

INTRODUCTION

The Illinois Department of Children and Family Services (DCFS) is pleased to submit this waiver proposal for testing innovative service-delivery strategies and for contributing to the evidence base of what works to ensure the safety, permanency, and well-being of vulnerable children and their families. This proposal builds upon the June 4 letter of intent that DCFS submitted to the Administration of Children, Youth and Families (ACYF) describing its intention to seek waivers of certain sections of title IV-E to implement and evaluate a number of evidence-based, trauma-informed interventions to improve child and family outcomes among children aged zero to three years old. The following sections of this proposal describe the purposes of the proposed project, identify the target population and expected outcomes of the evidence-based interventions (EBIs), delineate the hypotheses that will be tested by the independent evaluators, explain the method of measuring and ensuring Federal cost-neutrality over the course of the demonstration, and lay the foundation for the negotiation of the final terms and conditions of the waiver demonstration.

1. PURPOSES OF THE WAIVER PROJECT

The IDCFS proposes to conduct a Title IV-E Waiver Demonstration project to focus on the highly vulnerable population of very young children ages 0-3. The purpose of the proposed demonstration project is to build and test an effective policy and practice model that focuses on strategies designed to address the impact of early maltreatment and loss on very young children and promote healthy development and secure attachments. The intent is to implement an intensive concurrent planning process to expedite permanency, and to provide developmentally targeted parent training and support, including therapeutic interventions when indicated, to address developmental effects of maltreatment, trauma and promote attachment with permanent caregivers.

Problem Addressed by the Demonstration Project:

To understand why we have chosen this population and approach, we can look at Illinois in comparison to other states relative to overall rates of out-of-home placement, length of time in care, reunification rates, and re-entry rates.

Out-of-home placement rates: Nationally Illinois ranks 27th highest among all States and the jurisdictions of the District of Columbia and Puerto Rico. At 5.7 foster children per 1000 children under 18 years old, there appears to be some room for improving Illinois' standing on this measure. Currently Georgia registers the lowest out-of-home placement rate at 2.7 per 1000 children. This is below the 3.0 per 1000 goal that Casey Family Program has set for the nation as a whole by year 2020.

Figure 1: Out of Home Care Rate

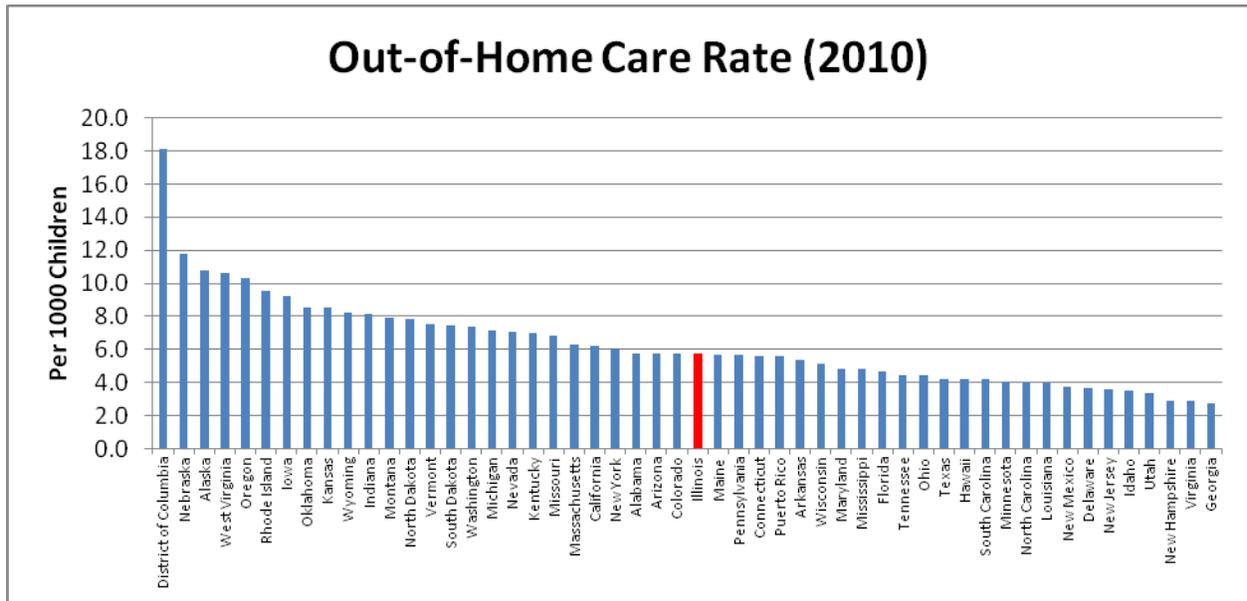
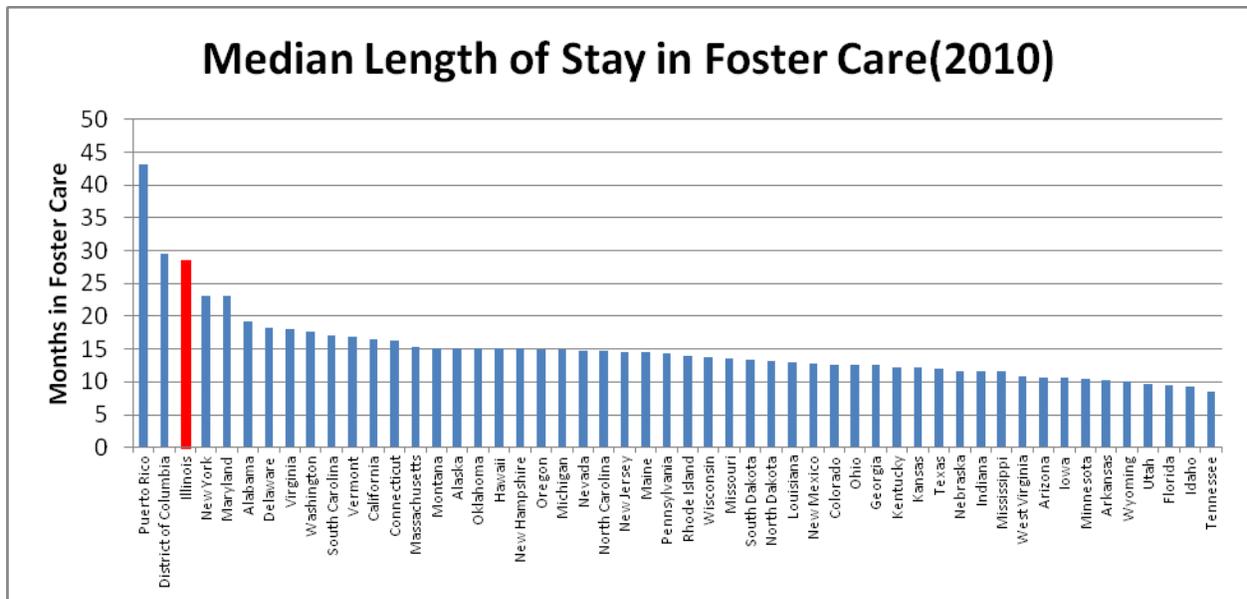


Figure 2: Time in Foster Care

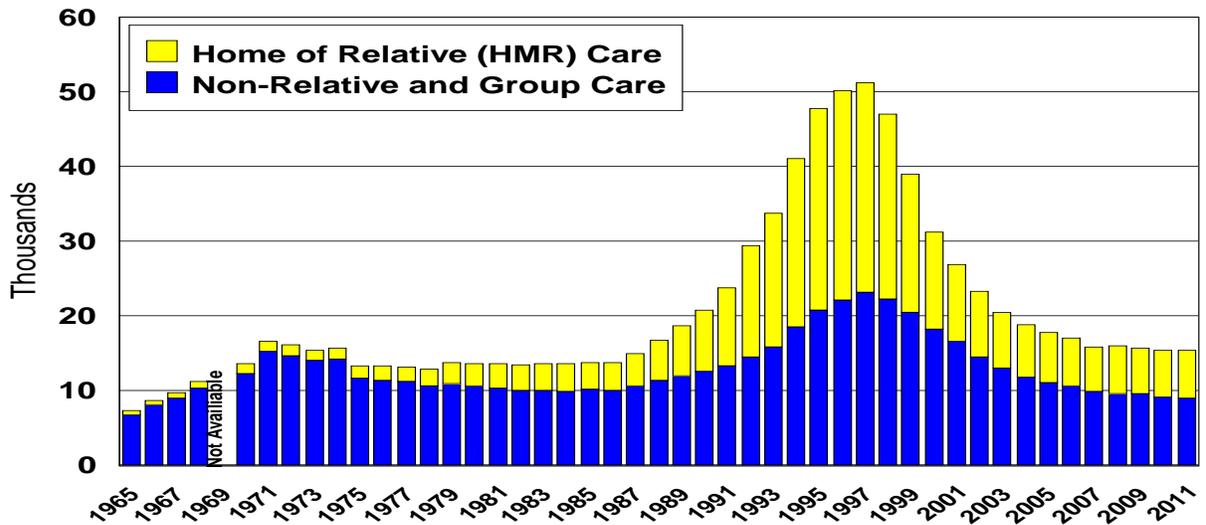


The factor that appears to contribute the most to Illinois' ranking on out-of-home care is the much longer time children spend in foster care. Illinois ranks 3rd highest in the nation at 28.6 months—the longest median length of stay of any State in the nation. This longer length of stay is related to the fewer number of children Illinois brings into care. The lower the entry rate, the more challenging and the less easy are cases to re-unify. This is

borne out by the chart below (Figure 5) that illustrates the correlation between low entry rates and longer times to reunification.

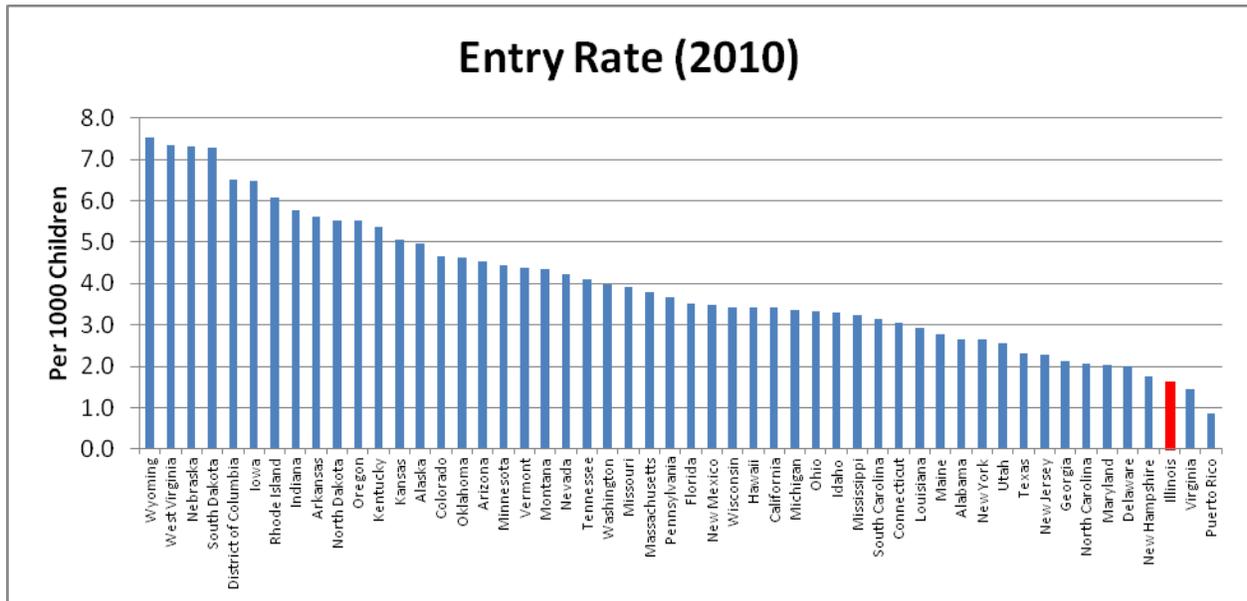
In recent decades, Illinois has made important strides in safely reducing the number of children removed from their homes and placed into foster care (see Figure 3). At the end of June of 1997, there were 51,331 children in Illinois foster care. This corresponded to a foster care rate of 16.1 foster children per 1000 population under 18 years old. By the end of June of 2011, there were 15,413 children in foster care, corresponding to a foster care rate of 4.8 per 1000 children.

Figure 3—Reduction in Foster Care Caseload



The nearly 70% reduction in foster care cases was accomplished by front-end improvements that safely served children in their own homes and back-end innovations that expedited the movement of children from foster care to permanent homes through adoption and guardianship. As a result, Illinois now registers one of the lowest foster care entry rates in the nation (see Figure 4).

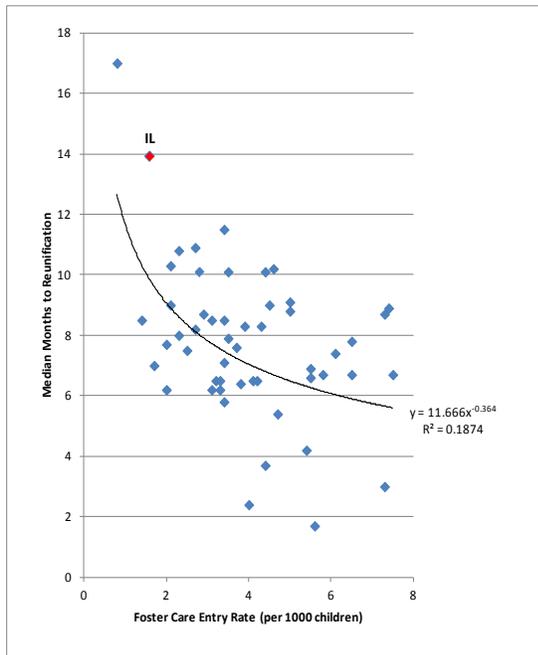
Figure 4—Illinois’s Ranking on Entry Rates into Foster Care



The fewer number of children Illinois brings into care helps to explain why it now ranks as having the longest median length of stay in the nation. The lower the entry rate, the more challenging and the less easy are cases to re-unify. This is borne out by the chart on the left that illustrates the correlation between low entry rates and longer times to reunification.

Correlation between Entry Rate and Time to Reunification

Figure 5—Correlation between Re-entry Rate and Time to Reunification

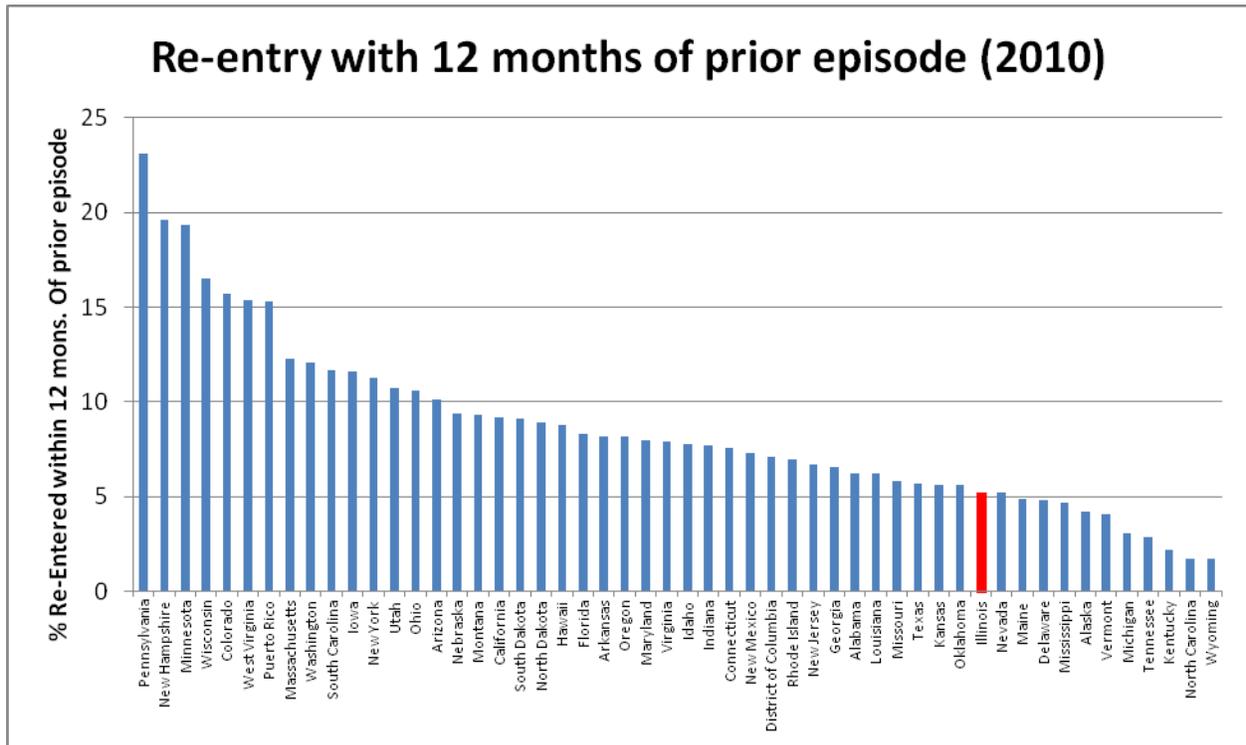


The best fitting regression curve indicates that the median times to reunification tend to fall the more children are taken into care per 1000 children in the population. The challenges that States like Illinois face, which turned the corner on high removal rates in the mid-1990s, is how best to deal with the underlying complexity of cases that inhibit their exiting the foster care system quickly. Of related significance is the fact that Illinois ranks 3rd highest in regards to the percentage of children who enter foster care at ages zero to three years old. Nearly one-half (47%) of children who are placed into foster care are aged three or younger. Because these early years set the stage for all that follows, they hold the greatest danger for long-term damage and the greatest potential for successful intervention.

The focus on the youngest children coming into care is further informed by the statistical picture focusing on the very young. In Illinois, while the number of children entering care has declined overall since FY05, and Illinois' entry rate remains well below the national rate, there has been an increase in the number of children in care between FY'07-FY'11. The largest increases were among 3-5 year olds. Children ages 0-5 make up an increasing percent (58%) of all children entering care in Illinois. This is higher than the national average (37% in FY10). The entry rates for infants (under age 1) are consistently higher than entry rates for other young children. Forty-eight percent of the babies entering care in FY11 were newborns under 3 months of age. About 41% of the total number of children in care are ages 0-5, with 3 year olds making up the largest percentage. Once in care, babies are unlikely to exit care within 6 months, and 25% of youth who aged out of care in FY11 first entered care at age 5 or younger (which is much higher than the national average of 15%). In Cook County, children ages 0-5 make up about 53% of all children entering care, with the largest percentage for babies under 1. In Cook County, about 311 babies entered care in FY11, and 64% were newborns entering care within the first 3 months. For this geographic area, fewer than 30% exit care within 6 months. And the percentage of youth who exited care in FY11 and first entered care at 5 or younger (31%) was twice the national average (15%). (Data from Casey Family Programs).

With young children coming into care primarily for neglect, but also for other forms of maltreatment, we know that the stress associated with these traumas has a serious impact on the development of young brains. These effects are known to be evident in all domains of development, including social –emotional development. Babies may be further traumatized by the process of investigation, removal and out-of-home placement, as these processes often involve conflictual interactions between professionals and family members and can evoke fear, resistance, and hostility. Attachments are disrupted and young children's regulatory capabilities may be compromised. The literature suggests, however, that when children are provided responsive caregiving, resilience is enhanced, and recovery from early stressors associated with removal and placement into substitute care is possible. When support is provided to parents, relatives and foster parents, and is complimented by appropriate therapeutic approaches, it may be possible to promote developmental growth and mitigate the early stressors associated with removal (Fisher and Stoolmiller, 2008).

Figure 6—Re-Entry Rates



Another indicator of the special needs of very young children is their higher risks than average of re-entry into foster care after they’ve been reunified (Wulczyn et al., 2011). Even though Illinois’ overall re-entry rate among all age groups is at the lower end of the national distribution, the higher rates of re-entry among the very youngest age group indicates a need for more effective evidence-based interventions for children after they are discharged from state care back to parental custody.

While ensuring safety and permanency can provide a secure and stable foundation for fostering the healthy and productive development of young children, there is growing recognition that these essential goals of child welfare intervention are not enough for helping children overcome early childhood adversities and the trauma of maltreatment and separation from their families. Because many of the trauma informed EBIs for addressing these problems are not reimbursable under the maintenance, training or administrative provisions of title IV-E, DCFS is requesting waiver authority to use federal foster care funds to provide these services to children and families which are not currently fundable under the usual IV-E program.

The proposed evaluation design builds on the rotational assignment system that DCFS has used for the last 15 years to assign foster care cases to DCFS teams and private child welfare agencies under performance contracting. Rotational assignment helps to insure that every team and agency gets a “representative mix” of children as new referrals so that no team of agency has an unfair advantage through creaming the “easy” cases. Even though rotational assignment is not a fully randomized process, the State’s experience with this assignment mechanism under its

successful AODA waiver indicates that rotational assignment provides an appropriate approach for accurately determining the efficacy of the EBIs in decreasing time to reunification and other permanent homes and improving child and family well-being.

Hypothesis:

The project is built upon the idea that that for young children entering care, the length of time in care can be shortened and well-being outcomes improved through a combination of intensive concurrent planning, parent training and support, and therapeutic intervention when indicated. Specifically the proposed waiver demonstration will test the following well- built hypothesis: children aged zero to three years old who are initially placed in foster care will experience reduced trauma symptoms, increased permanency, reduced re-entry and improved child well-being if they are provided evidenced-based intensive concurrent planning and trauma informed EBIs compared to similar children who are provided IV-E services as usual.

Innovations of the Project:

The project will identify children 0-3 entering care in Cook County during the project period. Following random assignment of DCFS regions and community-based foster care agencies, children referred on a rotational basis to these units will receive developmental screenings by early childhood development specialists. Children in the intervention group whose screening indicates the need for further assessment will receive assessments for effects of trauma and loss. Biological parents will participate in “Nurturing Parents”, an evidence-based parent education and treatment program shown to increase reunification rates.

Foster parents, and/or prospective adoptive parents will participate in “Circle of Security”, an evidence-based parent training program. For children whose assessments indicate the need for therapeutic intervention, regardless of the permanency goal, Child Parent Psychotherapy (an evidence-based trauma and attachment therapy model) will be provided. The use of evidence-based parent education and therapeutic models for biological parents, foster parents, and children with serious trauma and loss effects, along with an intensive concurrent planning process, enhance the innovation of this project.

The role of the caseworker is viewed as essential to the implementation and coordination of all services. Intensive concurrent case planning will be conducted by the case workers. In this model, the reunification goal will be pursued with increased visitation, accompanied by an early assessment of poor prognosis for achievement of the return home goal. Assertive family finding and caregiver training and support are provided to enable more accelerated movement to permanency when return home is not achievable. The DCFS Early Childhood program and the DCFS Office of Trauma Informed Practices will coordinate to provide caseworkers within the demonstration agencies with developmentally targeted training regarding the effects of maltreatment for infants and toddlers as well as provide them with an overview of the interventions being used by the project. This will assist the caseworkers in supporting the interventions with families during their normal casework interactions. It will also promote enhanced service coordination for the family with other parties in the case [i.e. the courts, early learning, medical providers etc.]. The model for enhanced concurrent planning has been developed by the Department in the DCFS reunification practice model. Full implementation of

this approach has not been achieved statewide and will benefit from field coaching of the supervisory staff which can be accomplished by the DCFS Supervisory Training to Enhance Practice (STEP) Program.

2. STATUTORY GOALS AND DEPARTMENT PRIORITIES

The statutory goals that the project is intended to accomplish are to achieve an *“increase in permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth”*, to *“increase positive outcomes for infants, children, youth and families in their homes and communities...”* and to *“Prevent the re-entry of infants, children and youth into foster care.”*

Specifically our demonstration project will address the areas of priority of the Department as follows:

- Producing positive well-being outcomes for young children by addressing trauma they experienced from abuse/neglect, and the secondary trauma and damage to attachments associated with removal and placement into substitute care utilizing developmentally targeted interventions;
- Enhancing the social and emotional well-being of children available for adoption by providing training and support to caregivers who may commit to adoption if they felt adequately prepared and supported, and by providing therapeutic intervention when necessary to facilitate the parent-child bond and thereby enhance healthy child development;
- Yielding more than modest improvements in the lives of children and families and contributing to the evidence base by implementing evidence-based therapeutic and parent support interventions, along with developing and practicing an intensive concurrent planning model;
- Leveraging the involvement of other resources and partners through the involvement of the early childhood development and therapeutic provider communities in the implementation of this project.

3. TARGET POPULATION

The primary target population is children who enter state custody under the age of four years old. During the fiscal years 2007 through 2010, almost 9,000 children aged birth through three years old entered foster care in Illinois. Of these, approximately 27 percent were from Cook County.

Figure 7 illustrates the trends and caseload dynamics for the primary target population in Cook County. On June 30, 2007, there were 1,531 children from birth through three in foster care. By the end of SFY 2010, the number of young children in foster care had decreased to 1,361. Between SFY2006 to 2010, the rate at which these young children entered foster care fluctuated annually between 492 and 675. The number of children exiting each year gradually declined from 725 in 2007 to 585 in 2010. Please note that exits include exits to permanence and children who exit the target population (turn 4 years old but remain in care).

Figure 7—Trends and Caseflow Dynamics, Children Birth through Three Years Old, Cook County, Illinois

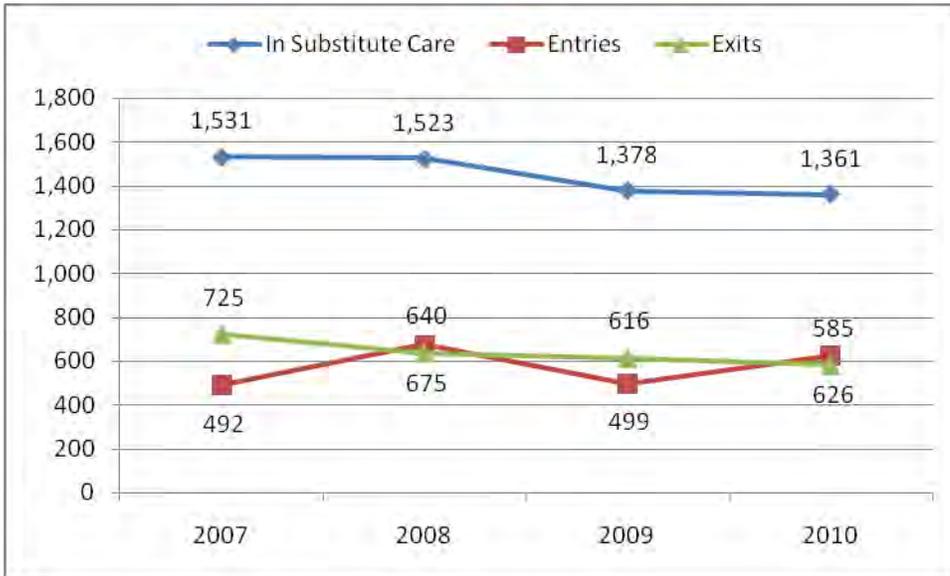


Table 1 presents demographic characteristics, child welfare history status information, and other risk factors for the primary target population that entered foster care in Cook and all other Illinois counties during this four year period. The data show several significant differences between Cook County and the rest of the state, especially with respect to race or ethnicity and age at first entry. Baseline measures of permanence and reentry data collected from entry and exit cohorts from fiscal years 2007 through 2009 reveal additional differences between Cook County the rest of the state. A smaller proportion of children in Cook County (17%) reunified in less than two years than in the rest of the state (36%) and children in Cook County had larger median length of stay. Although children in Cook County are slower to reunify than children in the balance of the State, children who were reunified in Cook experienced less reentry to care than children in the rest of the state. Of children exiting to reunification in Cook between fiscal years 2007 through 2009, 10.9% and 13% returned to care within 12 and 24 months, respectively. In contrast, 14.6% and 19.4% of reunified children in other parts of the state reentered care during these time periods.

Cook County also differs from the rest of the state in proportion of children with a diagnosis of either a disability or emotional disturbance, with higher proportions in Cook County. These statistics reinforce the importance of acquiring waiver authority to fund EBIs that can effectively address the social and emotional well-being of this age group of children.

Table 1—Characteristics of Children Aged Birth to Three at Removal in Cook County, Illinois SFY 2007-2010

DEMOGRAPHIC VARIABLES		
Characteristics	Cook County	Non-Cook County
Child is male	53.7%	52.4%
Child is African-American	72.3%	34.1%
Child is of Latino Origins	9.2%	4.0%
Age at last removal (mean)	1.03 yrs.	1.29 yrs
Less than one year old	62.2%	50.6%
1 to less than 2 years old	15.0%	19.9%
2 to less than 3 years old	9.8%	13.0%
3 to less than 4 years old	13.0%	16.5%
Child diagnosed as having a disability		
Yes	13.1%	6.3%
No or undetermined	86.9%	92.6%
Not evaluated	<.1%	0.3%
Child diagnosed as emotionally disturbed		
Yes	2.6%	1.8%
No	97.4%	98.2%
Not evaluated	0.0%	0.0%
Number of removals from the home		
One	96.3%	98.1%
Two	3.6%	1.9%
Three or more	0.1%	<.1%
Removal for parental AODA	0.0%	0.0%
IV-E Eligible	45.1%	41.9%
BASELINE MEASURES		
Reunified within 2 years of removal		
SFY2007 - SFY2009	17.0%	36.0%
Re-entered within 1 year of discharge to reunification		
SFY2007 - SFY2009	10.9%	14.6%
Re-entered within 2 years of discharge to reunification		
SFY2007 - SFY2009	13.0%	19.4%
Median length of stay		
SFY2007 - SFY2009	1030 days	726 days

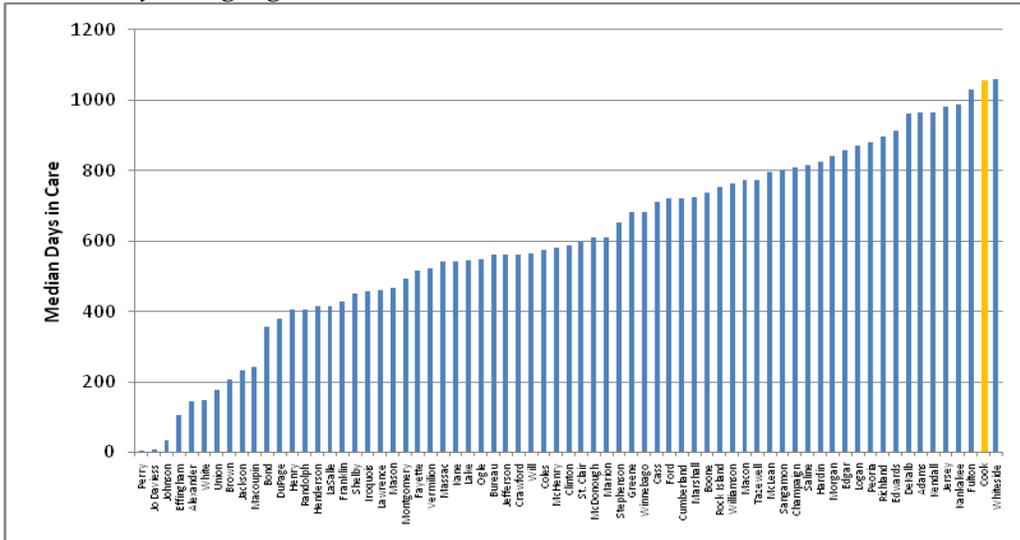
Note: Demographic data are from four years of AFCARS files; Baseline measures are from three years of data from the Integrated Database.

4. GEOGRAPHICAL AREAS

As discussed in the section on the target population, children aged birth through three years old have lower rates of reunification in Cook County than in the remainder of the state. In addition, children in Cook are more likely to stay in care for longer periods of time than children in the balance of the state. As such, the Illinois waiver will focus on children in Cook County. Figure 8 shows the median length of stay for children aged birth through three entering foster care in 2009. As shown, Cook County has one of the longest lengths of stay for young children.

Figure 8—Median Length of Stay in Care (SFY 2009) By County: Children Birth through Three

Cook County in Highlighted in Yellow



5. SERVICE INTERVENTIONS TO BE IMPLEMENTED

The State’s goal is to implement EBIs that have a greater than average likelihood of demonstrating clinically important improvements in the lives of children and families. The likelihood of demonstrating a large effect size is enhanced by the State’s targeting an age group that has historically experienced inferior permanency outcomes. Also by implementing EBIs that have a proven track record of success with similar populations, if not specifically with child welfare populations, the likelihood of demonstrating a significant effect size is greatly enhanced.

More than a decade’s worth of studies and technical assistance in implementation science (Fixsen et al., 2005) underscores the importance of the distinction between implementation integrity and intervention validity (Testa & White, in press). The overall success of a waiver demonstration is a product of the two. Failure to achieve the intended outcomes may reflect either a problem with the integrity of implementation or a problem with the validity of the intervention (Klein & Sorra, 1996). For example, an otherwise valid intervention could fail to produce the expected outcomes because of inadequate implementation or lack of fidelity to the model as intended by its developers. Conversely, a well implemented intervention that adheres closely to the developers’ intentions could also fail because of fundamental problems with the internal validity (efficacy) or external validity (effectiveness) of the intervention itself. Because program success depends both on the integrity of the implementation and the validity of the intervention, the proposed waiver project will attend to both the components of the demonstration.

Description of the Intervention:

In order to address the trauma and mental health needs; and to enhance the social and emotional development of young children within the target population, The Department has designed a continuum of interventions that are developmentally informed and evidence-based. The

interventions will be targeted to the demonstration target population dependent upon the assessed level of need for the infant/ toddler and their caregiver[s]. In all cases for this age group, the mental health needs of the child and caregiver must be considered concomitantly. Child well being for this population is largely determined by the capacity of caregivers to respond to the regulatory, emotional and behavioral needs of the young child. All interventions are designed to enhance this caregiving capacity. The Department is firmly committed to engaging all parties [i.e. biological parents, extended family and foster caregivers] that may be supportive to the child that is receiving the interventions in keeping with the Department's overall family-centered practice model.

Three Approaches Will Comprise The Intervention Model:

- 1. Child Parent Psychotherapy (CPP)-High Risk: Caregiver-Child Dyad:** Developed in the early 2000's and widely distributed in 2005, CPP is based on attachment theory, but combines and integrates principles from multiples theories (developmental, trauma, social-learning, psychodynamic and cognitive-behavioral therapies). CPP is a dyadic (caregiver and child) intervention for children from birth through age 5 who have experienced at least one traumatic event such as the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence, and as a result, are experiencing behavior, attachment, and/or other mental health problems. The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect. The Department has elected to utilize this model because research demonstrates that CPP is one of the best ways for children within the targeted age range to address child trauma, strengthen the child-parent relationship(Lieberman, Van Horn, & Ippen, 2005), and improve child outcomes including increased IQ scores and school readiness (Cicchetti, Rogosch & Toth, 2000). In addition, this intervention has been shown in randomized clinical trials to improve the mental health of both primary caregivers and their children, and to decrease levels of depression and anxiety in women (Lieberman, Ippen & Van Horn, 2006; Ippen, Harris, Van Horn & Lieberman, 2011).

The average length of CPP treatment is 50 therapy sessions, although some clients remain in treatment for up to 18 months. Sessions include the caregiver and child which is necessary to facilitate healthy attachment and mitigate the negative impact of trauma experiences. The model also allows for the inclusion of both the biological parent and foster parent in cases when reunification is being actively pursued. The developers, Dr. Alicia Lieberman and Dr. Patricia Van Horn have extensive training and experience in infant mental health and developmentally appropriate practices. **The model receives a ranking of 2 from the California Evidence Based Clearinghouse with a score of High for relevance to child welfare.**

- 2. The Nurturing Parenting Program (NPP)-Moderate Risk/Biological Parents:** Developed in the early 1980's and distributed nationally by 1985, NPP is a psycho-education and cognitive-behavioral group intervention targeted to biological parents that is aimed at modifying maladaptive beliefs that led to abusive parenting behaviors and to enhance the parents' skills in supporting attachments, nurturing and general parenting. The Department has elected to utilize this model because it was specifically designed for

biological parents and has demonstrated outcomes that support early reunification and prevents recidivism of the maltreatment and re-entry into care. The developers (Dr. Stephen Bavolek & Associates) offer a number of models for a variety of ages and family types often seen within child welfare systems. The demonstration project will utilize the Early Childhood (0-5) curriculum. The specific goals of the model are to:

- Increase parents' sense of self-worth, personal empowerment, empathy, bonding, and attachment;
- Increase the use of alternative strategies to harsh and abusive disciplinary practices;
- Increase parents' knowledge of age-appropriate developmental expectations;
- Reduce abuse and neglect rates.

The model is typically delivered in a group setting with 7-8 families and two co-facilitators. Sessions run approximately 90-minutes and the model is delivered over 23 weeks for the Early Childhood model. Home based observations are conducted to observe the implementation of the skills that have been acquired within the group. Specific outcomes that are demonstrated by the use of this intervention include: Parents participating in NPP developed more appropriate developmental expectations of their children, an increased empathic awareness of children's needs, more appropriate attitudes toward the use of corporal punishment, and a decrease in parent-child role reversal behaviors. **The model receives a ranking of 3 from the California Evidence Based Clearinghouse with a score of High for relevance to child welfare.**

3. **Circle of Security (COS): Mild-Moderate Risk/Foster Parents:** The COS parenting program summarizes over 50 years of research in child development, neuropsychological development, and attachment theory in a user-friendly workshop to improve caregiver-child relationships. Created by Dr. Kent Hoffman and associates, the model was designed as a psycho-educational parenting program. The COS approach has met a need in the field of early intervention for a clinical model that is theoretically sound, research-based, and user friendly for both parents and the professionals who work with them. The increased empathy on the part of professionals for their own struggles translates directly into helping parents build empathy for the struggles they experience within intimate relationships (Powell, Cooper, Hoffman & Marvin, 2009).

The COS parenting program utilizes multi-media methodology consisting of video clips of successful and unsuccessful parent-child interactions. The COS program offers parents a non-judgmental view of both parenting challenges alongside parenting competency models. Watching the Circle of Security DVD, participants learn to decipher children's behaviors as a way to communicate their attachment needs. Ample time for discussion and reflection invites participants to think about their own parenting practices, to talk about new found understanding of their children's behavior, and to share struggles and successes in parenting situations that took place between meetings.

In addition to the use of video, clear, simple, and effective handouts support the learning process. The program is divided into eight teaching units. The units are presented in a workshop format of 8-10 participants over an eight week period.

The COS workshops are developmentally targeted to children under the age of five. All materials presented are equally applicable to parents and other caregivers, including grandparents and foster parents, and are designed to speak to participants from a broad range of socio-economic and cultural backgrounds. The COS model has been found to be effective in reducing attachment disorganization and increasing attachment security for children in the age range between toddlerhood and the early school years (Cooper and Powell, 2006). It also provides needed support in high-risk populations for secure dyads to remain secure (Powell, Cooper, Hoffman & Marvin, 2009). **The model receives a ranking of 3 from the California Evidence Based Clearinghouse with a score of Medium for relevance to child welfare.**

Utilization of these approaches will be determined by an enhanced developmental screening conducted by the DCFS Early Childhood Program. The program has determined that the following criterion may apply to a determination of high vs. moderate risk groups:

High Risk Group:

- High scores on the Ages Stages Questionnaire: Social Emotional Tool
- Excessive Externalizing behaviors [i.e. biting, extreme tantruming];
- Extreme Regulatory difficulties [i.e. sleeping, eating and elimination];
- Multiple Placements [i.e. two moves within 6months];
- High levels of caregiver distress [i.e. inability to respond to the child's care needs due to poor social supports and overwhelming stress];
- Documentation of trauma exposure and symptomology [Obtained through the IA and CANs];
- Psychiatric diagnosis/ and or medication usage by the child and /or parent.

Moderate Risk Group:

- Trauma history without current symptoms;
- Lack of awareness of foster parent about the effects of trauma exposure on young children and their child's specific trauma history;
- Toddlers who are not expressing a range of developmentally appropriate affect;
- Children who have experienced severe medical illness/ medical trauma;
- Negative attributions by caregiver about the child;
- Overly compliant children who are unable to signal their caregiving needs.

Overview of Enhancements to the Developmental Screening Process:

1. **Intervention for high risk children and caregivers:** For infants and toddlers that are assessed to be at the highest level of risk/ need, caregivers and the child will receive Child Parent Psychotherapy (CPP) as the primary treatment model. This model can be

used with any caregiver, therefore the therapist can target the intervention to foster caregivers, biological parents and/ or to both entities.

2. **Intervention for moderate risk children and caregivers:** For infants and toddlers that are assessed to be at a moderate level of risk/ need, parent education models that are developmentally informed have been selected as an enhancement to traditional parent education models that may not be developmentally informed and therefore fail to emphasize the specific skills that are needed to support the healing of maltreated children within this age group. The Nurturing Parenting Program has been selected for moderate risk biological parents. Circle of Security has been selected for moderate risk caregivers.

Rationale for a Developmentally Informed Intervention Model:

All of the models share attachment theory as a primary theoretical framework that undergird the intervention approaches. Infants and toddlers in foster care often do not know how to signal or seek comfort from parents or foster parents; they may turn away, or be difficult to soothe leading to frustration in the relationship and risk of harm to the young child (Dozier, Dozier & Manni, 2002). Young children in foster care often experience increased dysregulation given the inability of the caregiver to appropriately identify the child's needs and to utilize effective strategies to address those needs. Trauma exposure and unmet mental health needs of biological parents and/ or foster parents may interfere with providing sensitive and nurturing care. When placed with foster parents with poor capacity for responding to the traumatized young child; there is an increased risk for developing disorganized attachments (Dozier, Dozier & Manni, 2002). Disorganized attachments represent a breakdown in attachment system and put children at increased risk for lifelong problems regulating physiology and controlling emotions and behavior leading to poor mental health outcomes (Dozier, Bick & Bernard, 2011).

Untreated mental health disorders can have detrimental effects on children's functioning and future outcomes (Zero to Three, 2009). Unlike adults, babies and toddlers have a fairly limited repertoire of responses to stress and trauma. Mental health disorders in infants and toddlers might be reflected in physical symptoms (poor weight gain, slow growth, and constipation), overall delayed development, inconsolable crying, sleep problems, or aggressive or impulsive behavior and paralyzing fears (i.e. dissociative/ freeze responses) (Parker, 2007). Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) predict subsequent aggressive behavior. Some early mental health disorders have lasting effects and may appear to be precursors of mental health problems in later life, including withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and traumatic stress reactions (Dozier, Bick & Bernard, 2011).

Healthy social-emotional development is strongly linked to success in elementary school (American Academy of Pediatrics, 2002). The emotional, social and behavioral competence of young children is a strong predictor of academic performance in elementary school. Social and emotional development is just as important as literacy, language, and number skills in helping young children prepare for and succeed in school. Those children who are not secure in relating to others are not able to trust adults and, as a result, are not motivated to learn. Furthermore,

school-age children who cannot calm themselves or be calmed enough to respond to teaching may not benefit from early educational experiences and may fall behind their peers.

The mental health of parents can affect young children. Maternal depression, anxiety disorders, and other forms of chronic depression affect approximately 10% of mothers with young children (American Academy of Pediatrics, 2003). These conditions often disrupt the parent-child bond as parents with mental disorders are less able to provide developmentally appropriate stimulation and parent-child interactions. Parenting and child development are most affected when depression simultaneously occurs with other factors (extreme poverty, substance abuse, adolescence, maltreatment, etc.). Infants of clinically depressed mothers often withdraw from caregivers, which ultimately affects their language skills, as well as their physical and cognitive development (Zero to Three, 2009). Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulty in school (Bethell, et al., 2004).

The Early Childhood Project was created in 1998 as a result of the B. H. Consent Decree to address the mental health and developmental needs of young children entering state custody. The program serves children from birth to five years old in the foster care program, and birth to three in Intact Family Services program. The Project provides developmental screenings for children aged birth to three and consultations and referrals for early childhood related issues for children from birth to age 5. Trauma, attachment, social-emotional functioning, and development are the primary areas of expertise.

The Integrated Assessment Program (IA) is a front –end assessment program that supplements and supports the casework process of child and family assessment through the early identification of the child’s and family’s developmental, educational, mental health, medical and social-emotional service needs, and referral to service programs. At the conclusion of the IA, the Early Childhood program assumes responsibility for making recommendations, referrals and monitoring these needs.

Currently, the Early Childhood Project administers the Denver II Developmental Screening tool, the Ages and Stages Questionnaire, and the Ages and Stages: Social and Emotional to screen the 0-3 population. For the purposes of this project, the project is considering making enhancements to the screening process. The following tools are under review as possible replacements and/ or additions to the current measures that are being used.

Table 2: Instruments Under Consideration:

Instrument	Description	Age Range
Battelle Developmental Inventory (BDI) 2 nd Edition (Newborg, (2004)	Assesses development in five domains; personal-social; adaptive, motor, communication, cognitive	0-8 years old
Bayley Scales of Infant and Toddler Development®, Third Edition (Bayley-III) (Bayley, 2005)	Asses motor (fine and gross), language (receptive and expressive), and cognitive development of <u>infants</u> and <u>toddlers</u>	1 to 42 months

Vineland Screener (Cicchetti, 1991)	Used to assess the personal and social sufficiency	0-18 years
Ages & Stages Questionnaire, <i>Third Edition</i> (ASQ-3), Squires & Bricker, 2009)	Screens 5 areas of development: Cognitive, Communication, personal social, fine motor and gross motor.	1 month-5 1/2 years
Denver Developmental Screening Test II (Frankenburg, 1990)	The screening assesses the following areas of development: Personal-Social, Fine Motor, Language, and Gross Motor.	0-6 years
Early Screening Inventory-Revised (ESI-R) 2008 Edition (Meisels, et. al, 2008)	The instrument addresses developmental, sensory, and behavioral concerns in the following areas: Visual Motor/Adaptive, Language and Cognition, Gross Motor Skills	3 years to 5 years and 11 months.
Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) (Squires, Bricker & Twombly, 2003)	Asses Personal-social (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)	3–60 months
Adult Attachment Interview(AAI) (George, Kaplan & Main, 1984)	AAI is a quasi-clinical semi-structured interview and taps into adult representation of attachment by assessing general and specific recollections from their childhood.	For Parents of all ages
Infant and Toddler Social-Emotional Assessment (ITSEA) (Carter & Gowan-Briggs, 2006)	It asses socio emotional functioning using 4 scales and 17 subscales. The four subscales include: (i) Externalizing Behaviors (ii) Internalizing Behaviors (iii)Behaviors expressing dysregulation (iv)Behaviors highlighting areas of competence.	12 to 36 months
Traumatic Screening Experiences Inventory Parent Report Revised C (PPR) (Ghosh et. al., 2002)	TESI-PPR is a screening for child's exposure to traumatic event. It is a 2 stage screening process: Stage 1 screens the parent regarding the child's functioning in various settings. Stage 2: Involves follow up on areas that came positive on the screens.	For parents of children under 7 and for children directly of ages 7-18
Trauma Symptoms Checklist for Young Children (Briere., n.d.)	The scales assess acute and chronic posttraumatic symptomatology and other psychological sequelae of traumatic events	3-12 years

6. TIME PERIOD

From initiation of the project to September 30, 2019.

7. SPECIFIC OUTCOMES

The specific child and family outcomes that will be assessed include the primary distal outcomes of *positive improvements in child well-being outcomes* and *decreased re-entry into foster care*. Also included is the primary proximal outcome of mitigated trauma symptoms associated with maltreatment and loss that is hypothesized to mediate the impact of the EBIs on the secondary proximal outcome of *decreased time to reunification and other permanent homes*. The outcome evaluation will also assess changes in the secondary distal outcomes of *improved early intervention and early education services for children with developmental delays*.

The proximal outcome of shortened time to permanency and the distal outcomes of decreased re-entry will be tracked with existing administrative data from the State SACWIS and related information from AFCARS and NCANDS as reported biennially to ACYF.

The proposed project will include high-quality measurements of well-being outcomes for all children and families served under the waiver demonstration both during and after placement. Primary data collection efforts will be undertaken to track changes in child well-being outcomes and improved caregiver capacity. The first involve the administration of CANS, Ages and Stages, and Integrated Assessment as explained above in Section 5. Appendix A includes examples of these instruments. The major data source of primary data on changes in child well-being and caregiver capacity will come from the administration of the child, caregiver and caseworker modules of the National Survey of Child and Adolescent Well-Being (NSCAW). The Illinois version (ILSCAW) will include modules that are designed to answer a range of questions about the functioning, service needs, and service use of children who come in contact with the child welfare system. It will examine the well-being of children involved with child welfare agencies and capture information about children's health, mental health, and developmental risks, especially for those children who experienced the severe trauma abuse and exposure to maltreatment.

Similar types of data from NSCAW have been disseminated by ACYF to highlight the compromised well-being of children who have come to the attention of the child protection system. Inclusion of the same data collection instruments in the Illinois waiver demonstration should allow not only the assessment of change in well-being status over time but also comparison with similar measures of well-being for the U.S. foster child population as a whole.

Appendix C lists selected NSCAW constructs, measures and associated instruments that will be administered for the target population of youth aged zero to three years old. These instruments are described in more detail as follows:

Indicators of Early Development

- *Early Cognitive Development*: The cognitive domain of the Battelle Developmental Inventory, 2nd Edition (BDI-2) will be used to assess cognitive development in children 3 years old and younger (Newborg 2005). The BDI-2 is a standardized, individually administered assessment battery of key developmental

skills in children. The Cognitive domain will be administered, which consists of the following three subdomains: (1) Attention and Memory for children 0 to 47 months old, (2) Perception and Concepts for children 0 to 47 months old, and (3) Reasoning and Academic Skills for children 24 to 47 months old. A Cognitive Development Quotient (CDQ) is estimated based on the subdomains. It is normed to have a mean of 100 and standard deviation of 15 (Newborg 2005).

- *Language Development:* The Preschool Language Scale-3 (PLS-3) will be used to measure language development, and precursors of language development, among children 5 years old and younger (Zimmerman et al. 1992). PLS-3 measures language development of children from birth to 6 years old. The Auditory Comprehension subscale measures receptive communication skills. The Expressive Communication subscale measures expressive communication skills. A Total Language score combines these two subscales. Each is normed to have a mean of 100 and standard deviation of 15.

Indicators of Social and Emotional Well-Being

- *Behavioral Problems:* Scores on the behavioral checklists developed by Achenbach and colleagues will be used as indicators of mental health and behavioral and emotional functioning for children 1.5 to 8 years of age. Externalizing, Internalizing, and Total Problem behaviors will be reported for the parent-reported (caregivers) Child Behavior Checklist (Achenbach 1991). Behavior ratings are considered clinically significant if scale T scores are at or above 64.
- *Adaptive Behavior:* Children's daily-living skills will be measured with the Vineland Adaptive Behavior Scale (VABS) Screener—Daily Living Skills domain (Sparrow et al. 1993), which will be administered to caregivers. Skills that will be assessed include basic eating and drinking, dressing, toileting, hygiene, housekeeping, time and money concepts, telephone use, and basic safety (Sparrow et al. 1993). Standardized scores are based on a mean of 100, with a standard deviation of 15.

ILSCAW will be administered at baseline, 18 months and 36 months after assignment to the demonstration. Unlike the CANS that will be administered to all children enrolled in the demonstration, NSCAW will be administered on only a sample of children that is sufficiently “powered” to detect a practically important change in well-being outcomes (see Power Analysis section).

8. Evaluation Design

The demonstration project includes several strong evaluation components that should help Illinois and the federal government to learn the extent to which the EBIs are successful in improving permanency and child well-being outcomes and addressing identified targets for change. The DCFS will contract with Dr. Mark Testa of the University of North Carolina at Chapel Hill to conduct the independent evaluation of the integrity of the project’s implementation and the validity of the EBIs in obtaining the desired outcomes.

The proposed evaluation design builds on the rotational assignment system that DCFS has used for the last 15 years to assign foster care cases to DCFS teams and private child welfare agencies under performance contracting. Rotational assignment helps to insure that every team and agency gets a “representative mix” of children as new referrals so that no team of agency would have an unfair advantage through creaming the “easy” cases. The concept of a level-playing field is very important to service providers, particularly for those of which felt they had not been treated fairly in the past (Taylor & Shaver, 2010). Appendix C describes the rotational assignment process used in Cook County, Illinois.

The AODA IV-E waiver demonstration that Illinois has been operating since 2005 also builds on the same rotational assignment system that is being proposed for this evaluation. The latest 2011 progress report on the AODA demonstration shows that rotational assignment successfully balanced the waiver services and treatment-as-usual (TAU) groups on many of the observed characteristics that affect permanency and child well-being outcomes.

Table 3 reproduces a table from the 2011 AODA progress report. It shows no remarkable differences between the two groups on such potentially confounding factors as the parent’s living arrangement and even the primary and secondary choice of drugs.

Table 3.—Characteristics of Birth Parents Allocated to DCFS Teams and Private Agencies Providing Treatment as Usual vs. AODA Recovery Coach (Waiver) Services, December 31, 2011

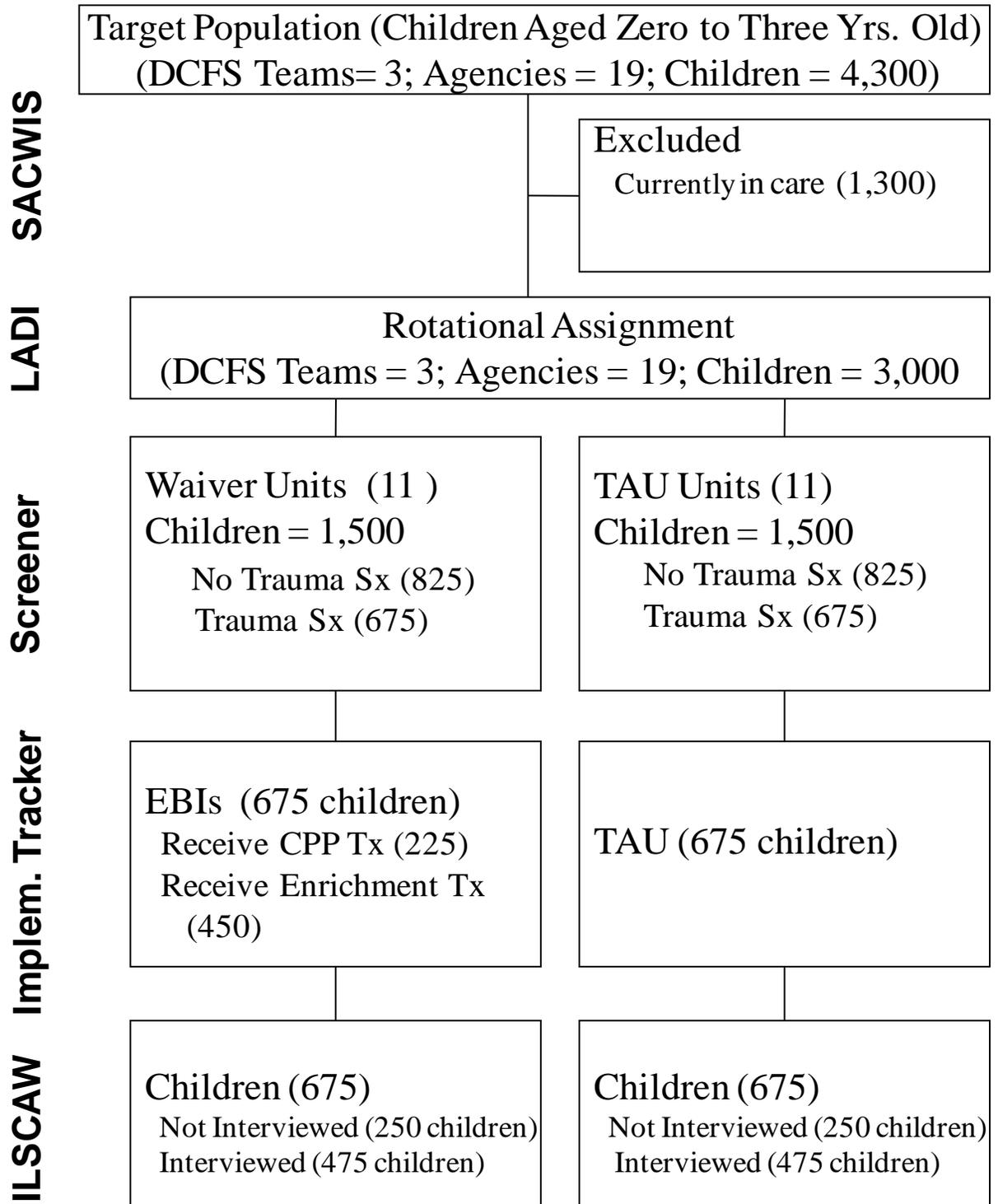
Characteristics	Treatment as Usual		Waiver Services	
Age of parent				
under 20	30	3%	74	3%
20 - 25	170	19%	370	17%
26 - 30	186	20%	398	18%
31 - 35	216	24%	486	22%
36 - 40	147	16%	453	21%
41 - 45	95	10%	243	11%
46 - 50	45	5%	102	5%
51 - 60	19	2%	57	3%
61 - 70 >	4	0%	6	0%
Gender (N=3102)				
Female	586	64%	1395	64%

Characteristics	Treatment as Usual		Waiver Services	
Male	326	36%	795	36%
Race (N=3102)				
African American	701	77%	1630	74%
Asian/Pacific Islander	4	0%	6	0%
Caucasian	126	14%	325	15%
Hispanic: Cuban	1	0%	2	0%
Hispanic: Mexcan	31	3%	107	5%
Hispanic: Puerto Rican	32	4%	78	4%
Native American	1	0%	7	0%
Other	16	2%	35	2%
Living Arrangement (N=3099)				
Alone	139	15%	374	17%
Community Shelter	15	2%	36	2%
Family	535	59%	1255	57%
Friends	128	14%	295	13%
Homeless	54	6%	141	6%
Other	34	4%	73	3%
State Institution	6	1%	14	1%
Unknown	0	0%	0	0%
Primary Drug (N=3094)				
Alcohol	199	22%	517	24%
Cocaine	251	28%	652	30%
Marijuana	223	24%	496	23%
Opioids	226	25%	492	22%
Other	4	0%	10	0%
PCP	7	1%	13	1%
Sedatives/hypnotics	0	0%	2	0%
Stimulants	0	0%	2	0%
Secondary Drug (N=3102)				
Missing	67	7%	151	7%
None	210	23%	581	27%
Alcohol	247	27%	585	27%
Cocaine	200	22%	466	21%
Marijuana	155	17%	323	15%
Opioids	27	3%	62	3%
Other	0	0%	2	0%
PCP	2	0%	7	0%
Sedatives	3	0%	4	0%
Stimulants	1	0%	9	0%

Assigning subjects to treatment and control groups through a quasi-random process such as rotational assignment is increasingly accepted as practical alternative to a fully randomized design for answering whether or not any observed changes in children and families can be attributed to the activities conducted under the demonstration, and if such outcomes are different from those that would have been achieved under “business as usual” conditions (Doyle, in press). Like random assignment, rotational assignment offers a neat solution to what Holland (1986) has called the fundamental problem of causal inference. Understanding this solution is helped by imagining parallel worlds in which the same family receives an experimental treatment in one world and the business-as-usual or control treatment in the other world. The difference in potential outcomes under the two treatment conditions, if it could be observed, would provide a precise estimate of the causal effect of the intervention on the individual family. Because such parallel-world experiments are impossible, researchers attempt to approximate such experiments at the macro level by assigning families according to some protocol that divorces the selection of treatment from what is particular about an individual case. In this way, an average group difference in outcomes can be observed that approximates the average effect of the individual causal effects that cannot be observed. Even though the causal effect of the intervention on any individual family cannot be known, the average differences in outcomes between control families and the treatment families exposed to the waiver services can be confidently attributed to the effects of the intervention rather than to any preexisting differences at baseline (selection), changes that would have occurred in any event (maturation), happenings that unfold over time (history), or differences in how the measurements are made (instrumentation).

In order to minimize the “cross-over” of cases from control to treatment conditions, the proposed waiver project will adhere to the same convention followed in the AODA waiver of first randomly assigning teams and agencies to waiver services and BAU arms. This reduces that likelihood of violating the “stable-unit-treatment-values” assumption (SUTVA) (Rubin, 1978, 1980) that is required for valid causal inference. The attribution of a causal effect to a specific intervention rests on the assumption that the outcome depends only on the treatment to which a child or family is assigned and not on the treatments of others around him, including the comparison treatment. Spillovers from the treatment group are more likely to occur when control and experimental cases share the same environment. For example, many trauma-informed interventions take as their goal the transformation of every part of the organization,

Figure 9—Allocation and Data Collection Plans



management, and service delivery system to include a basic understanding of how trauma affects the life of the child and family seeking services. Therefore, caseworkers assigned to a trauma-informed training program to improve their engagement with families might interact with other workers in their agency who were not assigned to the training program and influence the engagement skills of these control workers. The assignment of teams and agencies helps to insulate workers from these spillover effects. The assumption of no interference across teams and agencies is a more plausible SUTVA assumption than no interference across workers within an agency

Figure 9 illustrates the proposed assignment and data collection plans for the evaluation. Illinois SACWIS data show that as of June 2012 there were approximately 1,300 children aged zero to three years old who were being served by DCFS teams and private agencies in Cook County, Illinois. Based on the average size of entry cohorts that were placed in Cook County during Federal Fiscal Years 2007-2010, it can be projected that another 3,000 children aged zero to three in Cook County will be placed into foster care during the five-year demonstration period.

Approximately 150 of the children currently in care have been in DCFS custody for three or more years. Another 650 have been in care for a year or longer. These children and the remaining 500 children currently in care will be excluded from the demonstration. Rotational assignment is expected to evenly distribute the remaining 3,000 children into waiver teams and agencies (1,500) and TAU teams and agencies (1,500) that have been randomly assigned to the two groups prior to implementation.

Following the implementation of waiver authority, children assigned to both waiver and TAU groups will be screened for trauma and other functional impairments. Based on prior experiences in Illinois, it can be anticipated that 45% of the screened children will exhibit moderate to high trauma symptoms and other mental health problems. Applying this percentage to the 3,000 screened children yields approximately 1,340 children who could potentially benefit from one or more of the trauma-informed EBIs offered under the waiver demonstration-half of whom will be in the waiver group (675) and the other half in the TAU group (675)

It is projected that approximately one-third of the 675 children assigned to the waiver demonstration group will receive the CPP intervention (225) and the remainder will receive one or both of the enrichment programs of Nurturing Parents or Circle of Security (450). In order to draw statistically valid conclusion about the impact of the EBIs on child well-being outcomes, it is estimated that all of the children both waiver services and TAU groups would need to be sampled into ILSCAW in order to obtain completed responses for a total of 950 children (see Power Analysis below). This survey completion rate of 70% should yield a sample size that is sufficient to detect a 10 percentage point improvement in permanency rates and a 20% of a standard deviation improvement on several of the well-being measures discussed below.

Implementation (Process) Evaluation

The randomization of the 3 DCFS teams and 19 private agencies to the waiver and TAU groups will enable the independent evaluator to rigorously assess the impact of the State's active dissemination process in assisting waiver demonstration units to install, implement, and sustain one or more of the EBIs to improve permanency and child well-being outcomes. The independent evaluator will track the installation of policies and procedures, the organizational readiness of local districts to participate in the demonstration, the administration of screening tools, the fidelity of EBI implementation to the models as intended by the developers, and the types and volumes of the service outputs delivered to the target populations. These components of the evaluation are illustrated in the logic model presented in Figure 6.

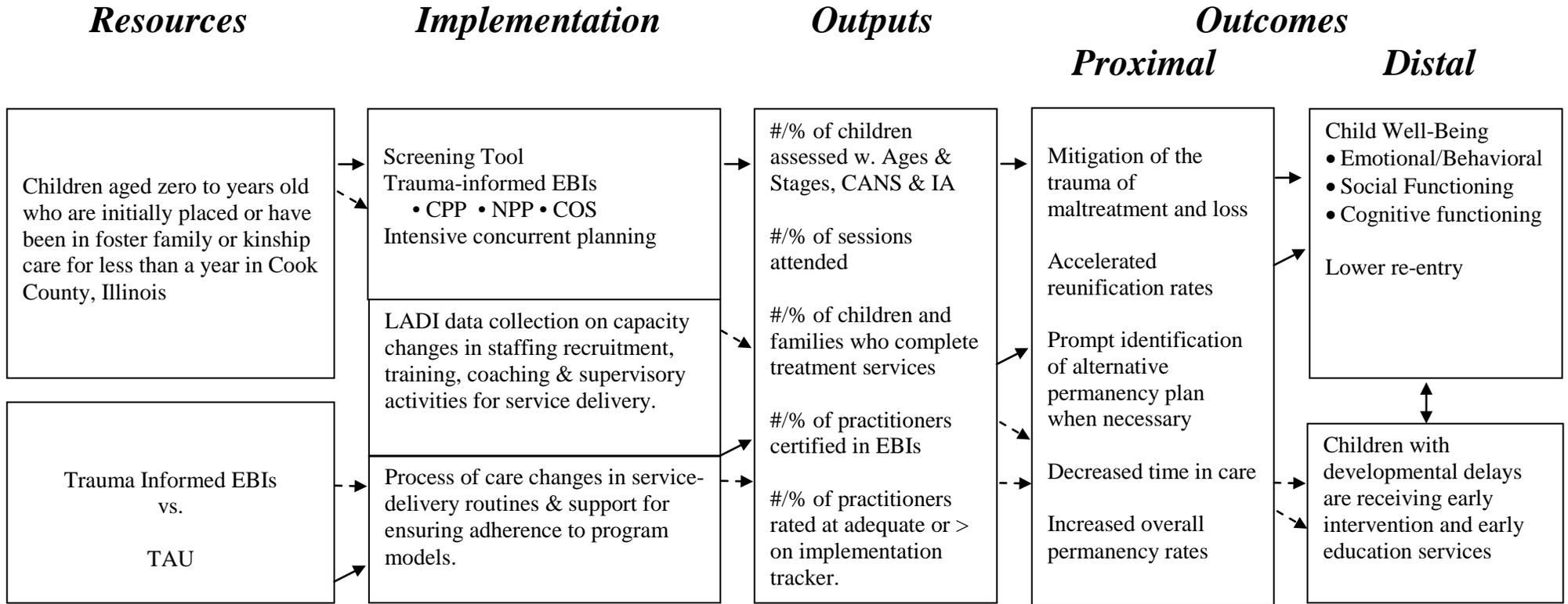
The process evaluation will involve baseline data collection using the Local Agency Director Interview (LADI) to gather detailed information on the local unit's characteristics, staffing, policies, caseload and populations served, and services provided to families. The LADI is a paper-and-pencil interview that will be administered by the independent evaluator to a person designated by the agency to complete the interview – typically (but not always) the team supervisor or private agency director. The interview will focus on many aspects of the organization, including:

- General agency characteristics (e.g., structure, staffing)
- Service availability and delivery to clients
- Current agency caseload and composition (e.g., types of out of home placements)
- Resources for investigations and risk assessments
- Staff training and education
- Collaboration and purchase of service contracts with private agencies and other service providers
- Local district policies guiding child welfare practice

The process evaluation will compare the LADI responses from the local districts assigned to both the waiver demonstration and TAU groups to assess the extent to which randomization succeeded in achieving statistical equivalence of the two groups of local units on these characteristics. It will also compare the two groups at baseline and at initial implementation of the EBIs to assess the impact of the State's active dissemination process on organizational culture and climate, administrators' attitudes toward evidence-based practices, and their readiness to implement the EBIs. Finally the evaluation will contrast the different methods of service delivery in the two groups with respect to efficiency, economy and other appropriate measures of program management. This tracking of service delivery methods will be especially important for the outcome evaluation in order to understand the extent to which the demonstration has materially altered the types and volumes of the service outputs delivered to the target populations in the two groups.

The volume of services delivered will be measured both in terms of the numbers of children reached and the degree of practitioners' adherence (fidelity) to the best practice model of service delivery as intended by the developers. To assess the fidelity of service delivery, the evaluation will use the Implementation Tracker (IT) that was developed by the National Implementation Research Network (NIRN). The IT is a

Fig. 10 – ZERO TO THREE WAIVER DEMONSTRATION LOGIC MODEL



External Conditions

Reductions in numbers of Cook County children entering foster care.

Longest median length of stay in the nation (50 states).

ACYF priority to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse or neglect.

Theory of Change

Traumatic events that led to out-of-home placement and the experience of removal can hinder children’s development into healthy, caring, and productive adults and keep them from reaching their full potential.

If providers can provide immediate access to EBIs to alleviate the distress experienced by children, they will be better supported to recover from adverse childhood experiences.

If caregivers of children exposed to adverse childhood events were specifically equipped with knowledge and strategies to manage traumatic reactions, the opportunity to intervene in a supportive, therapeutic relationship would add an essential element to achieving permanency and improving the well being of children.

End-Values

Child and family well-being

Family autonomy

Readiness for school

Cost-effective policy making

6-point scale that rates each allocated service-delivery position for implementation capacity and readiness. It ranges from 0 (vacant position) to 5 (meets performance assessment criteria consistently over a period of time). Scores are expected to rise from 2 (trained practitioner who begins serving clients) during initial implementation to 4 (meets performance criteria at time of assessment) or higher during the transition to full implementation. In general, the higher the aggregate score, also known as the Implementation Quotient (IQ), the greater is the integrity of the implementation and the greater is the chance that summative evaluation will show the intervention to be effective if it is truly valid.

Regardless of treatment, however, all 1,350 children randomly assigned to the EBIs and TAU groups will be eligible for sampling into NSCAW. This will allow for an intent-to-treat (ITT) analysis to be conducted, which preserves statistical equivalence between the intervention and comparison groups and enables internally valid conclusions to be drawn about the impact of assignment to the EBIs on child well-being and permanency outcomes. Further analysis will be done to estimate the local average treatment effect (LATE) on the sub-sample of children and parents who complete a full course of treatment.

During the conduct of the demonstration, the process evaluation should provide early feedback as to whether or not the demonstration has proceeded as intended, what barriers have been encountered and what changes are needed to allow for successful implementation. At the conclusion of the project, the process evaluation should help answer questions about why the intended outcomes were or were not achieved

Child Well-Being and Permanency (Outcomes) Evaluation

The planned outcome evaluations include a series of testable hypotheses concerning the changes in child, family and system outcomes that the demonstration is intended to achieve. As described above, the major data source of primary data on changes in child well-being and caregiver capacity for Cook County will come from the administration of the Illinois adaptation of NSCAW.

ILSCAW will be administered whether children remain in foster care or have been discharged to permanent homes or otherwise exited the child welfare system. This will enable the independent evaluator to assess the well-being outcomes of all of children that are sampled for participation in ILSCAW. Including all children in the ILSCAW ensures that the evaluation includes high-quality measurement of well-being outcomes for all children and families served under the waiver, including those returned to parental custody or otherwise discharged from foster care.

Power Analyses

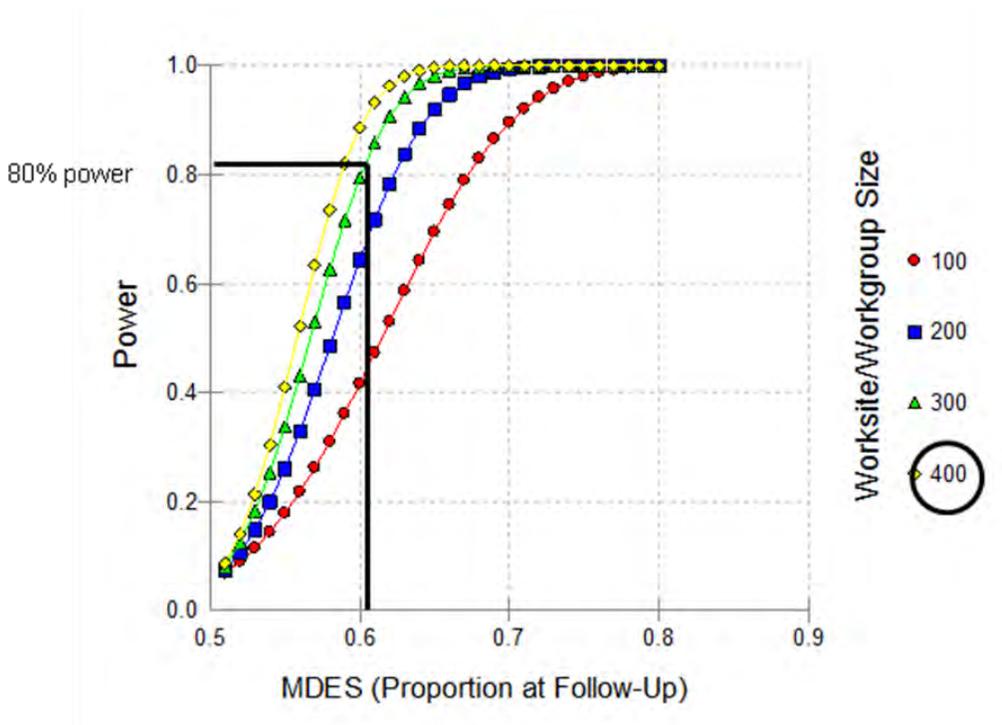
RTI statisticians ran a series of power analyses to determine optimal sample sizes under a variety of assumptions for detecting effect sizes of differing magnitude. Because the effect sizes associated with binary outcomes, such as reunification rates within 2 years of removal, are easier

to visualize than continuous outcomes, such as improvements in depression scales, the following discussion begins with the sample size requirements for detecting a practically important improvement in reunification rates.

An effect size refers to the difference between the desired outcome for those receiving the intervention compared those who didn't received the intervention. A rule of thumb for detecting a small effect size for binary outcomes is that the ratio of the odds of the outcome in the treatment group should be approximately 1.5 times the odds of the outcome in the control group. As shown in Table 1 above, 17 percent of children placed into foster care prior to age four are reunified in less than two years in Cook County. This corresponds to an odds of 0.20 : 1. Boosting these odds by 1.5 times the baseline rate corresponds to increasing the reunification rate to 23 percent within 2 years (= odds/odds+1).

Figure 11 illustrates the power calculations for Cook County with 100, 200, 300, 400 children per treatment arm (200, 400, 600, 800 children in total). The x-axis refers to the proportion in the treatment group at follow-up. Following the yellow line (400 cases), we have 80% power to detect a 10 percentage point increase in reunification rates in two years. The total sample size would need to be in the neighborhood of 800 children (400 in the TAU group and 400 in the waiver group in order to accurately detect a 7 percentage point improvement in the 2-year reunification rate at the risk of a 20 percent chance of a making Type II error of failing to reject the null hypothesis of no improvement when the null hypothesis is really false (i.e. the rate truly improved by 7 percentage points). This calculation also assumes that the risks of making a Type I error of incorrectly rejecting the null hypothesis of no improvement when it is actually true is only 5 times in a hundred trials (i.e. p value of .05). Because the completed sample size is anticipated to be 975, the power should be sufficient to detect a 7 percentage point improvement in permanency rates.

Figure 11 Power Calculations



For a continuous outcome, such as an improvement in well-being as measured on a language development scale, the rule of thumb for a small effect size is a 0.20 change in standard deviation. For continuous outcomes, the power calculations indicate that with (800 children) you can detect an effect size of just under 0.20.

It should be noted that these sample size requirements pertain only to the primary data that will be collected on child well-being outcomes using ILSCAW. Because CANS will be available on many more cases assigned to the waiver demonstration and the other primary and secondary proximal outcomes will come from the administrative data systems of SACWIS, AFCARS and NCANDS, the available sample sizes for measuring changes in these outcomes will be sufficient for detecting smaller effect sizes of the order of 1.3 for binary outcomes and .10 for continuous outcomes.

Table 4 illustrates how the randomization of DCFS teams and private agencies might look. Each unit district is paired-up with its nearest neighboring match based on the each unit's percentage of referral opportunities (PROs) for traditional and home of relative care. PROs are based upon reviews of past performance and current agency size: small high performing agencies can and do receive greater PROs than larger lower performing agencies. These values are calculated and reviewed by the CWAC Infrastructure, which is comprised of DCFS and POS agency executives and managers subcommittee, several times a year. The sum of all agency PROs totals 100% separately within the categories of traditional foster family and home of relative care.

In order to balance the sizes and performance levels of the units assigned to the waiver services and TAU groups, the DCFS Southern Region was purposely paired with the two DCFS Central and North Regions. In addition because of its large PRO, Children’s Home + Aid was purposely placed in the opposite group to DCFS South so that the two sides of the table were evenly balanced on PROs. The remaining matched pairs were randomly ordered by the “flip of the coin.” Even though each individual pair is not equivalently matched on both sets of the measures, the sums of PRO for traditional and kinship foster care of all of the pairs results in a better balance. Based on 2012 PROs, the left-hand side of the table is eligible to receive a little over one-half (52.2%) of traditional foster family cases based on rotational assignment and 48.2% of home of relative cases. Conversely, the right-hand side is eligible to receive 47.8% of traditional foster family cases and 51.8% of home of relative cases, respectively.

Table 4— DCFS Cook Regions and Private Agencies Matched Pairs by PRO

Unit	Trad. Foster Care PRO	Kinship Foster Care PRO	Unit	Trad. Foster Care PRO	Kinship Foster Care PRO
DCFS COOK SOUTH REGN	20.70%	5.00%	DCFS COOK NORTH REGI	7.60%	4.50%
LUTHERAN SOCIAL SERV	6.80%	11.20%	DCFS COOK CENTRAL RE	0.90%	4.00%
LAKESIDE COMMUNITY C	6.10%	5.30%	CHILDRENS HOME & AID	14.30%	26.00%
CHILDLINK	3.90%	3.00%	UHLICH CHILDREN'S AD	8.20%	3.60%
LUTHERAN CHILD & FAM	3.80%	3.60%	ASSOCIATION HOUSE OF	6.60%	1.60%
CHILDSERV	0.40%	8.20%	SHELTER, INC.	3.70%	0.00%
UNITY PARENTING AND	3.80%	0.50%	ONE HOPE UNITED	2.80%	1.40%
LYDIA HOME ASSOCIATI	2.80%	3.90%	ABJ COMMUNITY SERVIC	0.90%	2.60%
VOLUNTEERS OF AMERIC	2.40%	2.20%	AUNT MARTHAS YOUTH S	1.70%	1.30%
LAWRENCE HALL YOUTH	1.30%	1.20%	CENTERS FOR NEW HORI	0.70%	3.50%
ADA S MCKINLEY COMM	0.20%	4.10%	UNIVERSAL FAMILY CON	0.50%	3.30%
DCFS COOK SOUTH REGN	20.70%	5.00%	DCFS COOK NORTH REGI	7.60%	4.50%
LUTHERAN SOCIAL SERV	6.80%	11.20%	DCFS COOK CENTRAL RE	0.90%	4.00%
LAKESIDE COMMUNITY C	6.10%	5.30%	CHILDRENS HOME & AID	14.30%	26.00%
CHILDLINK	3.90%	3.00%	UHLICH CHILDREN'S AD	8.20%	3.60%
LUTHERAN CHILD & FAM	3.80%	3.60%	ASSOCIATION HOUSE OF	6.60%	1.60%
CHILDSERV	0.40%	8.20%	SHELTER, INC.	3.70%	0.00%
UNITY PARENTING AND	3.80%	0.50%	ONE HOPE UNITED	2.80%	1.40%
LYDIA HOME ASSOCIATI	2.80%	3.90%	ABJ COMMUNITY SERVIC	0.90%	2.60%
VOLUNTEERS OF AMERIC	2.40%	2.20%	AUNT MARTHAS YOUTH S	1.70%	1.30%
LAWRENCE HALL YOUTH	1.30%	1.20%	CENTERS FOR NEW HORI	0.70%	3.50%
ADA S MCKINLEY COMM	0.20%	4.10%	UNIVERSAL FAMILY CON	0.50%	3.30%
TOTAL	52.2%	48.2%	TOTAL	47.8%	51.8%

Key Hypotheses

The following hypotheses will be tested by comparing the outcomes for the EBI treatment and control groups within the research sites:

- (1) *Children in the waiver demonstration group will exhibit positive improvements in early childhood development, behavior problems, and adaptive behavior compared to children in the comparison group.*

The null hypothesis (H_0) can be stated as follows: The proportions of children with clinically significant scores in the waiver demonstration group are equal to the proportions in the comparison group. The expectation is that this hypothesis will be rejected.

$$W_d = W_c$$

This hypothesis will be tested for the entire ILSCAW sample.

- (2) *A higher proportion of children in the waiver demonstration group will be reunified within 2 years from removal compared to children in the comparison group.*

H_0 : The proportion of children reunified from the waiver demonstration group is equal to the proportion from the comparison group.

$$R_d = R_c$$

This hypothesis will be tested for the entire administrative data sample.

- (4) *Children in the waiver demonstration group will spend fewer average days in foster care from placement to permanency than children in the comparison group.*

H_0 : The average days of foster care from placement to reunification, adoption and guardianship in the waiver demonstration group is equal to the average days of foster care in the comparison group.

$$LOS_d = LOS_c$$

This hypothesis will be tested for the entire administrative data sample.

- (6) *More children with developmental delays in the waiver demonstration group will receive appropriate early intervention and early education services than similar children in the comparison group.*

H_0 : Scores based on reports from caseworkers and caregivers interviewed in the ILSCAW in the waiver demonstration group is equal to the scores based on reports in the comparison group.

$$D_d = D_c$$

This hypothesis will be tested for the entire ILSCAW sample in Cook County.

- (7) *Children reunified or placed permanently in an adoptive or guardianship home in the waiver demonstration group will re-enter foster care at a lower rate than children in the comparison group.*

Ho: The re-entry rate of children in the waiver demonstration group is equal to the re-entry rate in the comparison group.

$$Re_d = Re_c$$

This hypothesis will be tested for the entire administrative data sample.

9. Cost Analysis

Both the waiver evaluation will also incorporate a cost analysis of the costs of waiver services received by children and families by service type, funding source, service provider and costs per child and family. It will involve a comparative analysis of the costs of services received by children and families assigned to the waiver services group versus the costs of services for those that receive services as usual. The cost analysis will include an examination of the use of key funding sources, including Federal sources such as titles IV-A, IV-B, IV-E and XIX of the Social Security Act, as well as State and local funds. To the extent possible, the cost analysis will also include a cost-effectiveness component that estimates the costs incurred for each successful outcome achieved through the demonstration. Using these methods, the cost analysis will provide a frame of reference for understanding the relationship between demonstration costs and results.

Costs and Savings Estimates

Some of the costs associated with the support of the EBIs will be funded from the projected saving generated by reducing the numbers of children in foster care and shortening the length of stay of children in the treatment group. Figure 12 shows the IV-E foster care funds and caseload history over the past 25 years. It shows overall declines in the numbers of IV-E eligible cases and associated loss of IV-E reimbursable expenditures.

Figure 12

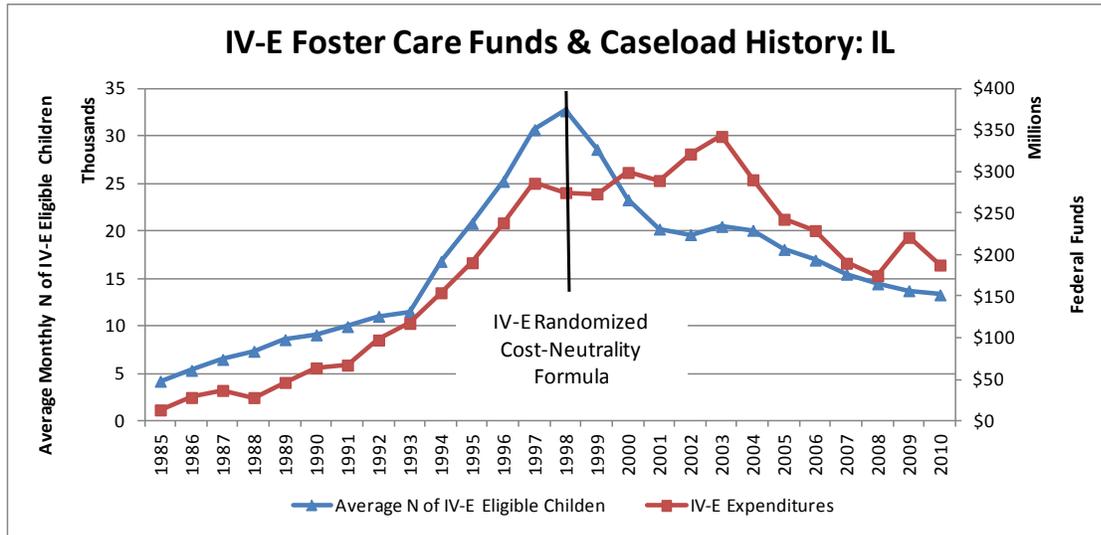


Table 5 shows the number of children, total length of stay and average length of stay for children who entered foster care at ages zero to three during the past five federal fiscal years. These figures will be used in the next section to provide an estimate of the costs and savings of the project and describe the basis for projecting that the project would be cost-neutral overall.

Table 5—Unduplicated Counts of Children Placed into Foster Care at Age Zero to Three Years Old and Lengths of Stay: FFY2006-2011, Cook County, Illinois

Site	N of Children (unduplicated)	Total Length of Stay (days)	Average Length of Stay (months)
Cook County	3,305	96,880	29.3

10. Cost Neutrality Limits

The methodology for assessing cost neutrality in the demonstration will be linked to the evaluation design employed to measure the outcomes of the project. The cost-neutrality limit (CNL) calculation described below will be performed separately for maintenance payments, training and administrative costs on a quarterly basis:

- 1) Calculate the average title IV-E cost per control group case by dividing the cumulative title IV-E costs for TAU cases by the number of ever-assigned TAU cases to the demonstration.

- 2) Multiply the average derived in step (1) above by the number of ever-assigned treatment cases assigned to the waiver services group. The result is the cumulative “counterfactual” costs for the waiver services cases.
- 3) The cumulative demonstration cost will be equal to the cumulative allowable title IV-E maintenance payments, training and administrative cost for the BAU cases plus the cumulative cost for the waiver services cases as calculated above.

The federal title IV-E payments to Illinois for this demonstration (covering maintenance payments and related training and administrative costs) will be made quarterly and will be determined by subtracting the federal IV-E payments made for the demonstration prior to the current quarter from the current cumulative demonstration cost as calculated above.

State estimates for the purposes of receiving quarterly grants for this demonstration will be based on the estimated title IV-E maintenance payments, training and administrative costs the State expects to receive under the cost-neutrality calculation above and such estimates will be subject to review by the HHS. All waiver services cases will be considered part of the demonstration for the entire duration of the demonstration and will not be included in non-demonstration title IV-E claims. Costs claimed for the demonstration project will be identified as distinct charges on the HHS quarterly claim form. All other title IV-E claims that are not related to this demonstration will continue to be filed in accordance with current quarterly claiming requirements for payments for allowable costs.

The average monthly title IV -E foster care administrative cost gross claim for the last 4 quarters is \$1,337 per child in receipt of title IV-E foster care maintenance assistance payments. The average monthly maintenance assistance payment gross claim per child for these same children is \$1,338. Using the figures from Table 5 above, it is projected that the waiver demonstration will reduce the average length of stay in waiver demonstration districts by 10 percent or 2.9 additional months relative to the average length of stay in the TAU districts.

The IV-E penetration rate in Illinois for Cook County is 40%. Applying this rate to the 1,500 children projected to be assigned to the waiver districts over the full five years of the demonstration (see Figure 9 above), a reduction of 2.9 months in the average length of stay should generate in the neighborhood of \$2.3 million in gross administrative claims ($1500 * .40 * \$1,337 * 2.9$) or \$1.1 million in IV-E federal reimbursements. If one-half of the reduction in length of stays results from reunifications, an additional \$1.2 million ($1500 * .40 * \$1,338 * 2.9 * .5$) will be added to the cumulative IV-E savings for a total of \$2.3 million in projected federal savings that the State could reinvest in supporting the costs of the waiver demonstration.

11. SIMILAR PROJECTS

Illinois does not currently have a similar project underway that is supported by State, tribal or private foundation funds that would be affected by the proposed demonstration. Illinois is coordinating the proposed Title IV-E Waiver application with five demonstration projects currently underway in the state. The Illinois Title IV-E Waiver application is carefully constructed to complement these other initiatives and enhance the overall effectiveness of the state's child welfare system. We anticipate that a small number of study participants may be eligible to be enrolled in the AODA waiver as well as the current waiver. For this select group of children, they will be identified and for the purposes of claiming, will be assigned to only one of the projects. Specific demonstration projects include:

AODA – Title IV-E Waiver

The project seeks to improve child welfare outcomes by providing enhanced alcohol and other drug abuse (AODA) treatment services to substance affected families served in the Illinois child welfare system. Project goals include:

- Increasing the number of substance-affected children in foster care that are safely returned home along with decreasing the length of time it takes for safe reunification.
- Increase the number of cases and the speed at which AODA impacted cases are moved to a permanency decision.
- Increase the number of AODA impacted individuals who remain in treatment for more than a 90 day time period.
- Reduce the number of subsequent oral reports of child abuse and neglect.

Permanency Innovations Initiative

The project seeks to improve permanency outcomes for children at distinctive risk of long term foster care in Illinois' child welfare system. Specifically the project tests an evidenced-based trauma intervention on the achievement of permanency for children aged 11 to 16 who have been in care two years and have trauma-related mental health symptoms and / or placement instability.

Recruitment and Kin Connections

The project seeks to improve permanency outcomes by applying Family Finding, an evidenced-informed intensive family search program. Specifically the project tests the application of Family Finding for cases of children ages 6 to 13 upon entry into care in Cook County. The project is initially limited to Cook County, with a small scale pilot planned for Champaign County, Illinois in year three of the five year demonstration project.

Adult Connections

The project is a demonstration grant awarded to a consortium of four child welfare agencies and seeks to improve outcomes for youth ages 16 and older who are preparing for emancipation from foster care. This project tests a combination of interventions, including mentoring, coaching and job search and placement activities.

Differential Response

Illinois is concluding a demonstration project testing a Differential Response program for child protection cases. The project tests a voluntary service model utilizing the combination of a safety assessment conducted by public agency personnel and the provision of short-term case work services provided by community agencies.

12. INVESTMENTS MADE IN PROPOSED SERVICES

Child Parent Psychotherapy is the service intervention that requires the most extensive training approach and the State of Illinois is fortunate to have internal capacity to provide training as well as agencies within the geography of the target population to provide the interventions. The Irving B. Harris Foundation, Child Trauma Research Partnership, and the Erikson Institute has sponsored the Illinois Child-parent Psychotherapy Learning Collaborative which provides high quality mental health and trauma-focused training to clinicians and mental health providers working with children age birth to 5 in a variety of settings. The Learning Collaborative is a training model that helps agencies implement Child-parent Psychotherapy and other effective child-parent therapeutic practices into their settings. Learning Collaboratives are considered one of the most highly effective strategies for deepening the mental health field's ability to provide therapeutic services to families with children ages birth to 5. Faculty includes local experts from Erikson and Jewish Child and Family Services with support from nationally recognized child trauma expert Patricia Van Horn, J.D., Ph.D. This initiative is currently funded by the Irving Harris Foundation. Currently 14 agencies statewide have been trained in the model with the predominate representation of agencies being in the Cook County region which will serve the target population.

13. ASSURANCES

The Illinois Department of Children and Family Services assures that it will continue to provide an accounting of that same spending for each year of the approved demonstration project.

14. STATUTORY AND REGULATORY REQUIREMENTS

Illinois Department of Children and Family Services request waivers of the following provisions of the Social Security Act and Program Regulations to operate a child welfare demonstration project. The first in the list of four is most needed while the remaining three items are included and possibly needed based on review of other states' demonstration waiver requests:

- *Section 474(a)(3)(E) and 45 CFR 1356.60(c)(3) – Expanded Services: To allow the State to make payments for services that will be provided that are not normally covered under Part E of title IV of the Act; and to allow the State to use title IV-E funds for these costs and services as described in the Terms and Conditions, Section 2.0.*
- *Section 472 (a) – Expanded Eligibility: To allow the State to expend title IV-E funds for children and families who are not normally eligible under Part E of title IV of the Act as described in the Terms and Conditions.*
- *Section 474(a) (1) – regarding the calculation of payments to States for foster care maintenance expenses.*
- *Section 474(a)(3)(A) and (B) – Regarding the calculation of payments to States for training expenses as they pertain to foster care.*

15. EFFECT OF DEMONSTRATION ON AUTOMATED CHILD WELFARE SYSTEM

The demonstration will affect the following Department information systems:

- a. Statewide Automated Child Welfare Information System (SACWIS); and
- b. Child and Youth Centered Information System (CYCIS)

The Department will add data fields to track children in SACWIS and CYCIS who are randomly assigned to either the Demonstration Control or Experimental Group. The data fields will facilitate the claiming cost neutrality calculations, for both administration and maintenance.

The demonstration will also have an effect on the Department Time and Effort Reporting System (TERS) used for claiming cost allocations for training required to implement the demonstration. The TERS system records training staff time allocated to train employees under the Demonstration.

The demonstration will also have an effect on the Department on-line training the Virtual Training Center, which is used to claiming cost allocations for training events required to implement the demonstration.

16. CAPACITY TO USE THE WAIVER DEMONSTRATION AUTHORITY

The Illinois Department of Children and Family Services has received and successfully implemented three previous Title IV-E Waivers: for Subsidized Guardianship, Alcohol and Other Drugs, and for Training. The IDCFS will make all necessary and indicated changes in policy and procedure, both programmatic and fiscal, which will enable us to achieve the goals of the project.

17. LETTERS OF AGREEMENT- See attached letters in Appendix D

18. PROPOSED PROJECT'S RESPONSE TO FINDINGS OF THE CFSR PIP

This proposed project supports current strategies embedded in the Illinois PIP that were developed in response to 2009 CFSR findings. Among the areas that Illinois was found to not be in substantial conformity with included: the appropriate and timely establishment of permanency goals, concurrent planning that advances timely permanencies, the facilitation of consistent and high quality parent/child visits, and family engagement in case planning efforts. Strategies developed and in the process of being implemented that address these identified issues include the training of all casework and supervisory staff in core practice areas such as; Family Centered Practice in a Trauma-Informed System, Family Connectedness and Visitation, and Stability for Children. The Supervisory Training for Enhanced Practice (STEP) program was also developed to help support and reinforce supervisory efforts around these and other key case practice areas. Other PIP strategies in the process of being implemented that relate to this proposed project include the strengthening of systems that are intended to drive the achievement of timely permanencies, and includes more clearly articulating the role of Child and Family Team

Meetings, Administrative Case Reviews and Permanency Hearings in the overall permanency planning process.

19. DESCRIPTION OF COURT ORDERS

The primary consent decrees affecting the Department are as follows:

BH v. McDonald mandates a wide series of reforms regarding standards of care and specific provisions in the placement of children, permanency planning, mental health, education, health care, protective services, initial assessments of children, adequate food/shelter/clothing, caseload ratios, information systems, licensing, training, and quality assurance.

Aristotle P. v. McDonald requires that DCFS make a diligent search to place siblings together whenever possible. When such placement is not possible, it requires that regular visits and frequent contact between the siblings be facilitated.

Bates v. McDonald requires that DCFS facilitate weekly visits between parents and children whose permanency goal is to return home. It also establishes timelines and requirement to provide related statistical information.

Norman v. Suter bars DCFS from removing children from their parents solely because of poverty or homelessness. It bars the agency from refusing to return children home for the same reasons. The consent decree also requires DCFS to provide housing, temporary shelter, cash assistance, food, clothing, childcare, emergency caretakers, and advocacy with public and community agencies.

Hill v. Erickson requires that DCFS provide adequate placements and other services for agency wards who are pregnant or parenting.

Burgos v. Suter mandates that DCFS provide appropriate social services in Spanish to Spanish-speaking clients. It also requires DCFS to hire bilingual employees in certain areas and positions and to place Spanish-speaking children of Spanish-speaking clients with Spanish-speaking foster parents.

David B. v. Pavkovic required certain Illinois state agencies to provide specialized services to delinquent youth. Although this decree was vacated in 1998, services still have to be provided by DCFS to delinquents under 13 years of age because of Public Act 89-21.

In Re Lee/Wesley requires the DCFS Guardian to notify the Guardianship and Advocacy Commission within 24 hours of admission of a Cook County ward to a mental health or drug dependency facility. It also requires that DCFS not hold wards in psychiatric facilities longer than medically necessary.

Katie I. et al v. Ted Kimbrough, the Board of Education, et al requires DCFS provide the Board of Education with notification and appropriate identification of wards in shelter

care. It also requires DCFS to enable educational enrollment and to verify the immunization records of wards in shelter care.

The proposed demonstration will not have an effect on the court orders listed above, with the exception of B.H. v McDonald in that it improves upon the Department's ability to implement standards related to permanency planning, mental health services, parent training, and initial assessments of children.

20. METHODS USED TO OBTAIN PUBLIC INPUT

Public input will be solicited via posting of a notice of intent to submit a demonstration proposal via the following media: the public State of Illinois website; the Taylorville Breeze Courier newspaper; the Child Welfare Advisory Council distribution list; and the Illinois Childhood Trauma Coalition distribution list. Respondents will be directed to provide comments to a central e-mail address within the Department. The notice will further indicate the availability of the full proposal after the July 9th submission date on the DCFS Website. Comments will be taken for 30 days following the posting of the full proposal and will be included in any revisions or responses to the Issue Paper from the ACF.

21. ASSURANCE OF HEALTH COVERAGE

All special needs children who have been adopted through the Department and receiving adoption assistance, are eligible for and covered by Medicaid for their health care.

22. CHILD WELFARE IMPROVEMENT POLICIES IMPLEMENTED OR INTENDING TO IMPLEMENT

The Child Welfare Program Improvement Policies which would be implemented are: A) The establishment of a bill of rights for infants, children and youth in foster care that is widely shared and clearly outlines protections for infants, children and youth, such as assuring frequent visits with parents, siblings and caseworkers, access to attorneys, and participation in age appropriate extracurricular activities, and procedures for ensuring the protections are provided. And G) The development and implementation of a plan to improve the recruitment and retention of high quality foster family homes trained to help assist infants, children, and youth swiftly secure permanent families. Supports for foster families under such a plan may include increasing maintenance payments to more adequately meet the needs of infants, children, and youth in foster care and expanding training, respite care, and other support services for foster parents.

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Appendix A- Tools Currently Used

**CHILD & ADOLECENT NEEDS & STRENGTHS
DENVER II DEVELOPMENTAL SCREENING TEST
AGES and STAGES QUESTIONNAIRE
AGES AND STAGES SOCIAL EMOTIONAL (SE) QUESTIONNAIRE**

CANS Overview

The Child and Adolescent Needs and Strengths (CANS 2.0) is a multi-purpose tool developed for children's services to support:

- Decision-making, including level of care and service planning;
- Quality improvement initiatives;
- And the monitoring of outcomes of services.

The CANS was originally developed as an expansion of the Childhood Severity of Psychiatric Illness (CSPI). The CSPI has been used to assess the appropriate use of high-end, expensive services such as psychiatric hospitals and residential treatment services. The CANS builds on the foundation of the CSPI but expands the assessment to include a broader conceptualization of needs and the addition of an assessment of strengths. It is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality of life (well-being). Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications.

The Domains of Child & Adolescent Needs and Strengths (CANS)

Trauma Experiences

- 1. Sexual Abuse**
- 2. Physical Abuse**
- 3. Emotional Abuse**
- 4. Neglect**
- 5. Medical Trauma**
- 6. Witness to Family Violence**
- 7. Community Violence**
- 8. School Violence**
- 9. Natural or Manmade Disaster**
- 10. War Affected**
- 11. Terrorism Affected**
- 12. Witness/Victim to Criminal Activity**
- 13. Parental Criminal Behavior (Birth parent and legal guardians only)**

Traumatic Stress Symptoms

- 14. Adjustment to Trauma**
- 15. Traumatic Grief/Separation**
- 16. Re-experiencing**
- 17. Avoidance**
- 18. Numbing**
- 19. Dissociation**

Child Strengths

- 20. Family**
- 21. Interpersonal**
- 22. Educational Setting**
- 23. Vocational**
- 24. Coping and Savoring Skills**
- 25. Optimism**
- 26. Talents/Interests**
- 27. Spiritual/Religious**
- 28. Community Life**
- 29. Relationship Permanence**
- 30. Resilience**

Life Domain Functioning

- 31. Family**
- 32. Living Situation**
- 33. Social Functioning**
- 34. Developmental/Intellectual**
- 35. Recreational**
- 36. Legal**
- 37. Medical**
- 38. Physical**
- 39. Sleep**
- 40. Sexual Development**
- 41. School behavior**
- 42. School Achievement**
- 43. School Attendance**

Acculturation

- 44. Language**
- 45. Identity**
- 46. Ritual**
- 47. Cultural Stress**

Behavioral/Emotional Needs

- 48. Psychosis**
- 49. Attention Deficit/Impulse Control**
- 50. Depression**
- 51. Anxiety**
- 52. Oppositional Behavior**
- 53. Conduct**
- 54. Substance Abuse**
- 55. Attachment Difficulties**
- 56. Eating Disturbance**
- 57. Affect Dysregulation**
- 58. Behavioral Regression**
- 59. Somatization**

60. Anger Control

Risk Behaviors

- 61. Suicidal Risk**
- 62. Self mutilation**
- 63. Other Self Harm**
- 64. Dangers to Others**
- 65. Sexual Aggression**
- 66. Runaway**
- 67. Delinquency**
- 68. Judgment**
- 69. Fire-Setting**
- 70. Social Behavior**
- 71. Sexually Reactive Behaviors**

Children 5 years and Younger

- 72. Motor**
- 73. Sensory**
- 74. Communication**
- 75. Failure to Thrive**
- 76. Feeding-Elimination**
- 77. Birth Weight**
- 78. Prenatal Care**
- 79. Substance Exposure**
- 80. Labor & Delivery**
- 81. Parent or Sibling Problems**
- 82. Maternal Availability**
- 83. Curiosity**
- 84. Playfulness**
- 85. Temperament**
- 86. Day Care-Preschool**

Transition to Adulthood

- 87. Independent Living Skills**
- 88. Transportation**
- 89. Parenting Roles**
- 90. Intimate Relationships**
- 91. Medication Compliance**
- 92. Educational Attainment**
- 93. Victimization**
- 94. Job Functioning**

Caregiver Needs and Strengths

- 95. Safety**
- 96. Supervision**
- 97. Neighborhood Safety and Resources**

- 98. Condition of the Home**
- 99. Marital/Partner Violence in the Home**

Knowledge of Parenting & Child Development

- 100. Knowledge of Child's Needs**
- 101. Nutrition Management**
- 102. Discipline**
- 103. Learning Environment**
- 104. Demonstrates Effective Parenting Approaches**

Identification & Use of Concrete Supports in Times of Need

- 105. Involvement with Care**
- 106. Parent/Caregiver's Knowledge of Rights and Responsibilities**
- 107. Financial Status**
- 108. Organization**
- 109. Resources**
- 110. Knowledge of Social Service Options**
- 111. Residential Stability**
- 112. Job Functioning**

Positive Family, Community & Social Connections

- 113. Partner Relations**
- 114. Relations with Extended Family**
- 115. Community Involvement**
- 116. Natural Supports**

Ability to Nurture Social And Emotional Competence of Children

- 117. Parent/Caregiver's Ability to Listen as Parents**
- 118. Parent/Caregiver's Understanding of Impact of own behavior on children**
- 119. Empathy with children**
- 120. Ability to Communicate**

Factors Contributing to Parent/Caregiver Resilience

- 121. Physical Health**
- 122. Mental Health**
- 123. Substance Use**
- 124. Developmental**
- 125. Parent/Caregiver Post-Traumatic Reaction**
- 126. Hygiene and Self-Care**
- 127. Independent Living Skills**
- 128. Recreation**

Commitment to Permanency Plan Goal – Caregivers Only

- 129. Collaboration with other parents/caregivers**
- 130. Caregiver Support for Permanency Goal**
- 131. Inclusion of the child in foster family**

Commitment to Permanency Plan Goal – Parents Only

- 132. Parent participation in visitation**
- 133. Relationship/contact with caseworker**
- 134. Involvement in Children**
- 135. Parent involvement/participation (Shared Parenting)**
- 136. Commitment to Reunification**
- 137. Responsibility in Maltreatment**
- 138. Relationship with Abuser(s)**
- 139. History of Maltreatment with Children**

OVERVIEW OF DEVELOPMENTAL TOOLS

The Early Childhood Project currently conducts developmental screenings of children birth to three in Cook County. The following developmental tools are used during the screening process to identify developmental delays:

- 1. Denver Developmental Screening Test II (Frankenburg, 1990)** - Used to screen children *birth to 3 months of age*. The Denver Developmental Screening Test is one of the oldest and best known brief measures of development (Glascoe et. al, 1992). First published in 1967 and then revised in 1990, the Denver II is a standardized instrument used to identify children at risk for developmental delays. The screening tool is designed for children birth to 6 years old and looks at four different domains of development: Personal-Social, Fine Motor, Adaptive, Gross Motor and Language. At the end of each screening, Pass, Fail or refusal scores are assigned to each item. Item performance is then reinterpreted in relation to the child's age in terms of 'caution' 'delay', 'no opportunity', 'normal' or 'advance performance'. Two or more delays represent an abnormal test score; while one delay or two or more 'cautions' is a questionable score. Abnormal and questionable scores are used as cutoffs in the early childhood program to refer children to Early Intervention for further evaluation. The birth to 3 months section of Denver II takes approximately 10 minutes to administer.
- 2. Ages & Stages Questionnaire, Third Edition (ASQ-3), Squires & Bricker, 2009** - Used to screen young children between the ages of 4 months to 3 years of age. The ASQ-3 is a standardized instrument designed to use for the identification of infants and young children who have developmental delays or disorders to determine the need intervention services. The measure is composed of 21 validated questionnaires that are completed by parents or other primary caregivers of children between the 1 month and 5 1/2 years of age. The ASQ consists of several questionnaires designed for each specific age group. Each questionnaire contains 30 developmental items that are written in simple, straightforward language and assesses five areas of development: Communication, Gross Motor, Fine Motor, Problem Solving, and Personal-Social. The tool takes 10-15 minutes to administer.
- 3. Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) (Squires, Bricker & Twombly, 2003)** – Used to conduct socio-emotional screenings for children between 3 months -3 years of age. The ASQ-SE includes a set of 8 validated questionnaires that focus on social competence and target challenging behaviors of children between to ages of 3 months to 5 ½ years. Each age-specific questionnaire contains 19–33 items. The tool focuses on socio-emotional functioning of young kids in the areas of: self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people (Squires, Bricker, & Twombly, 2002).

Appendix B- NSCAW Child Instrument

Overview of NSCAW Child Instrument

Module	CAPI Section	Construct	Measure	Author / Publisher	Child Age	Waves	Information Gathered
Child Household	CH	Child characteristics	Project-developed questions	N/A	All ¹	1, 2	Child's demographic information, and height, weight, and head circumference for children < 4
Cognitive Status	BD	Developmental / Cognitive status	Battelle Developmental Inventory (BDI) & Screening Test, Second Edition: Cognitive Skills	Newborg (2005)	<4	1, 2	Cognitive skills; administered to age 4 and older if K-BIT score = 0
Communication	CO	Communication skills	Preschool Language Scales-3 (PLS-3)	Zimmerman, Steiner, & Pond, The Psychological Corporation (1992)	<6	1, 2	Standardized assessment tool comprised of two scales: expressive communication and auditory comprehension; total language score computed

Overview of NSCAW Current Caregiver Instrument Module

Module	CAPI Section	Construct	Measure	Author / Publisher	Perm/ Non-Perm0	Waves	Information Gathered
Questionnaire Introduction	QP	N/A	Project-developed introduction script	N/A	P/NP	1, 2	N/A
Up-Front Verification Module	NP	N/A	Project-developed verification questions to drive instrument wording/flow	N/A	P/NP	1, 2	Verification of respondent contact information, relationship to child, out-of-home placement status, and legal guardianship
Household Roster	HH	Family composition and demographics	Project-developed questions	N/A	P/NP	1, 2	Family composition and demographic information necessary for classification and description of subjects.
Group Home Household Roster	GH	Group home classification and composition	Project-developed questions	N/A	P/NP	1, 2	Composition of group home facility, including number of children in home and relationship to child, and demographics of group home caregiver

¹Child household information was provided by caregivers for very young children.

Note: “YA” and “EY” stand for Young Adults and Emancipated Youth, respectively. At the follow-up wave, a subset of the sampled children will have “aged up” to adulthood (age 18 and older). At both waves, we expect to encounter youth who are legally emancipated from their parents.

Overview of NSCAW Current Caregiver Instrument Module

Module	CAPI Section	Construct	Measure	Author / Publisher	Perm/ Non-Perm0	Waves	Information Gathered
Child Health & Services	HS for permanent caregivers CS for non-permanent caregivers	Health and disabilities Services received by child	Child and Adolescent Services Assessment (CASA); Child Health Questionnaire from National Evaluation of Family Support Programs; Brief Global Health Inventory; and project developed questions on services Questionnaire for Identifying Children with Chronic Conditions – Revised (QulCCC-R) SLAITS The National Survey of Children with Special Health Care Needs II Services Assessment for Children and Adolescents(SACA) The National Early Intervention Longitudinal Study (NEILS) National Comorbidity Survey (NCS) National Health Interview Survey (NHIS) National Survey of America's Families (NSAF)	Burns, Angold, Magruder-Habib, Costello, & Patrick (1996) Stein, Bauman, and Silver (2001) Blumberg, Olson, et al. (2003) Stiffman et al (2000) Office of Special Education Programs in the US Department of Education (1998) Kessler (2000) National Center for Health Statistics within the CDC (1997) The Urban Institute (1997)	P/NP	1, 2	History of health, injury, and disability status of child; services received by the child
Adaptive Behavior	VI ages 0-2 VN ages 3-5 VE ages 6-12 VL ages 13-18	Adaptive Skills	Vineland Adaptive Behavior Scale (VABS) Screener - Daily Living Skills and Socialization Skills	Sparrow, Carter, & Cicchetti (1993)	P/NP	1, 2	Regular behaviors the child exhibits
Youth Behavior Checklist	TC for Children 1.5 - 5 BC for Children 6-18	Behavior problems	Child Behavior Checklist	Achenbach, University of Vermont-Burlington (2000)	P/NP	1, 2	Degree to which child exhibits different types of behaviors; The Behavior Problems Index (BPI) was administered at Wave 2 in place of the full checklist.
Income	IN	Income	Project-developed questions	N/A	P/NP	1, 2	Financial resources available to the child's household
Services Received by Caregivers	SR for post-baseline waves	Services received by caregiver	Project-developed questions	N/A	P	1, 2	Frequency and duration that services were received
Physical Health - SF-12	PH	Physical Health	Short-Form Health Survey (SF-12)	Ware, Kosinski & Keller (1996)	P/NP	1, 2	Caregiver's physical health status
Services Received by Foster Caregivers	FC	Services received by foster caregivers	Project-developed questions	N/A	NP	1, 2	Frequency and duration that services were received

Overview of NSCAW Current Caregiver Instrument Module

Module	CAPI Section	Construct	Measure	Author / Publisher	Perm/ Non-Perm ⁰	Waves	Information Gathered
Adoption Module for Foster Parents	AP	Adoption possibilities for child	Project-developed questions Adapted items from This Is My Baby Interview	N/A Bates and Dozier (1998)	NP	2	Adoption possibilities for child, including factors that encouraged or discouraged adoption decision
Depression	DP	Mental Health - Depression	Composite International Diagnostic Interview Short-Form (CIDI-SF) - module for depression Modified from National Comorbidity Survey (NCS)	Kessler, Andrews, Mroczek, Ustun, & Wittchen (1998) Kessler (2000)	P	1, 2	Caregiver experiences that indicate symptoms of depression
Alcohol Dependence (ACASI)	AD	Mental Health - Substance Abuse	The Alcohol Use Disorders Identification Test (AUDIT)	Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders, and Maristela G. Monteiro	P	1, 2	Caregiver experiences that indicate symptoms of alcohol dependence
Drug Dependence (ACASI)	DD	Mental Health - Substance Abuse	Drug Abuse Screening Test (DAST)	Skinner (1982)	P	1, 2	Caregiver experiences that indicate symptoms of drug dependence
Involvement with the Law (ACASI)	IL	Criminal Involvement of Parents	Project-developed questions	N/A	P	1, 2	Caregiver criminal history and involvement with the criminal justice system
Discipline & Child Maltreatment (ACASI)	DS	Behavioral Monitoring and Discipline	Parent-Child Conflict Tactics Scale (CTSPC) Neglect and Substance Abuse questions added	Straus, Hamby, Finkelhor, Moore, & Runyon (1998)	P	1, 2	Methods and frequency of discipline measures used by the caregiver with the child during the last 12 months
Domestic Violence (ACASI)	DV	Domestic Violence in the Home	Conflict Tactics Scale (CTS2) – Physical Assault Subscale	Straus, M.A. (1990)	P	1, 2	Type and frequency of violence occurring in the home and directed toward female caregiver in the last 12 months, and subsequent use of services

¹ Some items or sections of the NSCAW Caregiver instrument were dependent on whether the sampled child was living with a permanent caregiver (e.g., biological parent, adoptive parent) or a non-permanent caregiver (e.g., foster parent, relative, or informal foster caregiver).

Overview of NSCAW Investigative and Services Caseworker Instrument Module

Module	CAPI Section	Construct	Measure	Author/Publisher	Waves	Information Gathered
Questionnaire Introduction	QC	N/A	Project-developed intro script	N/A	1, 2	N/A
Up-Front Module	UF	N/A	Project-developed questions to drive instrument wording/flow and ensure data linkage	N/A	1, 2	Caseworker name and employee ID (to link child interviews to caseworker interviews); employer, date of birth, and name and relationship of child's current caregiver
Alleged Abuse	AA	Nature of abuse	English, D. J. & the LONGSCAN Investigators (1997). Modified Maltreatment Classification System (MMCS). For more information visit the	N/A	1	Details about the specific nature of the alleged abuse or neglect

			<p>LONGSCAN website at http://www.iprc.unc.edu/longscan/</p> <p>As modified from the Maltreatment Classification System outlined in:</p> <p>Barnett, D., Manly, J.T. and Cicchetti, D. (1993). Defining Child Maltreatment: The interface between policy and research. In: D. Cicchetti and S.L. Toth (Eds.), <i>Advances in Applied Developmental Psychology: Child Abuse, Child Development and Social Policy</i>. Norwood, NJ: Ablex Publishing Corp., Chapter 2, pp. 7-73.</p>			
Risk Assessment	RA	Risk Assessment	Project-developed questions based on questions from Michigan, New York, Washington, Illinois, Colorado risk assessment forms and checklists	N/A	1	Factors determining case decisions, including prior history of abuse or neglect, caregiver substance abuse, domestic violence in the home, caregiver mental health problems, poor parenting skills, excessive discipline, and so forth.
Services to Parents	SP	Services to parents	Project-developed questions	N/A	1, 2	Service needs for all cases.
Services to Child	SC	Services to child	Project-developed questions	N/A	1, 2	Services child may have received asked of all cases.

Appendix C
Rotational Assignment Process in Cook County

Appendix C

Rotational Assignment Process in Cook County

Prepared by Richard Foltz, IDCFS

Following is a description of the major components of the mainframe Statewide Case Assignment (SCA) system and the GIS application SchoolMinder. These components ensure that children are rotated to DCFS regional office and private agencies (i.e. units of assignment) based on variables such as agency size, agency performance, and school location.

Initial entries into foster care are the only placements that are rotated to agencies to DCFS offices and private agencies with performance contracts for traditional foster family and home of relative care. The 'Rules Determination' (RD) window in SCA helps Case Assignment/Placement Unit (CAPU) staff identify if the child is an initial entry. RD reviews past placement histories to see if the child has a prior case closing, is a sibling of another already open child case, etc. In the event RD identifies a prior relationship with the Department or private agency, the assignment process does not proceed towards rotation. Rather the child is referred to the agency that last served the child or currently serves a sibling of the child. If RD confirms the child represents a new case opening, the process proceeds to rotation.

To support rotation, the SCA and SchoolMinder applications include the parameters of percentage of referral opportunities (PROs), available traditional homes, and county of HMR referral. DCFS Cook County regions and private agencies with Cook County-based performance contracts (i.e., the units of assignment) receive a traditional or a relative PRO that is based upon reviews of past performance and current agency size: small high performing agencies can and do receive greater PROs than larger lower performing agencies.

County is the lowest level of geography used for selecting eligible providers for relative placements in Cook. However, individual locations of traditional foster homes are part of the placement decision making for traditional intake. Therefore, each week agencies are polled for their homes available for initial intake, and for updated foster home information such as: how many children a home is capable of accepting in the next week; the age range and genders of children the foster parent is willing to accept; and the single elementary and high school district the foster parent identifies can best serve the child. Foster parents in Chicago generally chose the particular elementary, middle and high school, not district, that can best serve the child. This information is data entered into SCA and then loaded into SchoolMinder. Included in this load from another source of data are the actual address locations of the available foster homes.

Once CAPU staff have identified a child as eligible for a rotational assignment into traditional foster care, they proceed to the SchoolMinder application and enter both the related demographics on age and gender and either the address of the birth parent, the Chicago public school being attended (if known) or the hospital or fire station, etc. where the child came into care if the more detailed information isn't known. SchoolMinder in turn uses the location information to determine in which Chicago Public School catchment area or Cook suburban school district that intake occurred and the agency-approved available homes that serve those same school districts or CPS catchment areas (providing the demographics of the

child or sibling group being placed matches the demographics the foster parent is willing to accept). Available homes that match the sibling group demographics are called eligible homes.

Along with identifying which available and eligible homes serve those education-based geographies, SchoolMinder also identifies the distance of eligible and available homes within groupings of 0 – 1, 2 – 5, 6 – 10 and five mile increments thereafter. CAPU clerical take these groupings of homes back to SCA and then apply the traditional PROs stored in SCA against the agencies supervising these homes.

The first grouping of data evaluated against PROs are those eligible serving the suburban school district or CPS school catchment home generating the traditional intake. Based on both competing agencies' PROs and recent intake patterns, agencies are listed in order of their eligibility for intake as of that moment. This list is the 'Call List' and CAPU staff use agency contact information stored in SCA to try and place the child with the first agency on the list and failing that, move to the second agency, etc. CAPU's role in the placement process is connecting agency intake staff with the supervisor of the investigator removing the child from the home.

Just as CAPU staff work their way down the 'Call List' to secure a placement, they also work their way down the list of foster home (and therefore, agency) groupings. So, if a traditional placement can't be found within the suburban school district of CPS catchment area from which the child originated, then all eligible homes within the 0 -1 mile grouping are evaluated. Then if a placement within that grouping is unavailable, homes (and their related agencies) within the 2 – 5 mile grouping are evaluated, etc.

Even though rotational assignment is not a fully randomized process, because the choice of a DCFS office or private agency to serve a particular family is not subject to the same selection biases that arise when the choice is left entirely to the discretion of families, practitioners, or the courts, much of the scientific rigor that is achieved with random assignment can also be gain with rotational assignment.