

# Systemic Review of Critical Incidents in Intact Family Services

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## Introduction

With the lowest foster care entry rate in the nation (1.5 children per 1,000 children in the population), Illinois has a high threshold for child removal (U.S. Department of Health and Human Services, 2017; U.S. Census Bureau, 2017). Safe implementation of this threshold depends upon:

- the use of accurate and sensitive tools for detecting safety threats and risk;
- processes that are aligned with timely detection of threats to safety, clear communication, and seamless transitions;
- shared responsibility among child protection and preventive service workers for accurate assessment and comprehensive service delivery; and
- availability of preventive services to stabilize and support families as they work toward meeting the needs of their children.

Incidents in which children known to the Illinois Department of Children and Family Services (DCFS) are harmed represent a failure of one or more of these components intended to safeguard and stabilize children in their parents' homes.

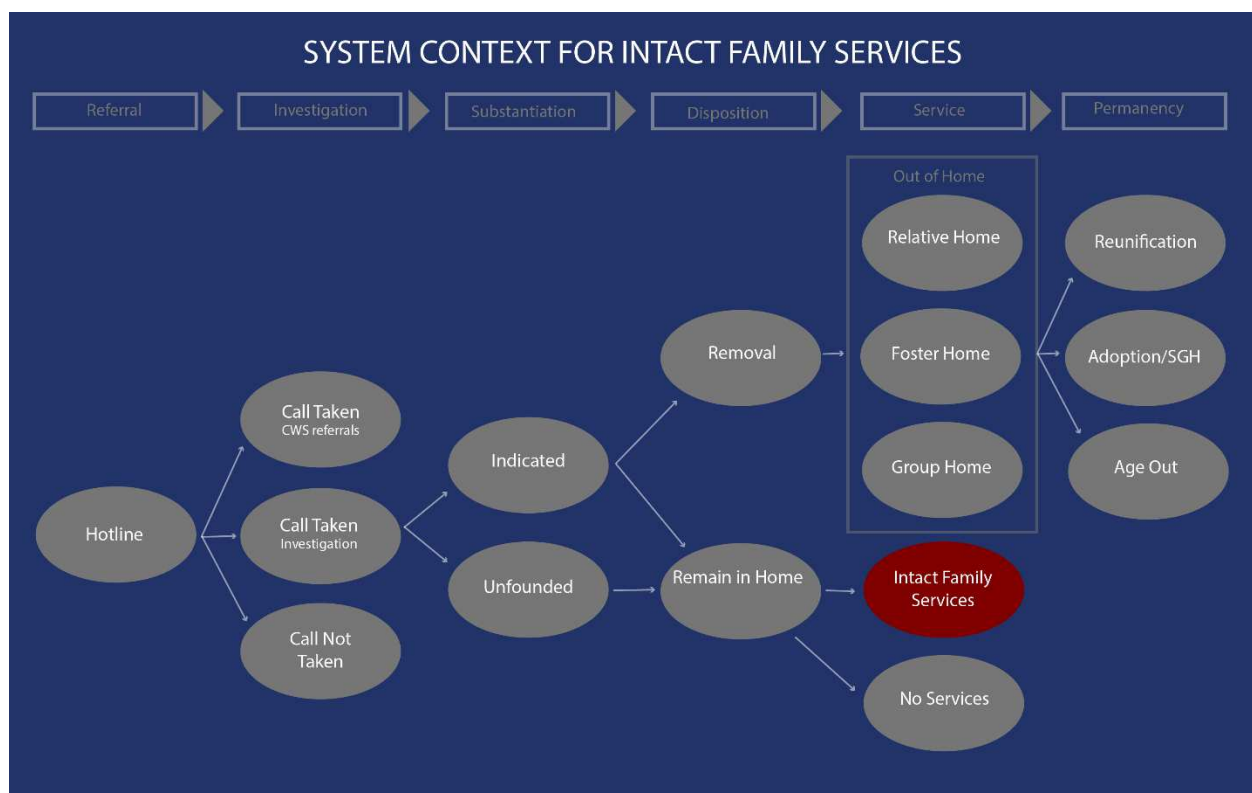
This review identifies the systemic factors that have influenced outcomes in individual cases of child deaths and critical incidents, as well as opportunities for improvement that can fortify and deepen the potential of Intact Family Services ("Intact"). To understand the complex interaction between individual decision-making and systems influences, Chapin Hall at the University of Chicago has applied a multidisciplinary systems approach to reviewing critical incidents among families receiving Intact Family Services that is grounded in safety science (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016; Covington & Collier, 2018).

This phase of work, requested by the Illinois Governor within a 6-week review period, identifies a set of priorities that DCFS can begin to address in the short term. It is intended to examine the immediate vulnerability of children in the context of Intact. It also recommends a series of activities that can be undertaken over the next 12–18 months to: (1) continue to clarify the needs of the population; (2) identify and prioritize key areas for improvement; and (3) structurally refine programs and policies to improve alignment with positive outcomes and fidelity to best practice approaches. This review culminates in a set of sequenced and prioritized recommendations for action in the short-, medium-, and long-term.

## Background

Ideally, preventive service models stabilize families and address the needs that bring them to the attention of child welfare systems. Services provided to families while they remain intact offer an opportunity for the child welfare system to continue to engage and observe a family while avoiding the trauma associated with separating children from their parents. While preventive service models are in place all over the country, they vary considerably in their organization, structure, program components, and eligibility requirements. Figure 1 illustrates the position of Intact in the larger child welfare context in Illinois.

**Figure 1. System Context for Intact Family Services**



Programs like Intact serve a crucial function with a population in which risks are identified but children remain in their parents' homes. Increasingly, child welfare systems may rely on preventive services to deliver community-based services to families to divert them from more intensive system involvement. In fact, the 2018 passage of the Family First Preventive Services Act (Public Law 115-123) promotes flexibility in the delivery of preventive services and provides new opportunities to leverage federal support to develop the preventive service continuum.

However, whereas there are federal standards for foster care with benchmarks and indicators that allow ongoing progress monitoring and comparison, there is no standard set of federal

benchmarks and indicators against which to judge compliance, quality, and effectiveness of preventive programs. In lieu of a standardized metric against which to measure, this review relies on the research literature to identify a set of core elements that should be part of evidence-based, in-home preventive service programs. These key elements include:

- **Direct teaching and problem-solving skills.** Building on parents' strengths, direct teaching and coaching can help parents acquire and demonstrate key skills and behaviors necessary for daily functioning in caregiving roles. This not only includes basic child care (e.g., nutrition, hygiene, health, nurturing, development), but also discipline, supervision, and household management. Teaching and coaching must be accessible and easily understood by parents (D'Aunno, Boel-Studt, & Landsman, 2014).
- **The provision of concrete emergency services/resources.** Studies of intensive family preservation programs have found supportive evidence that providing concrete services (e.g., financial assistance, housing, furniture, clothing, food, baby care supplies) is associated with improved family functioning (D'Aunno et al., 2014).
- **Cultural competency.** Culturally competent practice relies on the ability to understand, communicate with, and effectively interact with people across cultures as well as interventions delivered to families in the context of their cultural beliefs, behaviors, and needs. Higher scores on client ratings of their provider's level of cultural competency were associated with increased success in meeting case goals and satisfaction with services (Damashek, Bard, & Hecht, 2012).
- **Quality worker–client relationship.** Having multiple caseworkers during the life of the case is significantly associated with longer lengths of stay in child welfare and decreased likelihood of reunification. Thus, high turnover may have an impact on the ability to establish stable relationships between workers and clients and may have detrimental effects on client outcomes (D'Aunno et al., 2014).
- **Family engagement.** Engaging families early on in the life of the case predicts a greater likelihood of successful outcomes (Berry, 1992; Bitonti, 2002; Kinney, Haapala, & Booth, 1991; Lewis, 1991). Among families receiving intensive family preservation services, a greater amount of direct contact with workers was associated with statistically significant improvements in family functioning. For example, involvement of extended family, provision of concrete and advocacy services, small caseloads, and common race/ethnicity between caseworker and client were associated with increased levels of engagement. Family team meetings (also known as family group conferencing or family team decision making) are another widely used approach for engaging families in the case planning and decision-making process.
- **Assessment of family strengths.** Family-centered and strengths-based perspectives represent frameworks that guide service provision and are widely accepted standards of child welfare practice (Barth, 2008; Berry, 2005). The use of standardized assessment approaches to identify family strengths and needs enhances workers' ability to match families to services; which in turn results in significant improvements in family functioning (Meezan & McCroskey, 1996).



- **Safety planning.** Careful safety planning and interventions for managing safety prevent further abuse and the unnecessary placement of children in foster care. Safety planning and interventions not only assure that a child is protected but also improve the protective capacity of the parent (Berry, 2005).

In Illinois, Intact provides services to almost 5,000 families of nearly 12,000 children each year, or roughly 14% of cases in which there is a child maltreatment investigation (U.S. DHHS, 2017). The majority of these cases are “indicated” (i.e. involve substantiated allegations of abuse or neglect), although cases in which allegations of abuse or neglect are unfounded as a result of investigation may also be referred for and receive Intact. It is important to note that another 17,465 children (of the 23,745 involved with indicated investigations who remain in their homes) do not receive preventive services through Intact. This may be because families have taken steps to address identified problems, because they have declined services, or because the severity of the allegation does not warrant an Intact referral.

While Intact has always provided in-home services to families, over time a number of shifts resulted in the current configuration of administrative, supervisory, and frontline staff. With the privatization of Intact in 2012, the Department began to refer the majority (80%) of Intact cases to private provider agencies for case management and service delivery. The Department retained oversight of only those cases that were deemed “high risk” (when capacity allows), defined as cases in which at least one child is 3 years or younger and there is also a medically complex child, 2 or more prior investigations, multiple underlying conditions (e.g., domestic violence, substance abuse, sexual abuse, mental illness, developmental disability), one or more allegations of serious harm<sup>1</sup>, medical neglect, a safety plan, or the parent is a former foster youth (Illinois Department of Children & Family Services, 2018). Associated caseload ratios (10:1) and payment structures were put in place, but unlike the privatization of foster care case management the privatization of Intact provided little infrastructure support for incentivizing quality and monitoring performance. Intact services payments are tiered and taper with decreasing expectations for frequency of contact with families, but unlike foster care contract they are not performance-based on risk adjusted to account for variations in complexity and severity of cases. Quarterly reviews focus primarily on procedural compliance and are not tied to DCFS centralized contracting functions.

Also in 2012, in response to budget cuts, DCFS leadership made the decision to restrict services to those required by statute and qualifying for federal reimbursement. Although planned layoffs did not ultimately occur, the eligibility restrictions put into place to limit the population who could receive Intact remained. These criteria restricted all Intact (DCFS and private providers) to indicated cases that had experienced multiple investigations (i.e. more than 6), the involvement of an indicated “paramour” or other household member, the presence of young children (i.e.

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<sup>1</sup> Allegations of serious harm include death, head injuries, internal injuries, burns, wounds, bone fractures, tying/close confinement, torture, sexually transmitted diseases, sexual penetration, sexual exploitation, sexual molestation, death by neglect, head injuries by neglect, internal injuries by neglect, burns by neglect, wounds by neglect, bone fractures by neglect, failure to thrive, malnutrition, and the medical neglect of disabled infants.

under 6 years) in the home, or an intergenerational child welfare history (DCFS, 2012). While this may have resulted in a more involved, complex population of Intact cases, it was not accompanied by service enhancements or reduced caseloads.

Finally, in 2016, supervisory structures shifted to a “matrix model,” moving authority from the Deputies (for Child Protection and Permanency Divisions) to Regional Administrators. While this model of managerial oversight is meant to enhance collaboration across multiple initiatives, in this case it disrupted a clear chain of authority and accountability among investigators, supervisors and managers, who now report up to Regional Administrators rather than to the Deputy Director for Child Protection. This shift created disequilibrium between Intact (which remains under the Deputy for Child Protection) and investigations, who carry out the Child Protection functions of the Department but no longer report to the Deputy Director for Child Protection. Intact referrals now come from the Area Administrators (who report to the Regional Administrators) to Intact Utilization Supervisors, who report to the Statewide Intact Administrator and the Associate Deputy for Child Protection.

## Methods

Chapin Hall deployed a variety of strategies to understand the systemic factors that contribute to critical incidents, including:

- **Analysis of OIG reports.** Child Death and Serious Injury Investigation (DSII) reports produced by the Office of the Inspector General (OIG) for DCFS, the Governor, and the General Assembly in state fiscal years 2014–18 were analyzed using the Safe Systems Improvement Tool (SSIT). The SSIT integrates information to standardize findings across reports within three domains: professional (e.g., factors primarily present within professionals such as experience, knowledge, perceptions, and practice skills), team (e.g., pressures, communication, climate, and collaboration with community partners) and environment (e.g., internal and external access to resources, policies, services, and technologies).
- **Systems analysis of child deaths.** Three recent child deaths were reviewed for purposes of this report; two of these deaths occurred among open Intact cases. The third child death was a child who had returned to her mother’s custody. Intact was not involved at or near the time of death. Chapin Hall reviewed this case and focused on similarities between this case and the two child deaths in Intact. While pending criminal child abuse investigation records were not reviewed due to the sensitive and ongoing nature of the investigations themselves, other hard copy case records and Statewide Automated Child Welfare Information System (SACWIS) records within 3 years of the death were reviewed. Particular emphasis was given to DCFS involvement in the year preceding the death. Case-specific observations were processed by a multidisciplinary team of field experts to identify system-level influences. The team used an Accimap—a means for modeling the context in which unwanted performance variability occurs.

- **Document review.** The team reviewed documents pertaining to the delivery of Intact, including DCFS policies, action transmittals, forms, protocols, memos, training curricula, practice models, and evaluation reports. These documents were reviewed to verify or elaborate on information provided by key stakeholders, as well as to reconcile written policies with business processes described by key staff.
- **Stakeholder interviews.** Fourteen interviews were conducted with key stakeholders concerning Intact. Respondents were recruited by reviewers for their diverse perspectives on Intact; they included agency leadership, administrative program leadership and staff, private provider agency staff, monitors, evaluators, and advocates. Semi-structured interviews provided respondents with questions and prompts and solicited specialized information depending on the role of the respondent. Notes from these interviews were analyzed thematically and summarized to inform the findings and recommendations.

## Findings: Child Fatalities

Nationally, an estimated 1,750 children died from abuse or neglect in fiscal year 2016—a 7.4% increase over the number of child deaths due to abuse or neglect reported in 2012 (Child Welfare Information Gateway, 2018). The estimated national rate for child maltreatment deaths in the general population is 2.36 deaths per 100,000. Nearly 45% of maltreatment deaths occur to children under the age of 1 (U.S. DHHS, 2018).

In 2016, there were 64 child maltreatment deaths reported in Illinois—a rate of 2.19 per 100,000 children (U.S. DHHS, 2018). From 2012 to 2016, Illinois' reported annual maltreatment-related deaths have been as high as 105 and as low as 64, with a decrease every year since 2014. Although an explanation for these decreases is beyond the scope of this report, they occurred despite increases in rates of abuse and neglect. In 2015 there were 29,993 child abuse or neglect victims—an increase of 17.2% since 2014 (Child Welfare League of America, 2017).

Data extracted from the 5-year review of OIG reports provided additional insight into the incidents and manner of child deaths. Little variability was observed in deaths by age or manner of death across years. The majority of child deaths occurred in children younger than 1 year old (48%). Accident deaths were more likely to occur in children younger than 1 year old – representing 52% of all accidental deaths (Table 1).

**Table 1. Manner of Death in All OIG-Reviewed Deaths**

Age	Accident	Homicide	Natural	Suicide	Undetermined	Total
< 1 yr	65 (52.0)	19 (20.2)	70 (46.4)	0 (0.0)	87 (77.0)	241 (48.1)
1–5 yrs	23 (18.4)	24 (25.5)	37 (24.5)	0 (0.0)	21 (18.6)	105 (21.0)
6–10 yrs	10 (8.0)	5 (5.3)	15 (9.9)	0 (0.0)	3 (2.7)	33 (6.6)
11–14 yrs	11 (8.8)	8 (8.5)	17 (11.3)	4 (22.2)	0 (0.0)	40 (8.0)
15–20 yrs	16 (12.8)	38 (40.4)	12 (7.9)	14 (77.8)	2 (1.8)	82 (16.4)
Total	125 (100.0)	94 (100.0)	151 (100.0)	18 (100.0)	113 (100.0)	501 (100.0)

The OIG has the discretion to conduct a full Death and Serious Injury Investigation (DSII) if it is deemed warranted after a preliminary investigation. An in-depth review was conducted on the summaries, findings, and recommendations from the OIG's DSII reports. The DSII reports provided additional detail needed to establish trends and themes across years. Homicide was the most frequently occurring manner of death in DSII cases. Notably, while children 1–5 years old represented 21% of total child deaths (Table 1), they accounted for 41% of OIG DSII investigations (Table 2).

**Table 2. Manner of Death in OIG Death and Serious Injury Investigations**

Age	Homicide	Natural	Neglect	Undetermined	None noted	Total
unknown	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (20.0)	1 (2.4)
< 1 yr	6 (33.3)	3 (42.9)	2 (40.0)	2 (33.3)	2 (40.0)	15 (36.6)
1–5 yrs	9 (44.4)	1 (14.3)	3 (60.0)	2 (33.3)	2 (40.0)	17 (41.5)
6–10 yrs	2 (11.1)	3 (42.9)	0 (0.0)	0 (0.0)	0 (0.0)	5 (12.2)
15–20 yrs	1 (5.6)	0 (0.0)	0 (0.0)	2 (33.3)	0 (0.0)	3 (7.3)
Total	18 (100.0)	7 (100.0)	5 (100.0)	6 (100.0)	5 (100.0)	41 (100.0)

Deaths during open Intact cases represented 15% of all OIG DSIIIs. Deaths in the majority of DSII cases (85%) occurred during times where there was no open Intact case at the time of death (Table 3).

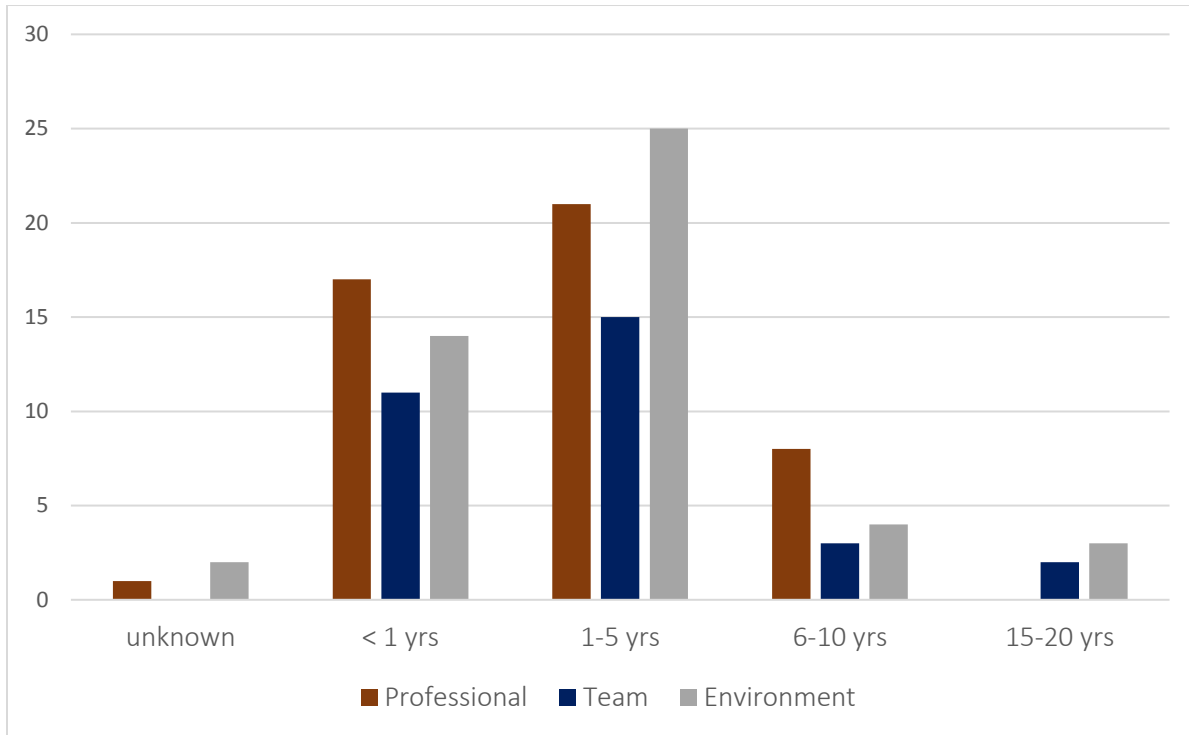
**Table 3. Intact Deaths by Year in DSII Reports**

	2014	2015	2016	2017	2018	Total
No Open Intact	8 (88.9)	9 (90.0)	8 (88.9)	7 (77.8)	3 (75.0)	35 (85.4)
Open Intact	1 (11.1)	1 (10.0)	1 (11.1)	2 (22.2)	1 (25.0)	6 (14.6)
Total	9 (100.0)	10 (100.0)	9 (100.0)	9 (100.0)	4 (100.0)	41 (100.0)

To support improvement efforts and communication, Chapin Hall used the SSIT to categorize the findings and recommendations noted by the OIG DSIIIs into three domains: professional, team, and environment<sup>2</sup>. Figure 2 displays the frequency of professional, team, and environmental factors identified in fatality cases across age groups illustrating that in addition to the work and interaction of individuals, environmental factors are always at play. Overall, the OIG identified issues related to professionals (e.g., cognitive fixation, knowledge deficit, and documentation) and teams (e.g., teamwork/coordination and supervisory support) in addition to environmental factors (e.g., policies, training, and service array) throughout the 5 years of OIG DSIIIs.

<sup>2</sup> The SSIT is a multipurpose information integration tool that allows the output of a critical incident review to be standardized into a set of items. The comprehensive set of items included in the tool represent the range of system and human interactions known to influence critical incidents (Covington & Collier, 2018).

**Figure 2. Identified Themes in Office of Inspector General Report Summaries, Findings, and Recommendations, by Child Age**



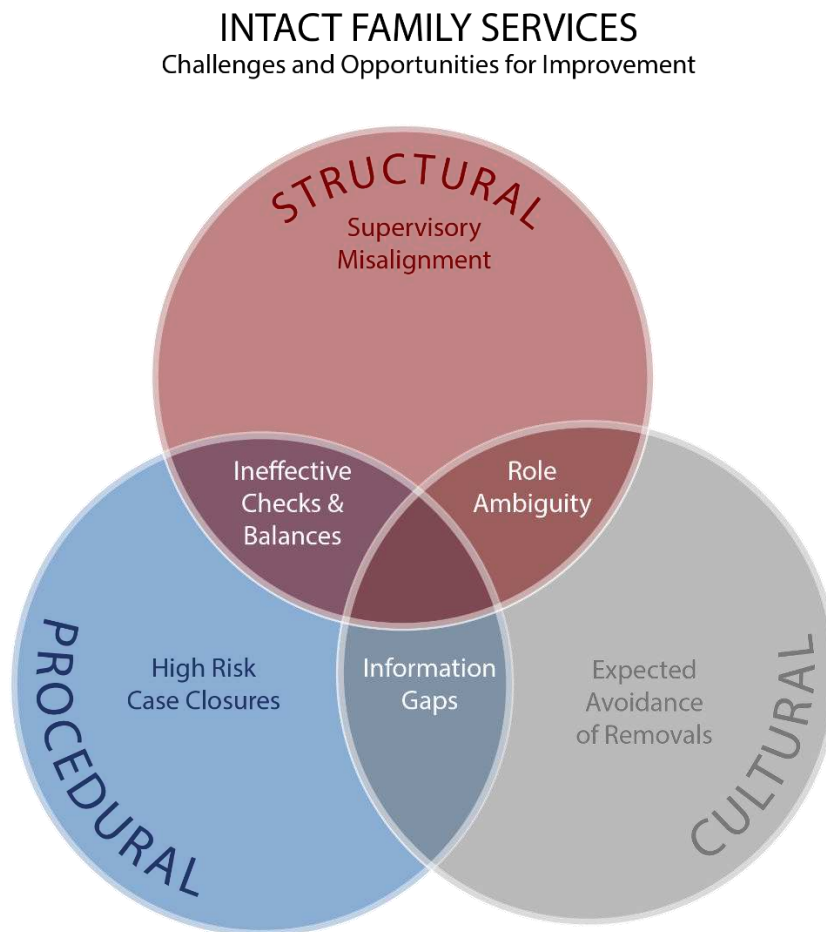
Although the OIG’s investigations included a relatively small number of open Intact cases, the review of DSIIIs found a number of related themes that offer opportunities for both DCFS and private agency partners. Across the 5 years of reports that were reviewed, recurring recommendations to address these opportunities called for professional development, policy enhancements, and new practice standards to improve:

- 1) critical thinking and risk and safety assessment skills;
- 2) coordination and communication between team members and external stakeholders (e.g., treatment providers, schools, law enforcement);
- 3) case planning and service linkage skills;
- 4) supervision competencies and support for case workers;
- 5) timeliness and accuracy of documentation;
- 6) caseloads and production pressures; and
- 7) decision support with technology solutions, such as alerts and dashboards, that take advantage of case records.

## Findings: Systemic Issues

In highlighting the systemic influences that create barriers to effective service delivery for Intact families, this review identified interrelated structural, procedural, and cultural opportunities for improvement. Structural issues refer to the way in which teams and individuals are organized and the varying degrees of accountability they hold for system outcomes. Procedural issues relate to case flow and business processes. Most importantly, cultural issues are commonly held beliefs and values expressed by multiple stakeholders representing different perspectives. Issues in all three areas have challenged critical thinking, sensitive assessment, and effective engagement of families. This review highlights six improvement priorities for DCFS; Figure 3 illustrates the six priorities overlaid on the interplay of the three types of challenges.

**Figure 3. Conceptual Model**



- 1) **Avoidance of removals.** In response to federal legislation that prioritized preserving families, timely permanency and relative placements, DCFS implemented a number of strategies in the mid-1990's that were highly effective for reducing the burgeoning number of children placed in foster care (Child & Family Research Center, 2008; Public Law 105-89). These included the Child Endangerment Risk Assessment Protocol (CERAP) to standardize front-end safety assessment, performance-based contracting with private provider agencies for foster care case management and the use of subsidized guardianship as a permanent placement alternative.

Today, the Illinois child welfare system remains motivated to avoid removing children from their parents, and DCFS relies heavily upon Intact to maintain the low removal rate. In the eyes of the Department, an Intact referral made by an investigator constitutes "reasonable efforts" to address a multitude of problems and prevent foster care placement. However, staff report beliefs that recommendations to remove children based on case complexity, severity, or chronicity will not be heard or upheld by the Division of Child Protection (DCP) or the court. Additionally, the current volume and complexity of cases referred to Intact challenge the meaningful engagement and planning needed to prevent removals. In the face of pervasive expectations that investigators will avoid and courts will overturn custody decisions—and without access to data and evidence to support their "hunches" (often based on decades of experience with similar cases)—Intact Utilization Supervisors may be reluctant to elevate cases for supervisory review or to reject Intact referrals. In this way, business processes are misaligned with the critical thinking and discernment needed to provide families with the services they need for stability and safety.

Of the two reviewed deaths that occurred in Intact, neither referral was received as a result of indicated abuse or neglect. In one case, an investigation was unfounded for abuse despite the DCP investigator overhearing the paramour ordering the child to "lay down." When the investigator entered the home, she found the child's torso exposed and covered in welts. The case was unfounded due to lack of medical evidence when hospital staff could no longer locate the welts the investigator had already seen. Despite these disparate findings, no escalation of this case occurred. In this case, the mother agreed to not allow her paramour around the children, but she did not honor the informal agreement and allowed the paramour further access to her children. The mother had a history of involvement with Intact and a history of domestic violence, but there was no court involvement or escalation of the case. In the second case review, the mother was cooperative with Intact but slow to accomplish tasks. She had a cognitive delay and had numerous individuals living in her small home, which she rented through a Section 8 housing voucher. In spite of the ongoing noncompliance with her leasing agreement, the soiled nature of the home, and several DCP investigations during the Intact case, a Child and Family Team meeting was not convened and escalation of services did not occur.



- 2) **Supervisory misalignment.** Historically, Intact occupied a larger administrative footprint within DCFS, led by individuals of seniority commensurate with that of other Division heads. In that scenario, negotiations over the appropriateness of Intact referrals (to DCFS or private providers) took place manager-to-manager and were resolved at the managerial level. In the current system, complicated by the “matrix” model of supervision (organized geographically rather than substantively), the positioning of Intact within DCP, and the mismatch between the level of the Area Administrator (who authorizes the Intact referral from investigations) and the Intact Utilization Supervisor (who receives the referral), checks and balances on Intact referrals are insufficient or ineffective. This results in referrals and the opening of Intact cases for families with extensive histories of physical abuse, despite the reservations of Intact staff and frontline workers that these cases may not be effectively served with the current model of Intact.

Neither of the deaths during open Intact cases were referred as a result of indication. Both families had extensive history with DCFS, but reviews noted a substantial amount of history was inaccessible due to cases being expunged or purged. Assessment of a family’s safety sometimes evolves over time. The unavailability of so much historical information may contribute to critical case details being lost and influences child welfare staff to rely on family’s accurate self-reporting on their history.

- 3) **Ineffective checks and balances.** It is difficult to question, negotiate, or decline an inappropriate Intact referral. Stakeholders expressed that cases with extensive histories or complex circumstances may not be effectively and safely served by Intact, yet there is a pervasive expectation that removals won’t be upheld by the State’s Attorney or the court, and that Intact requires the Investigator (and the Area Administrator, due to “matrix” supervision) to approve petitions to the court. This results in a population of Intact cases with extensive histories, some of whom have experienced Intact previously and are not inclined to work with providers.

During the Accimap session, professionals described Intact caseloads as often being over the prescribed ratio of one case manager to ten Intact cases. Furthermore, caseload sizes are not adjusted due to travel time or case complexity. Rather than decline referrals, provider agencies and DCFS overload themselves to assist as many families as possible and prevent removals into foster care. DCP investigators are inundated with caseload pressures to make referrals to Intact. Though they are often in compliance with the prescribed rate of 15 new investigations per month, this is the equivalent of an investigator receiving a new case nearly every other day. As a result, investigators tend to stop managing safety plans and assessments as soon as the Intact referral occurs. Such abrupt transitions hinder accurate and comprehensive assessment and delay engagement with other entities, like the courts.

- 4) **Role ambiguity.** DCP investigators work with many cases in challenging environments; stakeholders report that they tend to view their role as circumscribed to making and justifying the substantiation and/or removal decision rather than engaging the family and ensuring that information is communicated and services delivered. Intact relies upon

investigators to make safety determinations, formulate safety plans, engage families in voluntary services, and pass on important information that may not be electronically accessible to Intact staff. Whether due to demands on their time, the training they receive, or the agency's culture, DCP investigators tend to focus primarily on compliance with investigation and determination procedures. They often do not play the role articulated in the Intact policy for engaging the family or (with the exception of their expected attendance at the transitional visit/conference) working with the Intact staff to ensure that all information is communicated and the family seamlessly transitions to Intact (IDCFS, 2016).

In both instances where a death occurred during an Intact case, there was no evidence of ongoing collaboration between DCP investigators and Intact case managers. A meeting with all the assigned professionals who were working (or had recently worked) with the family would have been a helpful step toward risk assessment and service planning, but these meetings did not occur nor did any Child and Family Team meetings. Outside of the transitional visit with the family where both program areas were present, DCP investigators and Intact Case Managers only spoke occasionally, as new investigations concerning the family would open or close. In the case of the death of a child who had previously been in foster care, there were a substantial number of hotline referrals during the case. Investigators and other staff assigned to work with the family did not collaborate or share information to evaluate underlying conditions affecting the safety of the children. In addition to the caseload pressures on both Intact and Investigations staff, culture was described as a significant underlying factor. Investigators identify with law enforcement while Intact Case Managers identify as social work and mental health professionals. Intact and investigation teams rarely work in the same offices or for the same supervisors.

- 5) **Information gaps.** When DCP refers a case to Intact, the expectation is that DCP will submit all investigation notes and participate in transitional activities to communicate key features of case histories to the Intact worker. In reality, the Intact worker can view the SACWIS case once it is opened, but often cannot access the investigator's notes or key features of a lengthy case history. Because of the aforementioned role ambiguity regarding the role of the investigator, crucial information may not be communicated to the Intact worker. According to the annual evaluation of the Child Endangerment Risk Assessment Protocol (CERAP; Fuller, Wakita, Chiu, Nieto, & Lee, 2019), Intact workers do detect changes in safety that prompt them to administer a CERAP in 8–10% of their cases, particularly for safety threats regarding the mental health or substance abuse issues of a paramour who may come and go from the home. In slightly less than half of these cases, a determination of "unsafe" is made. This should trigger an additional investigation; in 20–28% of the cases in which a CERAP is conducted by an Intact worker, a child is ultimately removed from the home as a result (Fuller et al., 2019).

In all three reviewed cases, assessment and service planning documents did not include all facts known to DCFS. Although the Child and Adolescent Needs and Strengths (CANS

2.0) is supposed to consolidate information from multiple sources, among these Intact cases it was inaccurately scored and did not include important information known at the time. Appropriate scoring would have yielded more actionable items. While this may have been due to professional performance variability, it also seemed relevant case information was lost or not communicated among the many professionals in contact with the family. A domestic violence screening was also inaccurately scored. In the case of the child who died after being in foster care, an initial assessment described the mother believing that feeding her child was a "battle," but this was not well-addressed in service planning.

- 6) **High-risk case closures.** The Department's expectation is that Intact provide services to families for 6 months, at which time the case would be closed with no further agency involvement. Intact providers may contest this limit, however, on the grounds that families still require support. However, when complex and difficult-to-engage cases are referred to Intact and the provider agency cannot effectively work with the family, there is no clear pathway for closing cases with an appropriate amount of attention, consultation, and planning. This means that while the Intact provider can contact the investigator (who may or may not be the same individual who conducted the initial investigation), call the hotline (which may or may not initiate another investigation), or initiate court proceedings themselves, some providers report that when they cannot engage a high-risk family, they may simply close the case. These closures may be accompanied by hotline calls to notify DCFS of the planned case closing, but this is insufficient for ensuring the children's safety and does not engage DCFS in consultation or planning for the disposition of the most high-risk cases.

In one of the reviewed Intact cases, the case manager's notes questioned the need for the case to remain open for Intact services. However, this seemed inconsistent with the family's presentation (i.e., unclean and unkempt home, too many people living in the home), so system-level issues may have been affecting the case manager's goal to close the case. During the Accimap session, professionals noted that closing Intact cases within 6 months used to be a performance outcome and was heavily tracked; DCFS may have not sufficiently messaged their willingness for cases to extend beyond 6 months. Additionally, provider agencies are not incentivized to continue cases beyond 6 months because their pay rate decreases at 6 and 12 months. The process to extend the initial rate, which requires justification and approval, is often not pursued.

In addition to these six systemic issues, this review identified a list of problems and challenges that might be addressed using technology, fiscal contracting levers, monitoring, training, and policy refinements. These issues are summarized here:

- **Practice.** Review of individual cases and interview data highlighted gaps in skill and ability of staff to conduct regular, methodical safety assessments that include all of the adults who may impact a child's safety in the home. While staff are initially certified in the use of CERAP, they are never recertified to ensure that they continue to uphold a standard of accuracy and rigor in safety assessments. Similarly, the DCFS policy

concerning the assessment of paramours may not guide investigators to ask parents the types of questions that would ascertain the level of involvement of other adults in the lives of the children in their care.

- **Population.** While it has been suggested that the population of Intact clients is more severe, complex, and chronic now than it once was, it is difficult to verify this claim given shifts over time in the Department's methods for coding case open reasons. Inconsistent use of assessment tools such as the CANS create gaps in understanding the needs and strengths of families that could inform comprehensive and effective service planning.
- **Instability.** Stakeholders reported that a high degree of turnover among Intact workers, investigators, and safety plan monitors can contribute to information gaps and knowledge deficits. Along similar lines, the instability in Departmental leadership was also highlighted as a source of policy shifts and unclear direction for preventive service strategies.
- **Capacity.** Stakeholders reported concerns about their own capacity as well as that of community providers. While some caseloads have remained stable (10:1 for Intact providers), the increasing complexity of cases has made this ratio challenging to maintain. Concerns about the availability of community services focused on long waiting lists for substance abuse services that can jeopardize provider engagement and parents' commitment to treatment.
- **Oversight and monitoring.** Stakeholders reported that current monitoring strategies focus on compliance over quality and are not meaningfully integrated into continuous quality improvement or contracting strategies.

## Synthesis and Recommendations

The analyses described here have illuminated a number of specific action steps that DCFS can take. These shifts are based on research evidence and observation of best practices implemented in other jurisdictions across the country. Recommendations presented here address the issues described in the systemic review as well as the OIG reports; in each section, recommendations are arranged in order of immediacy, beginning with steps that can be taken in the near term.

Challenges associated with *high-risk case closures*, *role ambiguity*, and *ineffective checks and balances* limit the effective transfer and use of critical information across all levels of the system. Recurring issues related to *case planning*, *service linkage*, and *coordination and communication between team members* noted over time by the OIG may be evidence of longstanding underlying systemic issues. There are opportunities to introduce evidence-based strategies and standardize, where appropriate, case management practices. Handovers and transitions in care create the greatest risk and should be prioritized. To address these issues, we recommend:

- 1) **Develop and refine protocol for closing Intact cases.** While some Intact cases are closed when services are completed and the family is stable, other cases are closed when the provider feels there is “nothing more they can do”—either because the family has not complied with services or has been difficult to engage. In these cases the Intact provider may close the case and hope that a future hotline call will be made if circumstances warrant. This represents a missed opportunity to flag and intervene with families whose disengagement, paired with history of child maltreatment, may itself constitute a risk to child safety. Best practices around case closures should involve multidisciplinary oversight, closing case “conferences,” and clinical case consultation where indicated.
- 2) **Clarify goals and expectations across staff roles.** It will be important to clearly articulate expectations for every actor and agency involved in the work of promoting child safety; this means clarifying the roles of DCFS investigators and supervisors as well as Intact providers and staff. It is essential that investigators play an active role in engaging families as well as communicating historical and current information to Intact workers. A messaging strategy should also raise awareness about the ways in which all system actors can apply and carry out critical thinking when cases warrant additional attention, including initiating court proceedings when necessary.
- 3) **Utilize evidence-based approaches to preventive case work.** Examine models that have been piloted and tested in Illinois and other jurisdictions using:
  - a) Local opportunities to generate evidence. Illinois has piloted the use of a practice model (e.g., standardized approach to engagement, risk assessment, and strengths-based service planning) in local “immersion sites” (i.e. locations where multiple strategies are being piloted and evaluated simultaneously). Evaluation

data from these sites should be leveraged to determine if better outcomes can be achieved using this approach. Individual regions and providers have explored the use of the Recovery Coach model, 360 models for collaborating with the courts, and Solution-Based Casework (SBC; Antle et al., 2008) to improve engagement with both families and court partners on improving outcomes and promoting family stability.

- b) Resources that identify core components of successful preventive programs (<https://clas.uiowa.edu/sites/clas.uiowa.edu.nrcfcp/files/Core%20Elements%20of%20Child%20Welfare%20In-Home%20Services.pdf>)
- c) Peer consultation with Preventive Service Divisions from other jurisdictions (e.g., New York City, Washington, DC) that employ best practices.

The *expected avoidance of removals* and *supervisory misalignment* identified in the review of Intact services create tensions and competing priorities that reduce the safety and effectiveness of services. These findings are supported by recurring OIG recommendations to *improve critical thinking and assessment skills, reduce caseloads and production pressures, and improve supervisor competencies and availability*. The focus of improvement efforts should be on the lack of psychological safety, where team members are reluctant to speak up and challenge decisions, and an organizational structure that is not aligned with the Department's goals. To address these issues in the near term, we recommend that the Department:

- 4) **Improve the quality of supervision.** Building upon the model of supervisory practice outlined in Policy Guide 2018.09 (Illinois Department of Children and Family Services, 2018), the Department will need to continue to grow supervisors' capacity to promote learning and open communication on their teams. Intact teams should be prioritized for inclusion in training on the new practice model, but they may also require support to adjust the level of supervisory accountability and oversight and assess organizational culture. Measures of psychological safety within organizations can be used to identify improvement targets and support workforce development efforts. In addition to the emphasis on family-centered, child-focused, strengths-based and trauma-informed practice, supervisors can be coached to use team-level culture data to create a context that supports learning and improvement and discourages fear-based casework.
- 5) **Adjust the preventive services offered through Intact to meet the needs of the population.** Intact families have many different types of needs. Data analysis (e.g., latent class analysis) can be used to clarify the subgroups within the population referred for Intact and identify distinct needs and implications for services. Data from other public-serving systems (e.g., Illinois Departments of Human Services, Healthcare and Family Services, and Corrections) can also be leveraged to identify and understand the needs of vulnerable families. These population analyses will inform decisions about service planning, frequency of contact, and caseloads, and can allow the Department to ensure that adequate community based services and specialized staff are available to meet the needs of families struggling with mental health, substance use, and domestic violence. Cases with multiple "sequences" (e.g., many previous instances of abuse or neglect) or

similar allegations of physical abuse that remain unresolved may require more time and attention and a set of contingencies that may trigger an examination of whether short-term child removal is indicated.

- 6) **Restructure preventive services (generally) and Intact (specifically).** The structure and positioning of preventive services within DCFS should address the imbalances introduced by matrix supervision and encourage close collaboration between Intact and Investigations (DCP). This will allow Intact referrals to be appropriately triaged and coordinated and enhance oversight. It may also be necessary to add staff or contract resources to adjust caseload ratios and contact expectations so that they are calibrated to the current level of complexity and severity of Intact cases.
- 7) **Work with courts and State's attorneys to refine the criteria for child removal in complex and chronic family cases.** One of the most important organizational cultural issues is the reluctance to elevate cases in which removals may be appropriate, in part due to pervasive expectations that concerns will not be heard or considered. While Illinois' low removal rate has received national (positive) attention, it is nonetheless important to retain a critical lens when examining risk and safety in each individual case. DCFS should work to build consensus among courts and State's attorneys about the appropriate implementation of statutes concerning removal of children who have experienced multiple incidents of abuse. While they represent a minority of the children served by child welfare systems, research suggests that young children with previous allegations of physical abuse die at a rate 70% greater than children with allegations of neglect (Putnam-Hornstein et al., 2013). Engaging attorneys, judges, national experts, and local leaders in conversations about goals for improving safety among all children, as well as the barriers to doing so, will be essential to any system improvement effort.

The system's inability to make important case information available for decision making results in *information gaps* that may negatively impact risk and safety assessment. The need to improve the *timeliness and accuracy of case recordings and use of case records for decision-support tools* was a recurring theme noted by the OIG. Generating practice-based evidence to inform casework can help close the information gap.

- 8) **Redesign the assessment and intake process based on systemic review to: a) reduce redundant information collection and data input; b) support decision making with youth and families; and c) improve effective communication across child serving systems.** A lack of connection and continuity in the assessment process can create unnecessary, inaccurate, and redundant information collection and data input activities. Explore the use of a system-focused design strategy such as Lean process improvement workshops to reduce redundancy and improve the efficiency, reliability, and accuracy of assessments across all points in care (e.g., screening, intake, service planning, and care transitions).

9) **Direct attention to cases at greatest risk for severe harm.** Child welfare systems are increasingly making use of administrative data to speed the detection of cases that may require additional attention or intervention. DCFS should revisit the use of predictive models to identify risk factors for future maltreatment; identification of the families at greatest risk can inform targeted strategies to safeguard and protect vulnerable children. Predictive models should be transparent, incorporate the input of a broad array of stakeholders, and be supported by ethical safeguards to ensure equity (Chadwick Center & Chapin Hall, 2018). DCFS should explore use of these models to:

- direct consultative attention to high-risk cases;
- match families with appropriate services;
- direct attention to cases that require clinical consultation; and
- assess risk at case closure.

In addition to these recommendations, DCFS should consider steps to address the additional issues identified in this report. This would include an examination and redesign of contracts to Intact providers to promote staff retention, ensure effective caseload ratios, and incentivize performance, as well as the use of technological solutions that can be leveraged to promote information sharing between investigators and Intact as well as between Intact and community service providers.

## Conclusion

Ensuring child safety while promoting child well-being is one of the greatest challenges faced by child welfare systems. A recognition of the importance of child well-being has allowed Illinois to maintain a low removal rate in the face of increasing complexity of the issues families face; at this juncture, this approach requires strategic attention, planning, and vigilance to ensure the safety of children remaining in Intact families. This review highlights considerations for improving the effectiveness of services delivered to children and families.

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## Glossary

**Child and Adolescent Needs and Strengths (CANS):** Child-centered assessment tool used to facilitate discussion and guide decisions about service needs or population outcomes. In Illinois,

CANS are completed periodically on child cases to determine the child's current strengths and needs and changes in these over time.

**Child and Family Team (CFT):** A group convened to weigh in on the needs and best interests of the child and the plans for addressing these. The CFT includes the subject child(ren), caregiver(s), parent(s), informal family's supports (e.g., extended family, friends), and the professionals assigned work with the family (e.g., case managers, counselors, DCP investigators). In the context of a child welfare case, this team could have periodic meetings to assess the family's status and determine action steps.

**Child Endangerment Risk Assessment Protocol (CERAP):** A standardized safety assessment introduced in the 1990s to promote more effective front-end assessments.

**Child Welfare Service (CWS) Referral:** Sometimes the Child Abuse Hotline receives calls about suspected abuse or neglect that do not meet the criteria for an investigation under Illinois law, but the family would benefit from community linkages to services. In these cases, the family may be referred to their local DCFS office or one of our private agency partners in the community that can get them the help they need without opening an investigation.

**Critical Incident:** Child death or serious physical injury.

**Chronicity:** Repeat engagement; in a child welfare context, often refers to families who have had multiple open child welfare cases or multiple allegation of abuse/neglect over time.

**Intact Family Services:** In-home services offered to DCFS-referred families focused on providing education and case management in order to prevent children from entering foster care. Intact services are most often voluntary but may also be court-ordered, and can provide in-home counseling, crisis response, and linkage to appropriate treatment programs (e.g., substance abuse) or services (e.g., medical clinics, Section 8 housing assistance, childcare) at no cost to the family.

**Indication:** Outcome of an investigation determining that allegations of abuse/neglect are upheld and verified. In indicated cases the child welfare agency found sufficient evidence to support a claim that child abuse or neglect occurred; may be referred to as substantiation. Indication does not require as high a legal threshold of evidence as being found guilty of criminal child abuse or neglect.

**Indicated Paramour:** Current or ex-boyfriend or girlfriend who has been in a care-taking role and who has had a confirmed (indicated) allegation of child abuse or neglect by DCFS.

**Lean Process Improvement:** A systems-focused process for eliminating inefficiency and improving effectiveness in business processes. Lean workshops engage staff in a facilitated approach to identifying improvement opportunities in the current state of specific work activities and engages them in the design and implementation of the improved process. Lean specifically

targets solutions that increase the value of time spent on activities, reduce duplication of effort with routine tasks, and eliminate unnecessary re-work.

**Paramour:** Current or ex-boyfriend or girlfriend who has been or may be or is in a care-taking role; the paramour may or may not be residing within the family unit.

**Subsidized Guardianship Home (SGH):** An alternate permanency arrangement in which relative caregivers are given financial assistance to assume legal guardianship of a child in out-of-home care.