supervisor determines that the report should be re-directed to an investigation pathway, he or she will contact the State Central Register Supervisor without delay to have the report transferred to investigations. The State Central Register Supervisor will enter the date and time of the contact with the supervisor as the report taken date and time and enter an appropriate response code.

2) Strengthening and Supporting Families Worker

If the family refuses services anytime during the service period and/or the SSF Supervisor and worker have reasonable cause to believe that a child has been or is being abused or neglected and at risk of harm at anytime during the service delivery period, the supervisor will contact the State Central Register Supervisor without delay to make a report of abuse or neglect. The State Central Register Supervisor will enter the date and time of the contact with the SSF Supervisor as the report taken date and time and enter an appropriate response code.

AGENCY NOTE: A case assigned to the investigation pathway may not be reassigned to an assessment pathway.

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f) Families May Refuse Assessment Pathway Services

A family may refuse to accept assessment pathway services. However, if it is determined by the DR Supervisor after review of available assessment and safety information that the child's safety is compromised by the refusal, the DR Supervisor will re-direct the report to the investigation pathway in accordance with subsection (e) (1). If no safety concerns are identified, the case will be closed.

g) No Formal Determination of Maltreatment

Family members whose case follows an assessment pathway are not labeled as perpetrators. Children in an assessment pathway case are not labeled victims. Names of children or family members involved in the assessment pathway are not entered in the State Central Register, and services are provided without a formal substantiation of alleged maltreatment.

(Source: 35 Ill. Reg. _____, effective _____)

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Section 300.45 Five Year Demonstration of the Differential Response Program

a) Differential Response

Differential Response (DR) is a method that allows child protective services to respond to accepted reports of specific allegations of child neglect with either an investigation or family assessment response. Both responses focus on the safety and well-being of the child; promote permanency within the family whenever possible; and recognize the authority of child protection to make decisions about protective custody and court involvement when necessary.

Unlike an investigation which requires gathering forensic evidence and a formal determination whether there is credible evidence that child maltreatment has occurred, a family assessment is a non-adversarial, non-accusatory response. Cases opened for family assessment services are short term, and may not exceed 120 days. It is suggested that families that agree to participate in family assessment services are more likely to be receptive to and engage in the receipt of services. Families have the option to decline to participate in family assessment services, and if a review of the case information indicates that the child's safety is compromised by the refusal, the case will be referred back to the State Central Register and an investigation will begin within 24-hours of the referral if a normal response is required. If no safety concerns are identified, the case is closed.

Family members whose case follows a family assessment pathway are not labeled as perpetrators or victims. Services are provided without a formal substantiation of alleged maltreatment and a record of the case is not entered in the State Central Register.

b) State Central Register

The State Central Register (SCR) call floor workers will process alleged reports of neglect in accordance with Sections 300.20 and 300.30. Reports that meet the criteria for Differential Response will be randomly assigned by computer to Differential Response and forwarded to the appropriate region/site/field Differential Response Team (DRT) Supervisor for review and assignment. The SCR may also change a report from a family assessment pathway to an investigation pathway based on risk and/or safety issues to the child.

c) Differential Response Eligibility Criteria

All of the following factors must be present for a report to be assigned to Differential Response:

- 1) Identifying information for the family members and their current address is known at the time of the report; and
- 2) The alleged perpetrators are parents, birth or adoptive, legal guardians, or responsible relatives; and

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- 3) The family has no prior indicated reports of abuse and/or neglect; or
- 4) Prior indicated reports have been expunged within the timeframe or timeframes established by the Department for the indicated allegation or allegations; and
- 5) The alleged victims, or other siblings or household members, are not currently in the care and custody of the Illinois Department of Children and Family Services or wards of the court; and
- 6) Protective custody of the children has not been taken or required in the current or any previous case; and
- 7) The reported allegations shall only include Mental and Emotional Impairment (neglect only), Inadequate Supervision, Inadequate Food, Inadequate Shelter, Inadequate Clothing, Medical Neglect, and Environmental Neglect. The following circumstances involving the allegations of Mental and Emotional Impairment, Inadequate Supervision, and Medical Neglect prohibit the report from being assigned to a family assessment pathway.
 - A) Mental and Emotional Impairment reports taken as abuse (Allegation #17) will be assigned an investigation pathway.
 - B) Inadequate Supervision reports involving a child or children under the age of eight, or a child older than eight years of age with a physical or mental disability which limits his or her skills in the areas of communication, self-care, self-direction, and safety will be assigned an investigation pathway.
 - C) Medical Neglect reports that involve a child with a severe medical condition that could become serious enough to cause long-term harm to the child if untreated will be assigned an investigation pathway.

Upon receipt of medical neglect reports, DRT Supervisors will contact the reporter to confirm the information reported to the SCR and obtain any additional information concerning:

- The child's ability to obtain and implement a treatment/management plan;
- The child's current health problem and the seriousness of the outcome if left untreated;
- The child's physical condition;
- The child's developmental level/capacity; and
- If the child's current health problem is not treated, what is the seriousness of the outcome?

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If the supervisor concludes from the reporter's information that the case is not appropriate for Differential Response, the supervisor will without delay contact the SCR Call Floor Supervisor by telephone to have the report reassigned to an investigation pathway.

d) Differential Response Team

1) Differential Response Team Supervisors

DRT Supervisors will review and assign Differential Response reports no later than two hours after receipt of reports in the team's Outlook mailbox, excluding evenings, weekends and holidays. The DRT Supervisor and assigned Differential Response (DR) Specialist will meet at the time of case assignment, preferably in-person, for a supervisory conference to review and discuss case information (i.e., allegation, risk and safety issues, immediate needs, LEADS, and other case specific information).

2) Differential Response Specialists

A) Preparation for Meeting the Family

DR Specialists must complete the following activities prior to making initial in-person contact with the family.

- i) Interview the reporter if the interview was not completed by the supervisor.
- ii) If the reporter is mandated, provide the reporter with an explanation of the Differential Response.

Note: The SCR will generate a notice to mandated reporters notifying them of the family's participation in the family assessment pathway when the family assessment has been completed.

- iii) Interview other persons with information listed on the report.
- iv) Contact the family by telephone within 24 hours of case assignment to explain Differential Response, schedule the initial in-home family visit, and verify the names and dates of birth of all family members and other persons living in the household.

The initial differential response contact will involve the Differential Response (DR) Specialist, Strengthening and Supporting Families (SSF) worker, and the family, in the family's home, within three business days from the time the report is received at the State Central Register.

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Based on the reported needs and/or safety issues of the family, the DRT Supervisor may require that the initial contact with the family occur sooner than three days.

- v) Complete data checks and SOUNDEX members of the household if they have not been completed.
- vi) Complete LEADS check in accordance with Administrative Procedure #6 if the LEADS checks have not been completed.
- vii) Contact the Strengthening and Supporting Families (SSF) agency to coordinate the initial visit with the family with the assigned SSF worker.
- viii) Document all activities on a SACWIS contact note within 24-hours after they are completed.

B) Unable to Locate the Family

If the intake report contains inaccurate information (e.g., names, current locations) which the DR Specialist cannot use to quickly locate the family, the DR Specialist will take whatever steps are necessary, including but not limited to the following actions, to locate and establish in-person contact with the family.

- i) Contact the reporter or source of the report if listed on the intake report.
- ii) Ask the local, county, and state law enforcement agencies to check their records for information which would locate the child/family.
- iii) Conduct a records check of the Department of Human Services and Secretary of State, Division of Motor Vehicles records if a license number is known.
- iv) Conduct a diligent search in accordance with Administrative Procedure #22.
- v) Ask relatives and friends of the subjects to provide information to help locate the subjects.
- vi) Contact the local post office, Department of Human Services, utility companies and school to request a check of their records.

Note: If after completion of all the activities listed above, no contact is made with the family by the sixth business day after case assignment the DRT Supervisor will ensure that information in SACWIS is updated. The

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DRT Supervisor will also contact the SCF Supervisor without delay, no later than the seventh day after case assignment, to have the report transferred to investigations. The SCR Supervisor will enter the date and time of the contact with the DRT Supervisor as the report taken date and time and enter an appropriate response code.

C) Initial In-Person Meeting With the Family

The DR Specialist will provide the following information to the family with the assistance of the SSF worker.

- i) An explanation of Differential Response that includes the disclosure that participation in the program is voluntary, and that if the family declines to participate in the program the case may be closed or referred for investigation based on assessed risk and/or safety issues. If the family will not allow the worker access to the child or children, the family has declined family assessment services.

The DR Specialist will do the following if the family refuses to participate in family assessment services.

- Contact the DRT Supervisor within one hour after completion of the initial contact with the family to discuss case information and possible referral to the investigation pathway. Information to be discussed should include the intake summary, information obtained from the reporter; observations made during the initial family contact; CERAP; information obtained from the family; and other pertinent information. If the DRT Supervisor determines that safety issues exist and that the report should be re-directed to an investigation pathway, he or she will contact the SCR Supervisor without delay to have the report transferred to investigations. The SCR Supervisor will enter the date and time of the contact with the DRT Supervisor as the report taken date and time and enter an appropriate response code.
- If after assessment of the available case information, the DR Specialist and Supervisor determine that there are no safety concerns the case is closed.
- If the DRT Supervisor is not available and there are assessed safety issues, the DR Specialist will contact the SCR Supervisor to complete the transfer of the report to the investigation pathway.

REPORTS OF CHILD ABUSE AND NEGLECT

January 26, 2011 - P.T. 2011.02

- ii) Inform the family that they have the right to receive services in their primary language and in a manner that is non-coercive and protects their right to self-determination.
- iii) Verify identifying information and legal relationships of all household members.
- iv) Complete a Child Endangerment Risk Assessment Protocol Safety Assessment.

Note: Children must be interviewed out of the presence of their parents/caregivers and the alleged perpetrator if at all possible.

- v) Obtain the names and addresses of any non-custodial parents.
- vi) Complete a home safety checklist.
- vi) Complete a Domestic Violence Screen (CANTS 18-DV) in accordance with Appendix J of Procedures 300.
- vii) When an alleged child victim of a report of medical neglect is identified by the DR Specialist as having or possibly having special health care needs or a child with special health care needs is living in the home, the DR Specialist must refer the child for nursing consultation services no later than 24 hours of the initial family contact. See Procedures 300.70 (j) for referral information.
- viii) Obtain consent for release of information signed by a family member with the authority to give consent.

D) Post Initiation DRT Supervisory Conference

A post initiation supervisory conference will occur within 24-hours after the specialist's initial in-person contact with the family to review contact notes, reporter's information, Child Endangerment Risk Assessment Protocol Safety Assessment, data checks, and LEADS checks to ensure procedural compliance. If there are no issues, the specialist will submit the DR report file within 48-hours for approval by the DRT Supervisor.

e) Strengthening and Supporting Families

1) Strengthening and Supporting Families Supervisor

SSF Supervisors will provide management services that will include review and approval of assessments, service plans, Child Endangerment Risk Assessment Protocol Safety Assessments, cash assistance requests, appropriateness of service referrals, case file documentation, requests for assessment service extensions, and requests to close family assessment cases.

REPORTS OF CHILD ABUSE AND NEGLECT
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If the Strengthening and Supporting Families Supervisor and worker have reasonable cause to believe that a child has been or is being abused or neglected or at risk of harm at anytime during the service delivery period, the supervisor will contact the State Central Register Supervisor without delay to make a report of abuse or neglect. The State Central Register Supervisor will enter the date and time of the contact with the Strengthening and Supporting Families Supervisor as the report taken date and time and enter an appropriate response code.

2) Strengthening and Supporting Families Workers

SSF workers will do the following after the DR Specialist has completed his or her required tasks, and the parents have agreed to participate in family assessment services.

- A) Assume the role of the family's advocate and case manager.
- B) Engage the parents in a comprehensive and collaborative evaluation of the family's strengths and needs that will include the family's financial status, basic educational screening for the children; physical health, mental health and behavioral health screening for all family members. Information obtained will be used to construct a Genogram and Ecomap for use with the family.
- C) Obtain the names and addresses of those persons that provide a support system for the family.
- D) Obtain the names and addresses of any service providers that have been or are currently involved in providing services to the family.
- E) Obtain consent for release of information to contact service providers and persons in the family's support system.
- F) Initiate services to meet any immediate needs of the family, including food, shelter and clothing.

Families receiving Family Assessment services are eligible for cash assistance through the Differential Response Cash Assistance Program. The program provides cash assistance to families in the assessment pathway. Cash assistance requests are granted based upon the identified need of the applicant. An SSF worker submits a completed DR cash assistance form to his or her SSF Supervisor who forwards the form to the Regional DR Supervisor. Regional DR Supervisors are authorized to approve requests for \$400 or less. Requests over \$400 must be approved by the DCFS DR Project Director. Requests will be approved within 24 hours of application excluding holidays and weekends.

REPORTS OF CHILD ABUSE AND NEGLECT

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- G) Maintain a minimum of twice weekly contacts with the family which will include the children in the household, unless the SSF Supervisor and family determine that the contacts should occur more frequently.
- H) Establish a service plan with input from the family.
- I) Identify and implement services to address the causes of neglect.
- J) Maintain ongoing contact with service providers.
- K) Complete Child Endangerment Risk Assessment Protocol Safety Assessments in accordance with Procedures 300, Appendix G.
- L) Assess the family's reasonable progress in resolving the issues that brought them to the attention of the Department.
- M) Advocate for the family.
- N) Establish a discharge plan with input from the family.
- O) Submit the following documents to the SSF Supervisor before formalizing case closing with the family.
 - Case Closing Summary
 - Child and Family Service Aftercare Plan
 - Case note documentation of required child interviews
 - Provider treatment reports
 - Closing CFS 1441, Safety Determination Form
 - Completed LEADS and SACWIS/CANTS checks for all adult members of the household and all adults that are frequent visitors in the home.
- P) Complete SACWIS contact notes within 24-hours after an activity or contact has been completed.

State of Illinois
Department of Children and Family Services
Family Assessment Consent Form

On _____(DATE), I was advised that a report had been made to the Department of Children and Family Services' Child Abuse Hotline involving _____(name of Child). I have also been advised that this report meets the criteria for the Pathways to Strengthening and Supporting Family Program. As part of the Pathways to the Strengthening and Supporting Family (SSF) Program, I understand that the Department will not, as part of this Program, conduct a formal child abuse and neglect investigation that would result in an indicated or unfounded finding of child abuse. Instead, I understand that the Department will conduct a comprehensive assessment of me and my family in order to provide services to me and my family. I understand that the services are voluntary and that by signing this form, I am agreeing to participate in the Pathways to Strengthening and Supporting Families Program, to provide the Department with specific information about myself and my child and to participate in services.

I/we have discussed the Family Assessment/Differential Response Program with the worker, we understand the program and that it is voluntary.

I/we agree to participate in the Family Assessment/Differential Response Program.

I/we understand that nothing will be reported to the State Central Register due to my participation in the Family Assessment/Differential Response Program.

I/we understand that DCFS reserves the right to refer this case to DCP/Investigations at any time if there is reason to believe that substantial child abuse or neglect or a serious threat to the child's safety exists.

I/we understand that information gathered during the family assessment may be shared with the Courts, DCP/Investigations and other branches of DCFS.

I/we understand that I may withdraw my voluntary consent to participate in the Family Assessment/Differential Response Program in writing, submitted to my assigned Worker.

Parent/Caregiver: _____ Date: _____

Parent/Caregiver: _____ Date: _____

I have discussed the Family Assessment/Differential Response program and the consequences of non-compliance with the family and all those who will be participating in the assessment. I have their agreement to participate in the Family Assessment/Differential Response Program.

SSF Worker: _____ Phone Number: _____ Date: _____

Supervisor: _____ Phone Number: _____ Date: _____

Original to file
Copy to parent

State of Illinois
Department of Children and Family Services
Pathways to Strengthening and Supporting Families
Family Assessment

DR ID#:

Family Name:

CYSIS ID#:

Address:

Home phone #:

Cell #:

Date:

Name

Relationship to Child(ren)

Date of Birth

Differential Response (DR) Specialist:

Strengthening and Supporting Family (SSF) Worker:

SSF Agency:

What issues/behaviors brought this case to the attention of the Department? (Reason for case involvement.)

Family Assessment

Family's identified strengths:

Family's identified outcome(s):

Family's suggested intervention(s):

Current or Previous social service intervention:

Caregiver Assessment

Overall Family
Evaluation

- I. Knowledge of Parenting and Child Development:
 1. Knowledge of Child's Needs (100)
 2. Nutrition Management (101)
 3. Discipline (102)
 4. Learning Environment (103)
 5. Demonstrates Effective Parenting Approaches (104)
- II. Ability to Nurture Social and Emotional Competence of Children:
 1. Parent/Caregiver's ability to listen as parent (117)
 2. Parent/Caregiver's understanding of impact of own behavior on children (118)
 3. Empathy with Children (119)
- III. Identification and Use of Concrete Supports in Times of Need:
 1. Involvement in Care (105)
 2. Organization (108)
 3. Knowledge of Social Service Options (110)
- IV. Positive Family, Community, Social Connections:
 1. Partner Relations (113)
 2. Relations with Extended Family (114)
 3. Community Involvement (115)
 4. Natural Supports (116)
- V. Parental Resilience:
 1. Physical Health (121)
 2. Mental Health (122)
 3. Substance Use (123)
 4. Developmental (124)
 5. Parent/Caregiver Posttraumatic Reactions (125)
 6. Hygiene and Self-Care (126)
 7. Independent Living Skills (127)
 8. Recreation (128)
 9. Education

10. Employment

VI. Healthy Parent-Child Relations:

1. Parent/Caregiver's Ability to Listen as Parent (117)
2. Parent/Caregiver's Understanding of Impact of Own Behavior on Children (118)
3. Able to Communicate (120)

VII. Family Economics:

1. Parent/Caregiver's Employment Stability
2. Parent/Caregiver's Money Management Skills
3. Budget Stability

Safety Assessment

Overall Family Evaluation

Present placement is safe for the child(ren).

Supervision and monitoring of children are appropriate and functioning well.

Health or safety concerns on property.

Parent/caregiver generally demonstrates an ability to discipline her/his children in a consistent and respectful manner.

Family Resilience and Strengths

Specify efforts made by the parents to preserve the family related to the reason for referral to Pathways to Strengthening and Supporting Families:

Identify supports provided by service providers to strengthen and support family:

Client Service Plan

Service Referral Information:

Services	To be provided by Strengthening and Supporting Family Worker				Referral Information			Did client successfully connect with agency?	
	Yes	No	Yes	No	Agency Name	Client Name	Date	(check and confirm within 3 days)	
Accompanied to other linkage services	Yes	No	Yes	No				Yes	No
Anger management	Yes	No	Yes	No				Yes	No
Cash assistance / utilities / clothing / food	Yes	No	Yes	No				Yes	No
Computer literacy training	Yes	No	Yes	No				Yes	No
Child Care	Yes	No	Yes	No				Yes	No

Counseling services	Yes	No	Yes	No	Yes	No
Domestic violence services	Yes	No	Yes	No	Yes	No
Education / GED	Yes	No	Yes	No	Yes	No
Effective parenting classes	Yes	No	Yes	No	Yes	No
Employment / Job Assistance	Yes	No	Yes	No	Yes	No
Family support group sessions	Yes	No	Yes	No	Yes	No
Financial literacy training	Yes	No	Yes	No	Yes	No
Housing services	Yes	No	Yes	No	Yes	No
Job readiness training	Yes	No	Yes	No	Yes	No
Life skills training	Yes	No	Yes	No	Yes	No
Medical / dental services	Yes	No	Yes	No	Yes	No
Mental health services	Yes	No	Yes	No	Yes	No
Mentoring group	Yes	No	Yes	No	Yes	No
Parent café	Yes	No	Yes	No	Yes	No
Shelter services	Yes	No	Yes	No	Yes	No
Sexual abuse treatment	Yes	No	Yes	No	Yes	No
Substance abuse treatment	Yes	No	Yes	No	Yes	No
Teen parenting services	Yes	No	Yes	No	Yes	No
Violence prevention services	Yes	No	Yes	No	Yes	No
Paternal Involvement Center	Yes	No	Yes	No	Yes	No

Progress of Family Support Services

Case Disposition

Request Extension: Yes No

Rationale:

Approved: Yes No

Refer to Investigation: Yes No

Rationale:

Aftercare Plan Developed by Family:

Parent(s)/Guardian(s) Signature:

Parent(s)/Guardian(s) Signature:

SSF Worker Signature:

Supervisor Signature:

Date:

Protective Factors/CANS Definition

- I. Knowledge of Parenting and Child Development: understanding of role of parent, child development and parenting skills.

Knowledge of Child's Needs (100)

This item is perhaps the one most sensitive to issues of cultural competence. It is natural to think that what you know, someone else should know and if they do not, then it is a knowledge problem. In order to minimize cultural issues, we recommend that you think of this item in terms of whether there is information that could be made available to the parent/caregivers that would allow them to be more effective in working with their child.

Nutrition Management(101)

This item relates to the parent/caregiver's ability to provide the child with a healthy diet that meets the particular child's needs.

Discipline (102)

Parent/caregiver must demonstrate age-appropriate discipline with children. Discipline is defined in the broadest sense as all of the things that parents/caregivers can do to promote positive behavior with their children. If the caregiver consistently sets limits that are in line with that child's age and development, it would be rated a "0."

Learning Environment (103)

Parent/caregiver who creates a good learning environment, i.e. reads to children, assists with homework or finds others who can help children would be rated a '0'. If the child is not encouraged to learn or is prevented from learning, this item would be rated a "3."

Demonstrates Effective Parenting Approaches (104)

This item relates to a parent/caregiver's knowledge of parenting strategies and implementation of those strategies. A parent who is taking a parenting skills class who demonstrates those skills successfully in visitation may be rated a "0." For example, does the parent/caregiver use timeouts as a parenting strategy when their child is acting out? Does the parent/caregiver consider whether the child should sit, how long they should sit there, and how to handle a child who won't stay seated or is throwing a tantrum during the timeout?

- II. Ability to Nurture Social and Emotional Competence of Children: parent/caregiver's ability to communicate with and relate to child and to thereby foster child's healthy social and emotional life.

Parent/Caregiver's ability to listen as parent (117)

This item refers to the ability to listen to children and to listen to others as they give feedback on parenting. A "0" would be a parent who can understand both what he/she does well and areas in which their parenting needs to improve.

Parent/Caregiver's understanding of impact of their own behavior on children (118)

This item describes the degree to which a parent/caregiver understands how their past and current behavior impacts the child. A "3" is a parent who denies any impact of their behavior on a child. For example, a parent/caregiver who is a drug user/dealer who states, "What I do on my own time does not impact my children."

Empathy with Children (119)

Empathy is the ability to identify with and understand somebody else's feelings or difficulties. This item rates the ability of the parent/caregiver to demonstrate empathy with the child. For example, a parent/caregiver who responds to a child's tears following the conclusion of a visit with anger or annoyance would be rated a "2" or "3."

- III. Identification and Use of Concrete Supports in Times of Need: promotes a safe and healthy environment for their child, and has ability to identify and access resources as needed.

Involvement in Care (105)

A "0" on this item is reserved for parents/caregivers who are able to advocate for their child. This requires both knowledge of their child's needs, their rights, options and opportunities. A "1" is used to indicate parents/caregivers who are willing participants with service provision, but may not yet be able to serve as advocates for their child. A "2" is used to indicate parents/caregivers willing to get their child help but does not want any help themselves. A "3" is a parent/caregiver who is unwilling to continue to parent this child.

Organization (108)

This item is used to rate the parent/caregiver's ability to organize and manage their household within the context of intensive community services. Parents who need help organizing themselves and/or their family would be rated a "2" or "3."

Knowledge of Social Service Options (110)

This item refers to the parent/caregiver's knowledge of choices that they may have for receiving services, i.e. treatment options, services for children with special needs, etc.

- IV. Positive Family, Community, Social Connections: parent/caregiver's support network.

Partner Relations (113)

This item refers to a parent/caregiver's relationship with another adult and the functioning of that relationship. Does the parent/caregiver have a partner to help them?

Relations with Extended Family (114)

Extended family members can play supportive roles to parents/caregivers. Indicate the extent to which there is support from extended family members. This item takes the Resources item further by asking specifically about extended family that may or may not be part of the parent/caregivers network of support.

Community Involvement (115)

This item refers to the institutions in the neighborhood – community centers, churches, park districts, etc. and asks if the parent/caregiver is connected. A parent/caregiver who is actively involved in the community would be rated '0'. Again, this item builds off the Resources item and asks specifically if the parent/caregiver connected to members/organizations in their community?

Natural Supports (116)

This item refers to the family's support system, including church, community, family, friends, jobs, and teams that support interests, etc. These concrete resources can be called upon to support the permanency goal. This item does not include financial resources.

V. Parental Resilience

Physical Health (121)

This item refers to medical and/or physical problems that the parent/caregivers may be experiencing that limit or prevents their ability to parent the child. For example, a single parent who has recently had a stroke and has mobility or communication limitations might be rated a “2” or even a “3.” If the parent has recently recovered from a serious illness or injury or if there are some concerns of problems in the immediate future they might be rated a “1.”

Mental Health (122)

This item allows for the identification of serious mental illness among parent/caregivers that might limit capacity to parent the child. A parent with a serious mental illness would likely be rated a “2” or even a “3” depending on the impact of the illness. However, a parent whose mental illness is currently well controlled by medication might be rated a “1.”

Substance Use (123)

This item describes the impact of any notable substance use on parent/caregivers. If substance use interferes with parenting, a rating of “2” is indicated. If it prevents caring for the child, a “3” would be used. A “1” indicates a parent/caregiver currently in recovery, or a situation where problems of substance use are suspected but not confirmed.

Developmental (124)

This item describes the presence of developmental disabilities among parents/caregivers. A parent with limited cognitive capacity that challenges their ability to provide parenting would be rated here. Ratings are based on the level to which developmental disabilities interfere with parenting the child.

Parent/Caregiver Post-Traumatic Reactions (125)

Symptoms of Post-Traumatic Stress Disorder (PTSD) include nightmares, flashbacks, hyper vigilance and avoidance. These symptoms could be based on the parent’s own history of trauma and/or their child’s trauma. Ratings are based on the level to which PTSD interferes with parenting the child.

Hygiene and Self-Care (126)

This item describes the current ability of the parent/caregiver to take care of their own basic personal needs – dressing, bathing, eating, etc. This may be limited by short or long-term concerns with a person’s well being. For example, a parent with a severe illness or disability requiring 24-hour care would be rated a “3.”

Independent Living Skills (127)

This item focuses on the parent/caregiver’s ability to live independently with skills to manage finances, housekeeping and transportation. The current status of their ability would be rated.

Recreation (128)

This item refers to the hobbies and interests that the parent/caregiver pursues in non-scheduled time. Only legal interests should be considered.

VI. Healthy Parent-Child Relations: parents/caregiver’s ability to communicate with and relate to child and to thereby foster child’s healthy social and emotional life.

Parent/Caregiver’s Ability to Listen as Parent (117)

This item refers to the ability to listen to children and to listen to others as they give feedback on parenting. A “0” would be a parent who can understand both what they do well and areas where their parenting needs to improve.

Parent/Caregiver's Understanding of Impact of Own Behavior on Children (118)

This item describes the degree to which a parent/caregiver understands how their past and current behavior impacts the child. A "3" is a parent who denies any impact of their behavior on a child. For example, a parent/caregiver who is a drug user/dealer and says, "What I do on my own time doesn't impact my children."

Ability to Communicate (120)

This item refers to the parent/caregiver's ability to express their thoughts and feelings regarding their parenting and their child's needs and strengths. Some parents/caregivers struggle to get past the anger or sadness they feel when their child enters care. If a parent/caregiver cannot express these feelings, he/she may need therapeutic intervention to help him/her focus on getting their child returned home.

Ratings:

0 = no evidence – This rating indicates that there is no reason to believe that a particular need exists.

1 = watchful waiting/prevention – This level of rating indicates that you need to be observant in this area and/or consider preventive actions.

2 = action needed – This level of rating indicates that something must be done to address the identified need. The need is sufficiently problematic that it is interfering in the child or family's life in a notable way.

3 = immediate/intensive action – This level rating indicates a need that require immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level.

State of Illinois
Department of Children and Family Services
Pathways to Strengthening and Supporting Families
Voluntary Family Enhancement Plan

Family Case Name:

Case ID #:

Date Plan Initiated:

Type of Plan:

Initial

Revised

Closing

Agency:

Strengthening and Support Family (SSF) Worker:

Name of Family Member

Relationship to Child(ren)

Date of Birth

1.

2.

3.

4.

5.

Voluntary Family Service Outcome

Name of Family Member(s), for Whom the Service Outcome Applies:

Protective Factor(s) Being Addressed to Strengthen the Family: (choose one or more)

Parental Resilience

Social Connections

Knowledge of Parenting and Child Development

Concrete Support in Times of Need

Social and Emotional Competence of Children

Healthy Parent-Child Relationships

Strengths the Family Has and Will Utilize in Receiving Voluntary Service:

The Following Voluntary Service Outcomes Will Strengthen or Support the Family:

Service	Target	Actual	Evaluation	Evaluation
	Completion Date	Completion Date		

Who:

Needs to do what:

In order to:

Who:

Needs to do what:

In order to:

Who:

Needs to do what:

In order to:

Who:

Needs to do what:

In order to:

Evaluation of Progress Toward the Desired Family Service Outcome:

Date:

Evaluated By:

Narrative:

Overall Evaluation:

Family Planning Acknowledgments

I voluntarily participated in the development of my plan.

Parent's Signature

Date

I voluntarily participated in the development of my plan.

Parent's Signature

Date

By the signatures below, I agree to work voluntarily with the Department of Children and Family Services toward the goal of strengthening and supporting my family by correcting the behavior or conditions that require my family's involvement with the Pathways to Strengthening and Supporting Family Program. The agreed change in behavior or condition will ensure the health, safety, and well-being of my child and family. I(We) agree to cooperate with the Department of Children and Family Services and their assigned Strengthening and Supporting Family Worker, in order to help accomplish the family plan, as written.

Parent's Signature

Date

Parent's Signature

Date

Strengthening and Supporting Family Worker Signature

Date

Appendix E: Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING DIFFERENTIAL RESPONSE

In order to achieve the Department's goal of strengthening and preserving families in Illinois, the parties hereby agree that, subject to the provisions as set forth below, the Department will create and implement a statewide "Differential Response" demonstration project.

CREATION OF "DIFFERENTIAL RESPONSE" (D-R) TEAMS

The Department will temporarily create specific D-R teams consisting of D-R Family Assessment workers and a D-R supervisor in the various sub-regions in each of the four (4) DCFS regions throughout the state, according to the attached staffing plan. The Department shall delineate a specific catchment area for each D-R team (or assessment worker, where applicable) from where cases may be assigned, and shall not assign cases to a team (or assessment worker, where applicable) from outside of the specific catchment area, unless necessitated by operational need.

STAFFING OF "DIFFERENTIAL RESPONSE" (D-R) TEAMS

For the duration of this demonstration project, assigned D-R assessment workers and supervisors shall consist only of employees at DCFS, including any employees hired subsequent to the implementation of this project. All employees who meet the minimum requirements of the CWS title, including those employees in other titles who were hired on or before July 1, 2000 who meet the requirements of the predecessor (CWS II) title pursuant to the CWS and CPS Series Reclassification MOU and/or DCFS Cross-Bidding Agreement, shall be deemed eligible to be assigned as a D-R worker. All employees who are currently certified in the PSA, Opt. 6 title shall be deemed eligible for assignment as a D-R supervisor.

FILLING OF "DIFFERENTIAL RESPONSE" (D-R) POSITIONS

While not considered "permanent vacancies" as defined in Article XIX, the parties nevertheless agree that various tenets set forth in Article XIX, as well as in Articles XIV and XVIII are still applicable to the filling of the D-R positions. Acceptance of and movement to a D-R position shall not be considered as a personnel transaction (e.g. job assignment, transfer, etc.); rather, such acceptance of and movement to a D-R position shall be considered as a "detail," except that no employee shall be mandated to a D-R position, and the time frames for such will be expanded as delineated in the paragraph below.

The Department will temporarily create D-R Assessment Worker positions to be filled for 12-month and 18-month periods. The Department will also temporarily create D-R Supervisor positions to be filled for 24-month periods. While such positions are only temporary for the duration of the project, the Department will nevertheless post and fill the positions in accordance with Article XIX, Sections 2 (B) and 2(F) of the Collective Bargaining Agreement and DCFS Supplemental Agreement, except that such postings shall be done internally only and filled in the order and rotation set forth below. In addition to relevant information as to the work location/headquarters and work schedule,

the postings shall also include relevant information as to the specific catchment area delineated for the position/assignment as well as the duration of the assignment (12-months, 18-months or 24-months), as well as the identity of the supervisor. Additionally, employees bidding on the initial postings for these positions will have such bids retained for all subsequent postings, and shall not be required to resubmit bids for such.

- **ORDER OF SELECTION**

- Subject to the provisions of Article XVIII of the Collective Bargaining Agreement, D-R Assessment Worker positions shall be filled by eligible employees in either the RC-62 or RC-63 bargaining units, regardless of title, where such move would represent a "job assignment" to a CWS position if such position were to have been considered as a "permanent vacancy."
- Subject to the provisions of Article XVIII of the Collective Bargaining Agreement, D-R Supervisor positions shall be filled by eligible employees in the RC-150 bargaining unit where such move would represent a "job assignment" to a PSA-Option 6 position if such position were to have been considered as a "permanent vacancy."

- **ROTATION**

- After the initial filling of positions, subsequent assignments to the D-R Assessment Worker positions shall be done in accordance with the provisions of Article XIV, Section 5 (b), except that no employee shall be mandated to accept such assignment.
- If there are no additional volunteers or new bidders desiring assignment to a D-R position, employees already on a D-R assignment may, by seniority, request to have such assignment extended for the respective 12, 18 or 24 month period.

RETURN FROM "DIFFERENTIAL RESPONSE" (D-R) ASSIGNMENT

Assignment to a D-R position shall terminate at the end of the delineated time frame for the position, unless the assignment is extended pursuant to the provisions of the above section ("ROTATION"). All employees on D-R assignment shall, once their respective assignments have ended, be returned to their respective former job assignments in which they were the incumbent prior to accepting assignment to the D-R position. Either the employee or management may terminate the assignment to a D-R position prior to end of the delineated time frame for the assignment at each 6-month interval from when the assignment first started by giving written notice at least 30 days prior; employees will then be returned to their respective former job assignments in which they were the incumbent prior to accepting assignment to a D-R position.

FILLING OF VACANCIES AND LAYOFF WHILE ON D-R ASSIGNMENT

As the parties recognize that assignment to a D-R position is temporary only, such assignment shall not have any impact or otherwise interfere with the application of Article XIX as it relates to the filling of permanent vacancies or shift preference (annual shift bump). As such, employees accepting a permanent vacancy pursuant to Article XIX while

on D-R assignment will be moved immediately to the newly assigned permanent position; employees exercising rights under or subject to shift bump will have their new permanent assignment changed on paper only until such time that the D-R assignment has ended. Additionally, assignment to a D-R position as described above shall not have any impact or otherwise interfere with the application of Article XX. As such, an employee subject to layoff or bump under Article XX while on D-R assignment shall be treated as if the employee were in his/her permanent assignment/position.

While an employee is on a D-R assignment, management may in accordance with Article XIV, Section 5, detail employees to address staff shortages directly caused by a D-R assignment that impacts the on-going work requirements; however, with advance notice from the Department, such requests for detail timeframe extensions shall be considered by the Union committee and may be extended until such time that the D-R assignment, which led to the need to detail, has ended, and such requests shall not be unreasonably denied.

DISCIPLINE WHILE ON "DIFFERENTIAL RESPONSE" (D-R) ASSIGNMENT

Inasmuch that employees' participation in D-R is strictly voluntary, along with the fact the D-R positions are new and temporary, the Department will not utilize progressive and corrective discipline to address work performance or case related/case outcome issues and problems; rather, the Department will utilize counseling and corrective action plans to address any case related/case outcome or work performance problems or issues. This provision does not apply to any infractions or violations of work rules as delineated in Article VIII.

VACATION/BENEFIT TIME ON "DIFFERENTIAL RESPONSE" (D-R) ASSIGNMENT

Employees who request and are granted vacation requests pursuant to Article X, Section 6 prior to accepting assignment to a D-R position shall have such approved vacation requests honored if such time off falls during the time period of D-R assignment, unless such previously approved vacation time off will significantly conflict with D-R training. In cases where such a significant conflict exists, the employee will be notified of such and given the option of either voluntarily rescheduling the vacation time off or having his/her assignment delayed to the next available cycle. In any event, the composition and coverage areas for the D-R teams created by the Department, along with the availability of community agency workers shall not, in and of itself, be used as an operational need to deny vacation or benefit time off nor shall it deleteriously affect employees' access to benefit time.

FLEX SCHEDULES

Employees already on an approved flexible hours or alternative work schedule shall not have such schedules automatically terminated as a result of accepting a position on a D-R team, nor shall an employee already on an approved flexible hours work schedule be required to resubmit a new CFS-726. However, the D-R Project Director must review all flexible hour and alternative work schedules and may suspend while an employee is on D-R assignment, but only if such schedule interferes with the Department's operations in the D-R project. Employees not already on a flexible hours or alternative work schedule may

request to be placed on one while assigned to a D-R position, and such requests shall not be disapproved unless there is a bona fide operational need.

JOB DESCRIPTIONS

The Department will create a job description for each D-R position prior to the posting and filling of D-R positions. Once created, the Department will not implement any changes or modification to an employee's D-R job description during the tenure of the employee's assignment to the D-R position (12, 18 or 24 months). Should the Department wish to make changes to any D-R job description, the Department will notify and meet with the union committee to discuss the proposed changes, and the change(s) may only be implemented after the termination of an employee's assignment to the D-R position.

EVALUATIONS

The parties will continue to encourage periodic informal evaluation conferences between D-R Assessment Workers and their respective D-R supervisors, as well as between D-R supervisors and the D-R project director pursuant to Article XXVII, Section 1. Written evaluations pursuant to Article XXVII, Section 2, that are to be placed in an employee's personnel file shall be conducted in terms of D-R work performance only and shall acknowledge that the employee has volunteered to be detailed to D-R and that the performance evaluated is not reflective of the employee's permanent job assignment. With advance notice from the union, DCFS management, comprised of the D-R Administrator, Deputy Director of Human Resources and the DCFS Labor Relations Administrator will meet with the union committee to address an individual employee evaluation that may be of concern. Until the parties have resolved and addressed an employee's evaluation that has been raised by the union, such evaluation shall not become part of the employee's permanent record.

CASE ASSIGNMENTS

While the Department may set monthly case assignment goals, the Department will nevertheless consider an employee's availability, as well as the geographic locations of case assignments in relation to an employee's headquarters, and will adjust the number of monthly case assignments accordingly.


RESOLUTION OF DISAGREEMENTS/DISPUTES

Except for Evaluations as described above, all disagreements/disputes pertaining to the application or implementation of any of the above provisions are subject to Article V, Grievance Procedure; however, prior to the filing of a grievance, all disagreements/disputes shall first be discussed by a joint union-management committee who will make every effort to resolve the issue prior to a grievance being filed. If the parties are unable to resolve the issue through the joint union-management committee, then the timeframe to file a grievance shall commence once the parties have reached impasse and the grievance shall be filed directly to Step-3. Additionally, the joint union-management committee shall meet regularly to discuss any other labor-management issues directly related to the D-R project (e.g. extensions of timeframes for details, necessity to assign cases outside a catchment area, etc).


TERMINATION OF THE DIFFERENTIAL RESPONSE PROJECT AND AGREEMENT

This agreement will terminate when the Department determines to end the Differential Response Demonstration Project, or five (5) years, whichever is sooner. Should the Department desire to continue or expand "Differential Response" once this agreement has been terminated, it may only do so via the available provisions in the Collective Bargaining Agreement.

This agreement is entered into without precedent or prejudice to either party, except as it pertains to its enforcement.



For DCFS 5-13-10
Date



For AFSCME 5-17-10
Date

Appendix F: FY2012 Differential Response Agency Program Plan

Contract #:

STATE OF ILLINOIS Department of Children and Family Services

DIFFERENTIAL RESPONSE SERVICES PROGRAM PLAN (DCFS rules cited in this document are available at <http://www.state.il.us/dcfs>)

1.0 Provider Descriptive Information

1.1 Provider Agency Name: _

Address: _

-

1.2 Corporate Office Information

Legal Entity Status: _

License Status, if applicable: _

Accreditation Status, if applicable: _

Executive Director: _

Telephone #: _

1.3 Program Service Office Information

Address: _

-

Program Contact: _

Telephone #: __Fax #: _

1.4 Brief Description of Various Services Offered by Provider: ____

1.5 Brief Description of Services Provided Under DCFS Contract:

Differential Response is a strength-based, family-centered and community-involved approach to child welfare practice to provide assessment, intervention and support services for families. Working collaboratively, the Strengthening and Supporting Family Caseworker (SSF) and the family will develop and implement a service plan to address the family's needs. The SSF caseworker is the primary agent of change and will document family progress and the provision of an array of services to which the family has been referred.

1.5.1 Family Support Approach

Providers will be operating with a family support approach committing to the following:

1. Completing the Center for the Study of Social Policy (CSSP)'s on-line Strengthening Families self-assessment.
2. Programs and practices are consistent with a strengths-based, family-supportive approach
3. Protective factors training / orientation for all staff (at least annually -- and for new hires)
4. Supervision that models family supportive, strengths-based, relationship-based practice
5. Demonstrating meaningful collaboration and community linkages
6. Hosting / sponsoring / providing parent engagement and leadership development opportunities for DR clients

1.6 Geographical Service Area(s): _

1.7 Clients

Client Capacity Under Contract: _
Capacity at Any Given Time: _

1.8 Projected Average Length of Services: 60 days, no more than 90 days.

Three (3) – one month extensions can be granted with prior DR Project Director approval or designee.

1.9 Definitions

1.9.1 DR Project Director – DCFS manager

1.9.2 DR Specialist (DR) – DCFS case worker

1.9.3 State Central Register intake workers (SCR) – DCFS hotline workers

1.9.4 Strengthening and Supporting Family Caseworker (SSF) – private agency case worker.

1.9.5 Child Endangerment Risk Assessment Protocol (CERAP)

1.9.6 Family Assessment Tool

1.9.7 Children and Family Research Center (CFRC)

1.9.8 National Quality Improvement Center on the Differential Response (QIC-DR)

1.9.9 Child Welfare Advisory Committee (CWAC)

1.9.10 Participatory Engagement – engagement that is participatory results in parent(s) / caregiver(s) children and other household members having ownership of a direction, course of action, decision or its implementation.

1.9.11 Voluntary Family Enhancement Plan – Client Service Plan

2.0 Target Population

- 2.1 SCR intake workers will obtain as much information as possible from the maltreatment reporter to determine if a family is eligible for services.

Inclusions

Reports eligible for the family assessment pathway must meet all of the following criteria:

1. Either no prior family reports to the SCR; OR no prior *indicated* allegations of abuse and/or neglect; OR prior indicated reports have been expunged within timeframes ranging from five to fifty
2. No pending investigations
3. Alleged perpetrators are parents (birth or adoptive), legal guardian, or responsible relative
4. Alleged victims are not currently in IDCFS care or custody or wards of the court
5. Protective custody is not needed or taken
6. Allegations include, singly or in combination:
Inadequate Food; Inadequate Shelter; Inadequate Clothing Environmental Neglect; Mental Injury; Medical Neglect unless the report is made by physicians and involves a child with a severe medical condition that could become serious enough to cause long term harm to the child if untreated. or Inadequate Supervision unless the child or children are under the age of 8 with an emotional/mental functioning of that of a child under the age of 8 and there was no adult present or able to be located or if the adult is present but impaired and unable to supervise. And any additional allegations added during the contract term.

2.2 Exclusions

Families who have been determined by SCR that should continue on the investigative path OR families who have refused SSF services and/or it is determined by DCFS DR Supervisor that the risk level or safety concerns require a more intense level of supervision.

3.0 Referral and Admission Procedures

3.1 Referrals for assessment services will take the following path:

1. The SCR Call Takers will transmit a family assessment report to the local Differential Response Team established to initiate contact.
2. The DR Team Supervisor will review and assign the report to a DR Specialist and Private Agency within two hours of delivery to the team mailbox. (excluding evenings, weekends and holidays).
3. Initial contact with the family is a joint visit by the DR Specialist and the SSF Worker, and must occur in the family's residence. The DR Specialist will coordinate this joint visit. One primary task is participative engagement of all family members by both workers who will remain throughout the visit.

4. At the initial meeting with the family the DR Specialist will assess the safety of all children in the home by completing the CERAP. The DR Specialist must enter the CERAP into SACWIS within 24 hours after initial contact with the family.
5. Child(ren) who are determined to be unsafe, or if the level of risk is high, the DR Supervisor will have the authority to assign the case to the DCFS investigative pathway.
6. The SSF worker will assess the risk factors present in the home using the appropriate IDCFS risk assessment tool(s). This process can begin during the initial meeting and continue during subsequent meetings with the family.
7. Cases continuing on the DR assessment pathway will be referred to the Strengthening and Support Family Provider within two hours of receipt in the DCFS DR team mailbox by the DCFS DR Team Supervisor. The Provider will accept all cases referred by the DCFS DR unit that meet the target population outlined in Section 2.0.
8. DCFS will open a client record upon SACWIS assignment to POS. All people living in the household are part of the family constellation. It is DCFS responsibility to provide any and all information available to the SSF Provider which will allow the Provider to continue to assess the risk and service needs and provide services which will insure the protection and permanency of the children. The CYSIS case will be created after the initial in-person in-home contact with the family.
9. The SSF provider will assume case responsibility immediately following the in home visit and case opening by DCFS.

3.2 Department Responsibility

The Department agrees to conduct service program quality assurance reviews with lead agency and/ subcontracted Differential Response service providers that include:

- 1) Special reviews of records in response to indications of potential performance problems;
- 2) Ongoing review of administrative processes and outcome data; and
- 4) Program plan reviews to ensure that agencies are adequately staffed, trained and that required academic credentials for staff are maintained.

The Department agrees to conduct Differential Response services contract reviews with lead agency and subcontracted Differential Response service providers that include: :

- 1) Coordinate annual contract reviews covering contract usage, effectiveness in meeting performance criteria and outcome goals, adherence to time frames, compliance with program plan and efficient and effective use of Department funds;
- 2) Special reviews of billing records in response to indications of potential contractual problems;
- 3) Receive, review and approve applicable monthly, semi-annual and/or annual fiscal reports and
- 4) Maintain regular communication with agencies to provide technical assistance and problem resolution.

In general, the Department agrees to:

- 1) Communicate with the provider and Department management about performance and quality assurance issues.
- 2) Approve and monitor any corrective action plans.
- 3) Maintain record of referrals and discharges.
- 4) Receive and check billing forms for accuracy, approve bills and send bills to the appropriate vouchering unit for payment.
- 5) If applicable, assist agency caseworkers in obtaining relevant information from state data bases including: IDHS/TANF involvement, CANTS/SACWIS history, CYCIS history, and LEADS.

4.0 Program Staff

4.1 Qualifications

4.1.1 The SSF caseworkers will possess a minimum of a Bachelor's degree. They will have documented experience working with youth and families and will be knowledgeable of the child welfare system. This position is a combination of direct service and service monitoring.

4.1.2. Supervisors will have Master's level or higher with extensive experience in working with families at risk.

4.2 Minimum Staffing Expectations: the SSF caseworker will be working with a caseload maximum: 12:1. {Caseload can not exceed 12 cases per worker}. The SSF caseworker can only be assigned to work on cases accepted in the Differential Response Services contract. The SSF caseworker can not supervise any staff.

4.3 Staff Development

4.3.1 Agency shall participate in continued training as developed specifically by DCFS for the Differential Response Program. The Provider will assure that each SSF staff member is fully trained regarding the Differential Response program and the requirements contained within this program plan.

4.3.2 The Provider will assure that each SSF staff member is properly trained regarding travel procedures, guidelines, and regulations set forth by the State of Illinois Governor's Travel Control Board /Illinois Travel Regulation Council, as well as safety standards and the proper use of age-appropriate safety restraints/car seats.

4.3.3 The Provider shall maintain current documentation of all training and staff development activities.

4.3.4 Agency staff will participate in on going training and learning collaboratives.

5.0 Service Parameters

5.1 The SSF Provider agrees to support achievement of the outcomes of safety, permanency and well being for children and their parents and other family members served under this contract. The SSF Provider also agrees to ensure the safety and well being of all clients while receiving services under this contract. Staffing levels shall assure adequate supervision necessary to provide intervention to clients.

5.2 Provider Physical Plant

Services will be primarily delivered in the client's home, however, the Provider will maintain a facility large enough to safely accommodate their clientele if the need arises.

5.3 Description of Services

All interaction with and advocacy for the family is strength-based and family focused. It is important for the family to identify services needed to strengthen them as a unit and doing so preserves their right to self determination. The SSF caseworker should guide or frame this discussion to specifically focus on issues identified in the intake and any potential threats to child safety and well being.

The Provider will provide comprehensive case management through a mix of services. SSF caseworker's role will be that of a change agent. The SSF worker will act as a family coach or advocate and as such will provide crisis intervention and short term interventions; refer to and broker for needed services, if approved by DR Project Director or designee; identify services available in the community; transport clients to critical appointments; apprise the family of available federal, state and local benefits; provide cash assistance and in kind assistance; link families to community support groups; assistance with proper infant care/parent education; and assist the family in creating and maintaining a safe home environment. Twice weekly in-home visits unless family requests fewer contacts. Supervisor must discuss this request with the family and must document this in SACWIS. Frequency of contact is a critical decision to be determined by the supervisor or someone in the supervisory hierarchy with the family's agreement. A minimum of one visit per week is required.

The Provider agrees that most, if not all, of the direct services shall be delivered in the client home and that the need to test client motivation shall not constitute grounds for requiring office visits.

SSF supervisory responsibilities include, though are not limited to: Review and approval of family assessments and service plans; Weekly review of service plan progress; weekly staffing to facilitate determination for case closure; Frequency of contact with the family with their agreement: Weekly review of unsafe CERAP's; Approval of all safety plans; Ensure weekly monitoring of children who are subjects of safety plans; Approve terminations of safety plans; Approval of case closing CERAP's; Ensures contact and/or case note entry within 24-hours (one business day); Ensures appropriateness of service referrals and these are within family's community; Ensures development of a family Genogram and Ecomap to assist with understanding family dynamics and service provisions; In-person participation in family meetings; Reviews and approves cash assistance requests; Approves worker request for assessment service extensions; Submits assessment service extensions to the DR Project Director or designee within 30 days of required closure date; Reviews and approves all requests for family assessment pathway case closures; Ensures immediate contact to the hotline for any subsequent suspicion of

abuse and/or neglect; Ensures diligent efforts made and documented to contact and engage fathers and paternal family members.

6.0 Treatment Goals

- 6.1** The proposed mechanism of change in the non-investigation pathway is worker collaboration with the family which leads to better and quicker identification of family needs as well as increased family engagement, which then leads to better service provision. These outputs lead to the outcome of increased initial child safety, fewer emergency removals, decreased child and family service needs, increased family satisfaction with agency services, reduced maltreatment recurrence, increased worker satisfaction, decreased worker turn-over, and decreased overall agency costs as fewer children are placed into substitute care and fewer experience repeated reports.

The program treatment goals will be reported on a monthly basis by the SSF Provider to the DCFS DR Project Director or designee as follows:

- 6.1.1** 90 % of children served will remain safely in their homes during the intervention period.
- 6.1.2** 90% % of clients will not have a subsequent report 6 months after receiving Differential Response services.
- 6.1.3** 90 % of children will not have substantiated maltreatment allegations 6 months after receiving Differential Response services.
- 6.1.4** 90 % of children will not be removed from their homes 6 months after receiving Differential Response services.
- 6.1.5** 90 % of clients that receive Differential Response services were satisfied with services provided by SSF Provider.

7.0 Discharge Policy and After Care

7.1 Discharge Process when a client refuses services

Families who refuse to accept Differential Response services, the DR supervisor is to be immediately contacted (within one hour) to assess all available information. Factors considered for this assessment include; intake narrative, reporter contact, observations made during the initial contact, level of risk, safety, family interviews, etc. If the DR supervisor determines that the case should be re-directed to investigations the DR supervisor must contact the SCR supervisor immediately. If the DR supervisor is not available the DR specialist must contact the SCR supervisor immediately. The report date and time will be system driven based upon execution of the transfer request and the appropriate response code manually entered. Only moderate to high risk cases with significant safety concerns are to be sent to investigations.

If a family refuses to participate in the Differential Response and the level of risk is low and there are no identified safety concerns the case will be closed.

7.2 Discharge Process when client services are met

The SSF Provider is expected to provide services immediately within case opening and services will be completed within 90 days of case opening. Requests for service extensions past 90 days of case opening must be approved by the DR Director or designee.

The SSF provider will complete a CERAP and Case Closing Summary at the time of case closing.

8.0 Client and Program Reporting

8.1 Client Reporting

8.1.1 Provider is responsible for knowing current DCFS rules and procedures and shall ensure that all services provided to a client are documented in full compliance with program plan.

8.1.2 The Provider will complete a Family Assessment toward the development of a Voluntary Family Enhancement Plan. The initial Voluntary Family Enhancement Plan must be completed within 5 business days of the initial in home coordinated visit.

8.1.3 The Provider will document families' progress through services in a Client Progress Report every 30 days.

8.1.4 A Closing Summary accompanied by a CERAP will be submitted within two weeks of termination of services to the DR Project Director or designee.

8.2 Immediate Reporting Requirements

8.2.1 The SSF Provider is a "mandated reporter" of child abuse and neglect. Failure to comply with the Abused and Neglected Child Reporting Act (Ill. Rev.Stat.1985,ch,23,par.2051 et seq.) is a Class A misdemeanor and may result in license suspension or revocation. Furthermore, the acquisition of privileged information a Provider's client regarding abuse or neglect does not excuse the failure to report.

8.2.2 The SSF provider staff will immediately notify the DR Project Director or designee of any significant events, changes in family circumstances or unusual incidents involving the client or family members.

8.2.3 Personal information, other than mental health information, alcohol or drug treatment information or Aids/HIV information, may be shared without consent with the Provider when necessary for the proper provision of services. The information is limited to that which is necessary to provide services and shall not be re-disclosed.

8.2.4 The SSF provider staff will immediately inform the DCFS Project Director of all case terminations.

8.3 Program Reports

Programmatic reports will be submitted to the DR Project Director or designee upon request.

9.0 Contract Monitoring

9.1 Provider Monitoring

Provider agrees to participate in agency site visits for the purposes of contract monitoring conducted by DCFS contract monitor and / or DCFS designated staff.

The provider shall maintain personnel records of all employees who provide direct or Support services to Department clients. The following information for each employee shall be maintained in the provider's records: proof of education, including high school, college and training programs; a detailed summary of each employee or contractor's work experience; annual employee performance evaluations; documentation that a background check was completed, including but not limited to a CANTS check.

9.2 DCFS Monitoring

The DR Project Director or designee will participate in relevant Differential Response service activities including site visits, meetings, and conference calls.

The DR Project Director or designee will collect client and outcome data from the private agency regarding Differential Response services and will provide progress and financial data to CFRC; QIC DR; CWAC; etc.

10.0 Billing and Payment Procedures

10.1 Billing Submittal

For FY12, DCFS will guarantee a flat rate of pay per worker per month for first 6 months of the fiscal year (July – December 2011). Monthly guarantee is calculated based on the DCFS rate of \$48.00 an hour at 132 hours or \$6,336 a month. Starting January 1, 2012 the guarantee converts to fee for service at the \$48.00 per hour rate for all billable services specified in 10.2.

Monthly Submittal of payment claims for billable services provided will be made by use of the CFS 1042 Billing Summary Form, and will be submitted to the DCFS Regional Contract Monitor no later than the tenth working day of the month following that in which the service was provided. Bills for the initial 4 consecutive weeks of training may be submitted as soon as training commences.

The CFS 1042 Billing Summary Form should be filled out accurately for the services actually provided. Although a flat rate is guaranteed for the first 6 months of FY 12, data collection the first year to identify billings above & below the 132 hours a month is needed for the FY12 rate development. The flat rate means that reimbursement is guaranteed for the first 6 months for FY 12 at a specified level for FY11 with no casework payments below or above the guaranteed rate. This also means that two CFS 1042's will be needed. A regular summary as detailed below to capture actual family service detail, and a second one page summary bill for use during this guarantee period which attests that the caseload FTE costs were incurred and matches the actual record of payment.

Billing for services will be prepared each month by the provider and presented to the designated Department for review and receiving officer signature. Each billing will be

submitted on Form CFS 1042, Billing Summary furnished by the Department or a provider-generated computer Billing Summary that replicates the CFS 1042.

CFS 1042 Billing Summaries will be completed in accordance with the instructions on the back of that form, including DCFS ID Numbers for all clients. Each billing summary shall have only one service month for all clients from only one region.

A separate CFS 1042 must be submitted for each month and region. The Provider will complete Form CFS 1042 as instructed on the back of the form.

The hourly rate has been standardized so budgets will not be required

10.2 Description of Types of Service(s) that are Billable

Rate of pay for each worker is \$48.00 an hour.

The submission of a correctly completed CFS 1042 should constitute a valid bill. Payments may be withheld pending receipt of any of the reports mentioned above.

The following units of work output are billable at the conclusion of each service month.

Type of Service (TOS) billable at the above rate, shall be recorded in .25 hour segments.

10.2.1 Direct Services

- a. Contract language for start-up to guarantee \$6,336 per month per caseworker for the first six months of FY 12
- b. Maximum billable amount for services \$1,600.00 for the life of case
- c. \$400.00 cash assistance with exceptions approved by DR Project Director.
- d. Group sessions will be allowed and the rate will be pro-rated among the clients present, groups of 5 or more can have a co-trainer
- e. Average length of services is budgeted at two months; services delivery can go up to 3 months at provider discretion.
- f. Three (3) – one (1) month extensions can be granted only with prior Department approval – DR Project Director or designee.
- g. Reimbursement begins when the agency worker first leaves their headquarters or residence to meet with the client
- h. Short-term service providers do not have access to other paid DCFS contracts; provider is encouraged to make community based provider referrals for any long-term needs identified

10.2.2 Indirect Services

- a. Indirect services has a targeted maximum of 33% of billable services.
- b. Mileage will not be reimbursable, but is included in the rate
- c. Any telephone calls, etc. that do not lead to an initial contact are not reimbursable

10.3 Payment

The Department will make payments to the contractor upon submission of the monthly bill by the contractor to reimburse for the services provided by the program.