ILLINOIS BIRTH THROUGH THREE WAIVER: DEVELOPMENTALLY INFORMED CHILD AND FAMILY INTERVENTIONS

IB3

FINAL EVALUATION REPORT
REPORTING PERIOD:
7/1/2013 – 9/30/2018

PREPARED FOR THE ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES BY:

- SCHOOL OF SOCIAL WORK AT THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
- JUVENILE PROTECTIVE ASSOCIATION
- CHAPIN HALL AT THE UNIVERSITY OF CHICAGO
- SURVEY RESEARCH LABORATORY AT THE UNIVERSITY OF ILLINOIS
- HELEN BADER SCHOOL OF SOCIAL WELFARE AT THE UNIVERSITY OF WISCONSIN
- ERIKSON INSTITUTE
- UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

December 31, 2018

PREFACE

This final evaluation report presents findings from the Illinois Birth through Three (IB3) Title IV-E waiver demonstration. The waiver supported the adaptation of evidence-supported, trauma-informed parenting programs to the care and permanency planning for infants, toddlers, and preschoolers who were taken into the legal custody of the Illinois Department of Children and Family Services (DCFS). Even though enrollment in the demonstration is ongoing under an extension of waiver authority through September 30, 2019, this report focuses on the cohort of 1,889 children who were enrolled in the demonstration between July 1, 2013 and June 30, 2017. The waiver targeted children aged 3 years old and younger because research on child maltreatment and neuroscience confirm that the first four years of a child's life are a critical period for healthy social and emotional development. Consistent and responsive parenting can mitigate adverse developmental consequences of child maltreatment and promote healthy attachments between children and caregivers. However, if left unaddressed, adverse childhood experiences can increase the likelihood of negative outcomes later in life and well into adulthood.

The purpose of the IB3 waiver demonstration project was to support the adaptation of trauma-informed parenting programs and test their effectiveness on facilitating timely family reunification or alternative permanency options when reunification cannot be attained. The selected interventions of Child-Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP) were adapted to fit the needs of child welfare-involved children and support parents and caregivers in creating a supportive, developmentally-appropriate parenting environment.

The implementation and evaluation of the IB3 waiver demonstration was patterned after *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*[1] ("Framework"), which the U.S. Children's Bureau disseminated to support the implementation and evaluation of federally-funded programs and innovations. The Framework conceptualizes the implementation and evaluation process as cycling through five phases of "increasingly generalizable studies"[2] prior to scaling-up the program for widespread dissemination.

During the Identify & Explore phase of waiver implementation and development, a group of Illinois officials, voluntary agency administrators, and university partners identified the exceptionally long lengths of stay in Illinois foster care as a special area of concern, particularly for children aged birth though three years old. After conducting a literature review, the team selected CPP and NPP as appropriate interventions to address the developmental needs of

[1] Framework Workgroup. (2014). *A framework to design, test, spread, and sustain effective practice in child welfare.* Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.
[2] Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Belmont, CA: Wadsworth.

children in foster care and to enhance the parenting competencies of the families with whom they are intended to be reunified.

CPP is a dyadic (caregiver and child) intervention for infants, toddler, and preschoolers who have experienced at least one traumatic event such as the sudden or traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence, among others. The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (caregiver) as the vehicle for imparting to the child a positive feeling of safety, permanence, and well-being. NPP is delivered as a group intervention for 7 to 8 caregivers and aims to enhance their parenting competencies with respect to the following: setting age-appropriate expectations, cultivating empathy for children's needs, using alternatives to physical discipline, establishing appropriate role responsibilities, and encouraging children's free expression of thoughts and opinions. It is aimed at modifying maladaptive beliefs that lead to abusive and neglectful parenting behaviors so that children can be safely and permanently reunified with their families. NPP was adapted to include a parent version and a foster caregiver version for the demonstration.

The IB3 demonstration background and context, theory of change, target population, interventions, outcomes, and allocation method for approximating the comparison (counterfactual) treatment for evaluation and cost-neutrality calculations are summarized in this report. The targeting of infant, toddlers and preschoolers together with the selection of two evidence-supported interventions and focus on the improvement of permanence and well-being led to the demonstrations' primary research question:

> Will Illinois children aged birth through three years old, who are placed in foster care in Cook County, experience reduced trauma symptoms, increased permanence, reduced re-entry, and improved child well-being if they are provided CPP or NPP programs compared to similar children who are provided IV-E services as usual?

Table of Contents

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

The final evaluation report presents findings from the Process Study of the integrity of the waiver's implementation and its impact on key output and implementation measures regarding population coverage, adherence to program design, the extent of client participation, and participant satisfaction with programs. It also presents findings from the Outcome Study of the intent-to-treat children and their caregivers assigned to the intervention group and its impact on the stability of foster placement, length of time in foster care, rates of reunification, adoption or guardianship, developmental catch-up, continued safety and improved socio-emotional well-being. Finally, the report includes findings from the Fiscal Study.

The major findings from all three studies are enumerated as follows:

- IB3 demonstration achieved adequate levels of implementation integrity with respect to population coverage, exposure to treatment, adherence to program design, and participant satisfaction.
- The allocation of cases to IB3 intervention and services-as-usual (SAU) agencies evenly balanced treatment groups (allowing "apples-to-apples" comparisons) on most of the agency, child, and caregiver characteristics that could potentially influence safety, permanence, and well-being.
- There were no significant differences between the agency groups at round one, but during the second round, administrators from intervention agencies reported a higher average readiness (about 75% ready vs. about 50% ready) to adopt a new trauma-informed program compared to administrators from comparison agencies. Administrators from intervention agencies also indicated a higher level of preparedness to evaluate evidenced-based programs compared to administrators from comparison agencies.
- Approximately 90% of children were screened for developmental risk within 45 days of case opening using enhanced screening tools. Children categorized as high risk (56%) and those screened as moderate risk (32%) had experienced significant trauma in at least one or more areas.
- An estimated 47% of intervention children in foster homes had caregivers who reported receiving training compared to 28% in the comparison group. Half of the intervention caregivers specifically recalled completing NPP or CPP training.
- Among completers in the intervention group, an estimated 65% of surveyed caregivers found the NPP program to be very or extremely helpful, and 67% found the CPP program to be very or extremely helpful. There were no differences in satisfaction levels among participants who completed one or both programs sequentially (e.g., NPP followed by CPP).

- Children allocated to the intervention group achieved levels of family unification (i.e. reunifications and legal guardianships with biological and fictive kin), which were ***46% higher*** than the odds for children assigned to services as usual. At the close of the observation period, there was an estimated **7.3 percentage point difference** between the likelihood of family unification in the IB3 Services group compared to Services as Usual.
- Simple tests of differences indicated no statistically significant differences between children assigned to intervention and comparison agencies with respect to standardized assessments of developmental growth, trauma symptoms, and measures of parenting competencies.
- An emerging line of inquiry concerns kinship foster caregivers. Compared to non-kin foster and permanent caregivers in the intervention group, relative caregivers were significantly less likely to voice the opinion that the child under their care had emotional, behavioral, learning, or attentional problems (26% vs. 60%). In contrast, kinship caregivers in the SAU group were nearly as likely as non-kin and permanent caregivers in the SAU group to express an opinion that the child under their care had emotional, behavioral, learning, or attentional problems (45% vs. 50%). Exposure to trauma-informed, parenting training programs appears to moderate the opinions of kin that their grandchildren, nieces, nephews, and cousins have emotional, behavioral, learning, or attentional problems.
- Comparison caregivers at earlier screenings reported a higher average of improvements on measures of social and emotional functioning than intervention caregivers but over time children in the comparison group had lower reported social/emotional functioning than children in the intervention group. In other words, children in the comparison group started off at an advantage but by the fourth assessment, children in the intervention group were doing better than children in the comparison group on the above indicators.
- Results from analyzing changes in parenting competencies suggest that completion of NPP is associated with reunification and improvements on parenting competencies (parent-child roles and empathy). Predicted rates of reunification were higher for birth mothers who completed NPP and were considered low risk with respect to parent-child roles and empathy than birth mothers who were considered high risk.
- The Illinois Birth through Three Demonstration completed five years of full implementation. The cumulative costs savings (maintenance and administration) for IB3 through the June 30, 2018 quarter was $432,568. Thus the demonstration was able to fund the extra costs of delivering evidence-supported services within the pre-established cost-neutrality limits. The demonstration yielded a surplus of hundreds of thousands in federal dollars that would have been forgone in the absence of the waiver demonstration.

Sample

Between the enrollment period of July 1, 2013 and June 30, 2017, 8,910 age-eligible children were taken into DCFS custody. This study followed that cohort through September 30, 2018.

The cohort was restricted to the enrollment period that ended June 30, 2017 so that we would have at least a 15-month follow-up period for the evaluation. Of the total children removed from their homes, 6,477 children were outside the demonstration site of Cook County. Another 544 children had exited care within 45 days of case opening or were placed under the case management of Cook County agencies not involved in the demonstration. Of those taken into custody, 1,889 children were assigned to the waiver demonstration, which accounted for 21% of all age-eligible children entering legal custody in Illinois during the observation period.

The waiver demonstration utilized a two-tiered, unbiased allocation procedure to assign children and families to the intervention and comparison groups. First, IDCFS teams and private agencies in Cook County were randomly allocated to an intervention or comparison cluster. Second, children and families were assigned to a specific cluster based on the rotational assignment system that DCFS routinely uses to allocate foster care cases to DCFS teams and to private child welfare agencies for case management services. Rotational assignment resulted in a balanced allocation of the assigned cases: 894 children to intervention agencies (47%) and 995 children to comparison agencies (53%).

Even though rotational assignment typically results in the allocation of add-on, sibling cases (i.e., siblings born or removed after an earlier case opening) to the same treatment group as their older siblings, case transfers among agencies can sometimes result in siblings' being assigned to different treatment groups. Fortunately, the number of sibling groups with mixed assignments was rare: 22 (1.6%) out of 1,352 family clusters. The results of analyses are essentially the same whether these mixed-assignment cases are included or excluded from the analyses.

Local Agency Director Questionnaire (LADQ) Survey

To assess the comparability of agency clusters, DCFS administered the LADQ during the months of February and March of 2013 and again between the months of February and July of 2017. All but one agency (from the comparison cluster) completed the first round and 16 out of 18 still-active voluntary agencies completed the second round of the pencil-and-paper form.

There were 247 group comparisons between intervention and comparison agencies. Round one findings showed that random assignment mostly balanced the two clusters with respect to agency structure, service delivery, agency expenditures and staff resources, staff and caregiver training, parenting training, trauma treatment, agency relationships, trauma-informed practice, evidence-supported programs, director background, and local economic conditions. The two clusters were unbalanced on the following comparisons in which intervention agencies reported offering more post-permanency services, more elements of parent training and trauma treatment programs, and reduced funding ($p < .05$):

- Offer of post-permanency services:
    - Support networks after reunification
    - Any other services after reunification
    - Percent adopted/guardianship get services after
    - Financial services after adoption/guardianship

    - Any other services after adoption/guardianship
- Parent training programs:
    - Child development
    - Communication skills
    - Positive discipline
    - Real-life parenting
    - Traumatic triggers
    - Regulation of emotions
    - Ability to understand others
    - Daily, predictable routine
- Reduced funding.

Because of the large number of group comparisons, it was expected that some or all of the significant differences could have arisen by chance. Based on round one data, it can be assumed that the comparison cluster provided a balanced "counterfactual" for estimating the effects of IB3 services on the outcomes observed for families in the intervention cluster.

The differences in post-permanency services disappeared during the second round of the questionnaire as intervention and comparison agencies similarly reported about their use of additional services for families after permanence. Also, at round two, while a smaller percentage of intervention agencies (66% vs. 71%; $p < .05$) reported providing support networks after reunification, a larger percentage of intervention agencies (22% v. 16% $p < .05$) provided financial services after adoption or guardianship compared to comparison agencies. These percentages reported were significantly different between the intervention and comparison groups. Moreover, there were no significant differences in parent training programs between intervention and comparison agencies at round two.

The questionnaire also asked questions about respondents' assessment of their agencies' readiness for a new trauma-informed program. There were no significant differences between the clusters at round one, but during the second-round respondents from intervention agencies reported a significantly higher average of readiness (about 75% ready vs. about 50% ready; $p < .05$) to adopt a new trauma-informed program compared to respondents from comparison agencies. These responses were based on agencies having an adequate number of families who could benefit from such a program, staff perceiving the advantage of implementing evidence-supported programs (EBPs), and their agencies' readiness to evaluate them.

Fortunately, with respect to most of the other questionnaire items describing the characteristics of agencies and their services, the two clusters were balanced overall. With the large number of tests of statistical differences (247 comparisons), the small number of imbalances between the clusters at round one may be due to chance rather than true differences. Positive differences at round two include the higher level of preparedness of intervention agencies to implement trauma-informed practices and to evaluate evidenced-based programs compared to comparison agencies.

Process Study

Caregivers and caseworkers of children who entered the demonstration in FY14 and FY15 were administered telephone surveys during the period from July 1, 2017 to January 30, 2018 by the Survey Research Laboratory (SRL) at the University of Illinois at Chicago. The SRL completed primary data collection with caseworkers and caregivers from a sample frame of 1,029 children assigned to the demonstration prior to July 1, 2016. Figure 4 displays the CONSORT (*Con*solidated *S*tandards of *R*eporting *T*rials) diagram that summarizes the flow of participants through each stage of the field experiment. The diagram indicated that three children succumbed prior to the start of data collection (as a result of medical frailties at birth), 24 children sampled for the pre-test were dropped from the main study, and six were ineligible because of limits on the number of child interviews per caregiver. The protocol for surveying the caseworkers of the remaining 996 children confined data collection to children who were either still in care at the start of the survey period in July of 2017 or were no longer in care and their case had been closed for less than 6 months. The 996 children who were targeted for the caseworker and caregiver surveys were used to measure the integrity of program implementation regarding coverage, exposure, adherence, responsiveness, and the impact of the demonstration on proximal outcomes of mitigation of trauma symptoms, accelerated rates of family unification, and prompt identification of alternative permanency plans. The response rate for caseworkers was 88%. For cases discharged within 6 months of case closing, 43% of reunified cases had birth parent interviews compared to 46% of guardianships and 48% of adoptions.

Child Characteristics

Child characteristics are evenly balanced across all four sources of data on children. There was an equal proportion of girls and boys (48% vs. 52%) for all 1,889 children tracked for the Outcomes Study. These proportions varied only slightly for the subset of children that were the focus of the Process Study and the Caseworker and Caregiver Surveys. These similarities, which are true for most of the characteristics, give us confidence in the generalizability of the survey data to the full sample that can be tracked with administrative data.

Focusing on the full sample of 1,889 children, 28% of children were less than a month old when they were taken into foster care; 21% were between 1 to 6 months of age, 22% were between 7 and 19 months, and 28% were older than 20 months.

There were equal proportions of children, approximately one-quarter each fiscal year, who were enrolled in the demonstration. The samples for the Process Study and SRL Surveys excluded the more recent fiscal years to allow for adequate follow-up time. Slightly over 50% of the children represented an initial placement case at first contact. The remainder included children who were removed from an intact family case, were add-on siblings to an existing placement case, or were reopened after a prior case closing. There was extensive prior contact of children's families with DCFS. Over one-half of the children had families that had one or more prior contacts prior to the child's enrollment in the IB3 demonstration.

Nearly one-third of the cases were managed by DCFS at 45 days of case opening and approximately one-half of the children in the sample were initially placed with kin. A majority of the cases were opened due to a neglect allegation (80%), whereas 18% were opened because of physical abuse.

The above child characteristics are based on complete information, which was available from administrative data. There are other child characteristics, however, which must be estimated from incomplete administrative data because the information either was not recorded or was not entered into the automated data system. The Latino origins of one-fourth of the full sample could not be determined because the ethnic heritage of the family was not recorded. The absence of information on ethnic origins was higher among the fiscal year 2014 and 2015 cohorts included in the Process Study and SRL Surveys. In spite of the limitations, it is estimated that a majority of the children were black (73%) and a majority were not Latino (61%).

Data entry lags accounted for some of the missing data on the 15% of the enrolled children who lacked risk level determinations. The extent of missing data is less of a problem among the children who were the subjects of the Process Study and SRL Survey. In spite of the incompleteness of the information, approximately one-half of the children were determined to be high risk and an additional 28% to 30%% were determined to be at moderate risk given their trauma experiences. It is important to note that children categorized as high and moderate risk had experienced significant trauma in at least one or more types of trauma.

Caregiver Characteristics

The characteristics of caregivers differed based on their status as either a foster caregiver or a permanent caregiver, which included birth parents, adoptive parents, and permanent guardians. There are two sources of data on permanent and foster caregivers: 1) the survey conducted by the SRL with 364 caregivers and 2) the assessment instruments compiled on the 728 caregivers who participated in the NPP program.

Permanent caregivers, who completed the SRL survey, included a slightly smaller percentage of African-Americans (52%) than foster caregivers (66%). Birth parents who participated in the NPP program were more evenly balanced compared to foster caregivers: 61% vs. 57% African-American. There were similar distributions of non-Latino caregivers in both groups. Permanent caregivers in the SRL survey profiled younger in age: 28% were aged 34 years old and younger compared to 10% of foster caregivers; 13% were aged 55 years old and older compared to 26% of foster caregivers. The age differences were more pronounced among NPP participants, where permanent caregivers were almost exclusively birth parents: 80% were aged 34 years old and younger compared to 18% of foster caregivers; 1% were aged 55 years old and older compared to 25% of foster caregivers. Because only 37 of the permanent caregivers who responded to the SRL survey were birth parents (out of 130 permanent caregivers), the characteristics of NPP participants provide a more accurate portrait of the differences between birth parents and foster caregivers than the SRL survey.

Permanent caregivers in the SRL survey also reported fewer years of education on average: 78% had less than a four-year college education compared to 65% of foster caregivers. Again, the differences were more pronounced among NPP participants: 94% of birth parents had less than a four-year college education compared to 76% of foster caregivers. Approximately equal percentages were employed full-time outside of the home (50%) in the SRL survey, whereas only 26% of birth parents were employed among NPP participants. In the SRL Survey, a larger percentage of permanent caregivers self-identified as males (15%) than foster caregivers (6%). There was a similar percentage-point difference among NPP participants, but one-third of the birth parents were fathers compared to 23% of foster caregivers.

Focusing only on NPP participants, 15% of birth parents were married compared to 45% of foster caregivers. The differences in family size were negligible: 23% of parents and foster caregivers had two of their own children, approximately 40% had three to five children, and 10 of birth parents and 13% of foster caregivers had six or more of their own children.

The largest difference between birth parents and foster caregivers involved their financial status: 41 percent of birth parents did not disclose any source of income whereas 10% of foster caregivers failed to report their annual income. Among birth parents who reported an annual income, 64% said it was under $15,000, whereas among foster caregivers who reported an annual income, 20% fit into this income bracket. At the upper range of the income bracket, 25% of foster caregivers reported annual incomes in excess of $60,000. Only one percent of birth parents reported earning this much money on an annual basis.

Information on kinship ties between caregivers and children was available only from the SRL survey. Among foster caregivers, 26% were related to the child on the maternal side and 10% on the paternal side. Most non-kin foster caregivers reported they were licensed foster parents (97%) whereas less than 66% of kinship foster parents reported being licensed.

Summary of Clinical Services

The clinical services provided in the waiver include screening of both intervention and comparison cases and provision of evidence-supported interventions for children assigned to the intervention group.

The assessment processes and the associated algorithm for determining risk resulting from trauma exposure is one of the most substantial innovations of the demonstration. Findings in this report reflect a balanced distribution of risk across intervention and comparison cases, which support the valid implementation of the risk determination processes for the waiver. Almost 90% of children tracked in the Process Study were screened for developmental risk using enhanced screening tools. Even though higher than expected proportions of children screened as high risk (56%), which resulted in a waiting list for intensive dyadic (parent-child) interventions, referrals to small group NPP accommodated much of the need for services while caregivers waited for a CPP slot to open up.

There was universal screening of all assigned children within 45 days of case opening, but there were delays in imputing the results into the IB3 data system. Children were supposed to be re-screened every 6 months. However, 40% of the children assigned to the demonstration were not re-screened during the period of observation. Children who were screened more than once either had no change in their risk level, a positive change, or a negative change. Of the 730 children who were screened more than once, 15% were screened as high risk during their first screening and last observed screening. Likewise, 16% of children with completed caregiver interviews experienced no change in their high-risk status. Regardless of initial risk status, 68% of children in the full sample experienced no change in risk status at their last observed screening. Of those whose risk status changed, 12% experienced an improvement (e.g., from high risk to moderate risk) whereas 19% experienced a negative change (e.g., from low risk to high risk). Children in the comparison and intervention groups equally experienced no change or changes in their risk levels.

According to program data from August of 2018, there have been 908 referrals to NPP-Parent Version (NPP-PV) and 377 referrals to NPP-Caregiver Version (NPP-CV) based on findings from the risk determination process. Over the lifetime of the waiver, 38% of birth parents in the intervention group referred for the NPP-PV program successfully completed, whereas 44% of the foster caregivers referred to the NPP-CV program successfully completed the program. Completion rates were much higher among caregivers who attended at least one NPP session: 83% of foster parents completed compared to 73% of birth parents. One of the reasons for the higher rate of NPP completion among foster caregivers is the fewer number of sessions required for the caregiver version compared to the parent version of NPP: 81% of foster caregivers who started NPP were able to complete all of the sessions within 90 days. One-half of birth parents who started the program took between 3 and 6 months to complete all of the sessions. Moreover, 37% of cases recommended for CPP successfully closed. Only 19% of high-risk cases and 32% of moderate risk cases were not referred to at least one modality of IB3 intervention.

In order to assess differences in program referrals between treatment groups, the SRL survey queried caregivers about offers of and participation in parenting training and completion of NPP, CPP, or both programs sequentially. Caregivers on the waiting list for CPP were offered NPP training until a CPP slot opened up. According to survey responses, 60% of children in permanent homes had caregivers who were referred or offered training in parenting skills, whereas 53% of children's caregivers in foster homes were referred or offered parenting training.

Being assigned to the intervention group significantly boosted the chances of receiving an offer of parenting training compared to the comparison group. In the intervention group, 71% of children in permanent homes had caregivers who reported receiving an offer of parenting training compared to 52% of comparison children in permanent homes. Similarly, 62% of intervention children still in foster homes had caregivers who received an offer compared to 44% of comparison children. The differences are statistically significant at the .05 level.

The differences in the offer of training carries forward to differences in actual participation rates between treatment groups: 43% of intervention children in permanent homes had caregivers who reported receiving parenting training compared to 29% in the comparison group and 47% of intervention children in foster homes had caregivers who reported receiving training compared to 28% in the comparison group. The group differences for children in permanent homes were not statistically significant, because the sample of children in permanent homes was too small to rule out sampling error. On the other hand, the group difference highlighted above for children in foster homes was statistically significant ($p < .05$).

According to survey responses, approximately one-half of the caregivers who reported received parenting training in the intervention group fulfilled their requirements by completing NPP, CPP, or the two programs in sequential order. There were no permanent caregivers in the comparison group who reported completing NPP or CPP, but 9% of foster parents in the comparison group (cross overs) reported completing NPP or CPP training. Overall, 22% of children in the intervention group had caregivers who completed NPP, CPP, or both programs. Even though only one out of every five children assigned to the intervention group had caregivers who reported completing the intended treatment, the odds of completion were five times larger than the odds of cross-over completion from the comparison group.

Of the 22% of caregivers in the intervention group who completed NPP or CPP training, 65% of surveyed caregivers found the NPP program to be very or extremely helpful and 67% found the CPP program to be very or extremely helpful. There were no differences in satisfaction levels among participants who completed one or both programs sequentially. Caregivers reported feeling slightly more enthusiastic about NPP than CPP: 33% found NPP to be extremely helpful whereas 17% found CPP to be extremely helpful. This sample size of completers, however, is too small to draw conclusions about the significance of the difference.

Outcomes Study

Permanency Outcomes of Full & Survey Sample

Several logistic regression models were estimated using permanency data through September 30, 2018. Simple logistic regression models with the intervention assignment as the only predictor showed that the odds of reunification with birth parents for children assigned to the intervention group were 36% higher than for children not assigned to the intervention group. The odds ratio increases to 46% higher when children who were placed under the permanent guardianship of kin or fictive kin are combined with reunifications (hereafter labelled family unification when reunification and guardianship are pooled together). The odds ratio for family unification further rises to 57% higher when the sample is restricted to children who were removed from their parents' custody after 6 months of age. There was only a marginally significant intervention effect for children removed at birth or before 6 months of age.

On the other hand, the odds ratio for adoption was 24% lower for children assigned to the intervention group than for children not assigned to the intervention group. This adoption difference was significant only among children removed at birth or before 6 months of age. There was no difference in adoption odds among children removed after 6 months of age. Therefore, the impact of the IB3 intervention is best understood as shifting permanency outcomes towards family unification away from adoption rather than boosting overall permanency rates. When all three permanency outcomes of reunification, guardianship, and adoption are combined, the difference in permanency outcomes narrows to statistical insignificance.

Similar results were found for the 996 children who were eligible for the caregiver survey. However, the differences in overall permanency odds vanished completely after the reunification option with birth parents is mostly set aside by the courts for children who have been in long-term foster care for longer than 3 years. Among the 996 children, there were equivalent proportions who remained in long-term foster care in the comparison group (43%) compared to the intervention group (43%). Thus, family unification is the more relevant outcome for the IB3 evaluation than overall permanency rates considering that the primary goal of the IB3 interventions is to preserve primary attachments by unifying children with their birth or extended families without terminating parental rights. A secondary goal is to improve the developmental and well-being outcomes for the children who remain in long-term foster care.

Time to Family Permanence

The differences in permanency pathways can be further refined by taking into account variations in both permanency type and time to family permanence. Two years after removal, 12% of children assigned to services as usual had been unified with their families compared to 14% of children assigned to IB3 services. Four years after removal, 32% of children assigned to services as usual had been unified with their families compared to 38% of children assigned to the intervention group. Thus, children in the IB3 group are more likely to be unified with their parents or placed under the guardianship of kin without severing parental rights than children in the comparison group.

Taking days since removal into consideration, a simple hazards model with intervention assignment as the only predictor showed that the transition rate to family unification at any duration after removal was 27% higher for children assigned to the intervention group than for children not assigned to the intervention group. Similar results hold for the 996 children who were eligible for the caregiver survey.

The transition rate rises to a 31% difference when the sample is restricted to children who were removed from their parents' custody after 6 months of age. Again, there were no significant intervention effects for children removed at birth or before 6 months of age. This result likely reflects the difficulty of fostering meaningful attachment relationships with birth parents when children are removed at birth or taken shortly after they are born. As was true with the simple

odds model, children assigned to the intervention were 30% less likely than children in the comparison group to transition to adoption at any time period after removal. As a consequence of the higher rate of adoption in the comparison group, the difference in the overall transition rate to family permanence between the two groups diminished to zero.

When statistically controlling for child-level characteristics[3] and using a two-tailed test, findings continued to show a significant intervention effect as well as higher likelihoods of achieving family unification among children with the following characteristics: primary reason for case opening was physical abuse, 12 months of age or older, and were of Mexican-American descent. Limiting the analysis to the 996 children in the sample frame yielded similar results.

Because majority of the children in the sample had 4-6 caseworkers assigned to their case, a substudy was conducted to examine the impacts of changes in caseworker assignment, as well as worker characteristics, on family unification. Findings showed a robust intervention effect, which suggests that assignment to IB3 services increases children's odds of returning home to a birth parent or with extended family at a quicker rate than children who are not assigned to IB3 treatments. Moreover, the odds of experiencing family unification were also high for older children who have likely already formed some degree of attachment to caregivers compared to infants. Lastly, children assigned to workers with MSW degrees were less likely to unify with family compared to children whose workers did not possess an advanced degree. This finding suggests that workers with advanced social work degrees may have a more conservative decision-making approach to permanency decisions compared to workers without MSW degrees.

Well-being Outcomes of Survey Sample

One of the aims of the demonstration project is to alleviate the trauma experienced by children so that they have improved prospects of recovering in a supportive environment from adverse childhood experiences. Thus, the evaluation focused on the impact of the intervention on children's emotional and behavioral problems, trauma symptoms, and developmental growth. Current caregivers were interviewed for information about themselves and the children in their homes. A simple regression model, using the sample of children with completed caregiver interviews, showed no significant intervention effect on children's emotional/behavioral problems. However, post-hoc analyses showed the intervention effect varied according to the relationship of the caregiver to the child. While there were no differences among caregivers assigned to the comparison group, kin foster caregivers assigned to the intervention were significantly less likely to report child emotional/behavioral problems than non-kin foster caregivers. This finding suggests that either children placed with kin experience fewer emotional/behavioral problems as a result of the offer of parenting training than their counterparts in the comparison group or are less likely to perceive children's behaviors as problematic as a result of the training.

[3] Covariates included child sex, initial placement with kin, abuse reason, type of case opening, child screened as high risk at baseline and Mexican-American descent.

When examining how children's social and emotional functioning change during their time in foster care, findings from the outcome study showed that both intervention and comparison caregivers report improvements on several indicators (e.g., attachment, self-regulation, initiative) over time. However, comparison caregivers at earlier screenings report a higher average of improvements compared to intervention caregivers but over time children in the comparison group had lower reported social/emotional functioning than children in the intervention group. In other words, children in the comparison group start off at an advantage but by the fourth assessment, children in the intervention group were doing better than children in the comparison group on the above indicators. These findings suggest that offering trauma-informed parenting programs can improve children's social and emotional functioning over time compared to offering typical family services.

Results from analyzing changes in parenting competencies suggest that completion of NPP is associated with reunification and improvements on parenting competencies (parent-child roles and empathy). Predicted rates of reunification were higher for birth mothers who completed NPP and were considered low risk with respect to parent-child roles and empathy than birth mothers who were considered high risk.

Fiscal Study

The IB3 demonstration targets caregivers and children aged 0–3 regardless of their IV-E eligibility for federal reimbursement. The project terms and conditions authorized DCFS to claim federal IV-E reimbursement for innovative programs that are not ordinarily claimable for the 30% of children enrolled in the demonstration who did not meet IV-E eligibility standards. By offering families developmentally appropriate parenting training and support, such as CPP and NPP when indicated, it was anticipated that children assigned to the intervention group would exit more quickly from foster care than children assigned to services as usual. Any federal savings that result from the achievement of timelier family reunification or expedited alternative permanency arrangements compared to services as usual (SAU) are retained and can be reinvested by the state. Additional spending on the intervention group, which is in excess of the average cost neutrality limit for the SAU group, is borne entirely by the state if anticipated permanency improvements are not realized.

The terms and conditions specified that the determination of cost neutrality would rely on an analysis of the costs of cases within the SAU group. The average allowable IV-E costs of a case in the comparison group is assumed to estimate the amount that would have been spent on each intervention case in the absence of the demonstration and is used as the baseline for assessing cost neutrality. The total cumulative title IV-E allowable costs for the SAU group was divided by the number of cases within those groups, and the result was projected to the children assigned to the intervention group to determine the amount the State can be paid in title IV-E funds for the demonstration.

The Illinois Birth through Three demonstration completed five years of full implementation. The cumulative costs savings (maintenance and administration) for IB3 through the June 30, 2018 quarter amounted to $432,568. Thus, the demonstration was able to fund the extra costs of delivering evidence-supported services within the pre-established cost-neutrality limits. The demonstration yielded a surplus of hundreds of thousands in federal dollars that would have been forgone in the absence of the waiver demonstration.

INTRODUCTION AND OVERVIEW

Background and context

The IB3 Title IV-E Waiver Demonstration focused on a very vulnerable population of maltreated children: infants, toddlers, and preschoolers aged birth through three years old who had been removed from their parents' custody and placed into the protective custody of child welfare authorities. Advances in neuroscience confirm that the first three years of a child's life are an extremely sensitive period for social and emotional development. Not only does maltreatment have adverse effects on the developing brain, but the deprivation of consistent and responsive parenting can lead to changes that result in potentially long-lasting deficits in cognitive and behavioral functioning. If not appropriately addressed, these adverse childhood experiences can increase children's vulnerability to stress and predispose them to social, emotional, and health problems throughout their adult life.

The Illinois Department of Children and Family Services (IDCDS) conducted a 5-year demonstration project that delivered trauma-informed, developmentally-appropriate services to young children and their caregivers in Cook County, Illinois. The state of Illinois ranks low in terms of foster care removal and entry rates. Despite its low rate of child removal, Illinois ranks 27th highest in per-capita rate of out-of-home care compared to other states and jurisdictions and ranks third highest in the nation for longest median length of stay in foster care. Thus, children who are removed from their homes typically have high safety concerns and spend a long time in care before successfully returning home or achieving legal permanence.

Purpose of the Waiver Demonstration

The purpose of the IB3 waiver demonstration project was to support the adaptation of evidence-based, trauma-informed parenting programs and test their effectiveness in addressing the adverse effects of maltreatment and in promoting secure attachment relationships. The selected interventions of Child-Parent Psychotherapy (CPP) and Nurturing Parents Program (NPP) were intended to create a developmentally appropriate, responsive parenting environment that can facilitate timely family reunification or expedite alternative permanency arrangements when reunification cannot be attained. By offering families developmentally appropriate parent training and support, including child-parent therapeutic interventions when indicated, it was anticipated that children assigned to the intervention group will experience reduced trauma symptoms, increased permanence, and improved child well-being compared to children who received services as usual.

Target Population

The population and approach were chosen after examining Illinois' overall rates of out-of-home placement, length of time in care, reunification rates, and re-entry rates compared to other states.

Targeting the Youngest Children in Care

The priority IDCFS placed on evidence-based interventions with the youngest children coming into foster care was reinforced by the statistical fact that a greater proportion of removals into foster care were composed of children under the age of four compared to a decade ago. While the number of children entering care has declined overall, children aged birth through three made up an increasing percentage (47%) of all children entering care in 2010, which was significantly higher than the national average (37%). Figure 1 shows that children under the age of four make up a larger percentage of children entering care in 2010 compared to 2000.

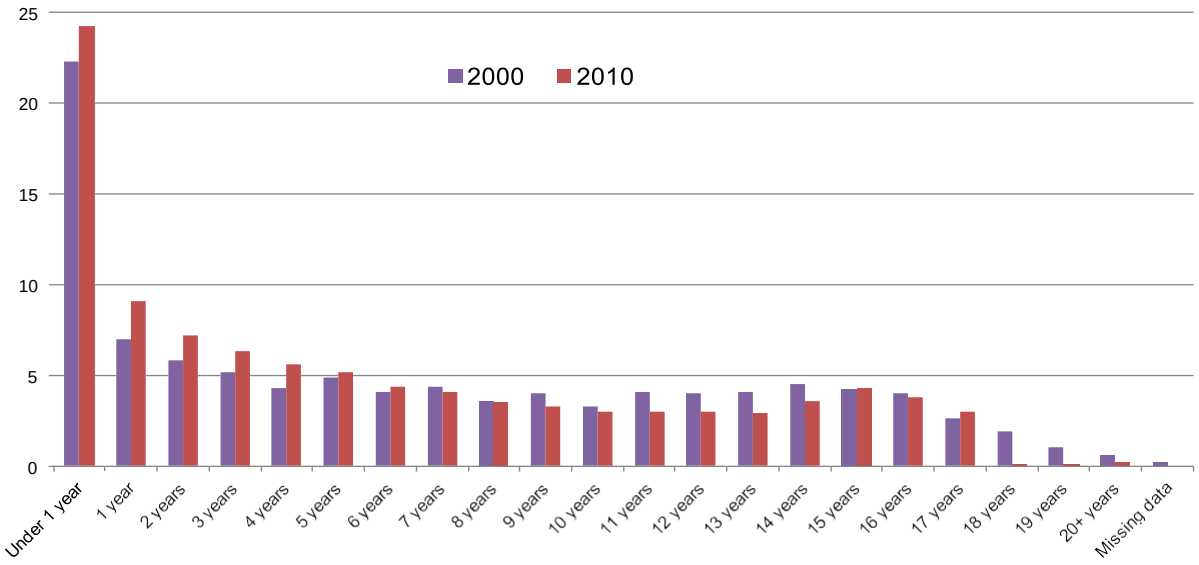


Figure 1. Children Entering Foster Care in Illinois

Reunification Rates

The challenges facing Illinois in reunifying vulnerable children are especially visible among children who are taken into foster care under 4 years of age, particularly those who reside in Cook County, Illinois. Within their first year of entry, only 6% of children under 4 years old were reunified with their birth families in Cook County. This compares to a reunification of 22% among the same aged foster care population in the balance of the State. It takes another four years for Cook County reunification rates to reach the levels achieved within the first year of entry in the balance of the State.

One of the reasons for lower reunification rates among the same aged foster care population in Cook County compared to all Illinois counties was Cook's lower than average removal rate. In addition, children in Cook were more likely to stay in care for longer periods of time than children in the balance of the state. As such, the Illinois waiver focused on children in Cook County. Cook County has one of the longest lengths of stay for young children. Another reason

appears to be the prolonged time that the Cook County child welfare and court systems take before reaching a permanency planning decision. Because the early years of childhood set the stage for all that follows, the lengthier time that Cook County foster children stay in foster care holds the greatest danger for long-term damage but also the greatest potential for successful intervention.

Foster Care Re-entry

Another reason to address the special needs of very young children is their higher risks than average of re-entry into foster care after they have 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.

Interventions and Components

The implementation and evaluation of the IB3 waiver demonstration was patterned after *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* ("Framework", Framework Group, 2014), which the U.S. Children's Bureau disseminated to support the implementation and evaluation of federally-funded programs and innovations (see Figure 2). The Framework conceptualizes the implementation and evaluation process as cycling through five phases of "increasingly generalizable studies" (Shadish, Cook & Campbell, 2002) prior to scaling-up a program for widespread dissemination. The process begins with the Identify & Explore phase to identify or refine the understanding of a child welfare problem and the needs of a target population. During this phase, a multidisciplinary team constructs a theory of change, identifies possible solutions, and selects for implementation a promising innovation with the best available evidence of past success.

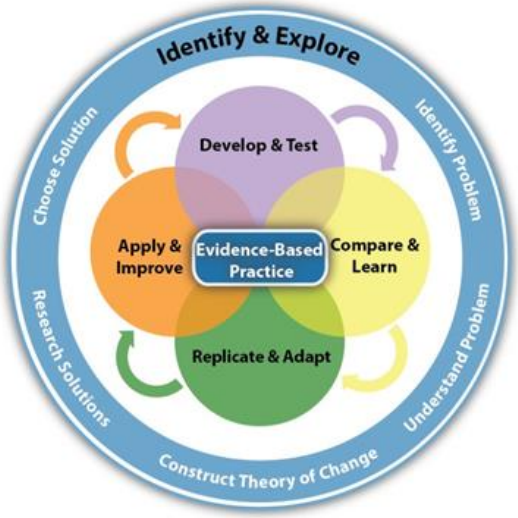


Figure 2. The Framework

Depending on the strength of the evidence, the process may advance immediately to the Replicate & Adapt phase if the existing evidence is strong; or gather additional data at the Compare & Learn phase if the evidence is suggestive; or start-off at the Develop & Test phase if the evidence is weak (Testa, DePanfilis, Huebner, Dionne, Deakins & Baldwin, 2014). There are very few evidence-supported interventions (ESI) that have been developed specifically for child welfare populations. They have to be translated to settings and places that are quite different from the setting and place in which the ESI was originally found to be effective. As a consequence, many imported interventions with strong evidence of past success in other fields must be substantially adapted for implementation with child welfare populations. They must be

re-tested for their implementation integrity and intervention validity and undergo usability testing and formative evaluation at the **Develop & Test phase** of the evidence-building process. This is true for the two ESIs selected for the IB3 waiver demonstration.

During the Identify & Explore phase of waiver implementation and development, a group of Illinois officials, voluntary agency administrators, and university partners identified the exceptionally long lengths of stay in Illinois foster care as a special area of concern, particularly for children aged birth though three years old. After conducting a literature review, two evidence-based programs were selected as potentially well suited to address the developmental needs of children in foster care and to enhance the parenting competencies of the families with whom they are intended to be reunified.

1. **Child Parent Psychotherapy (CCP)** is a dyadic (caregiver and child) intervention for infants, toddler, and preschoolers who have experienced at least one traumatic event such as the sudden or traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence, among others. The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (caregiver) as the vehicle for imparting to the child a positive feeling of safety, permanence, and well-being.

2. **The Nurturing Parenting Program (NPP)** is delivered as a group intervention for 7 to 8 caregivers and aims to enhance their parenting competencies with respect to the following: setting age-appropriate expectations, cultivating empathy for children's needs, using alternatives to physical discipline, establishing appropriate role responsibilities, and encouraging children's free expression of thoughts and opinions. It is aimed at modifying maladaptive beliefs that lead to abusive and neglectful parenting behaviors so that children can be safely and permanently reunified with their families. The model is specifically designed for biological parents and supports early reunification. Illinois is implementing two versions of NPP: a birth parent version (NPP-PV) and a caregiver version (NPP-CV) that is offered to foster parents and kinship caregivers. Sessions run approximately 90-minutes and the NPP-PV model is delivered over a 16-week period. The NPP-CV version is delivered over an 8-week period. Home based coaching, including the focal child, is conducted to observe and apply skills that have been acquired within the NPP-PV group, which can extend the program for up to 7 weeks.

After rotational assignment of children to intervention or comparison agencies, the Integrated Assessment (IA) screening was conducted for all children who entered out-of-home care in Cook County, Illinois. The tools used in the screening were used to make two determinations: 1) the category of risk assigned to the child (high, moderate, or low); 2) services, if any, needed to address the trauma and attachment issues. Parents and caregivers of children determined to be at High risk level and who exhibit the most severe trauma symptoms were recommended CPP. NPP was deemed appropriate for parents and caregivers whose children were considered at Moderate risk.

The Evaluation Framework

Theory of Change/Logic Model

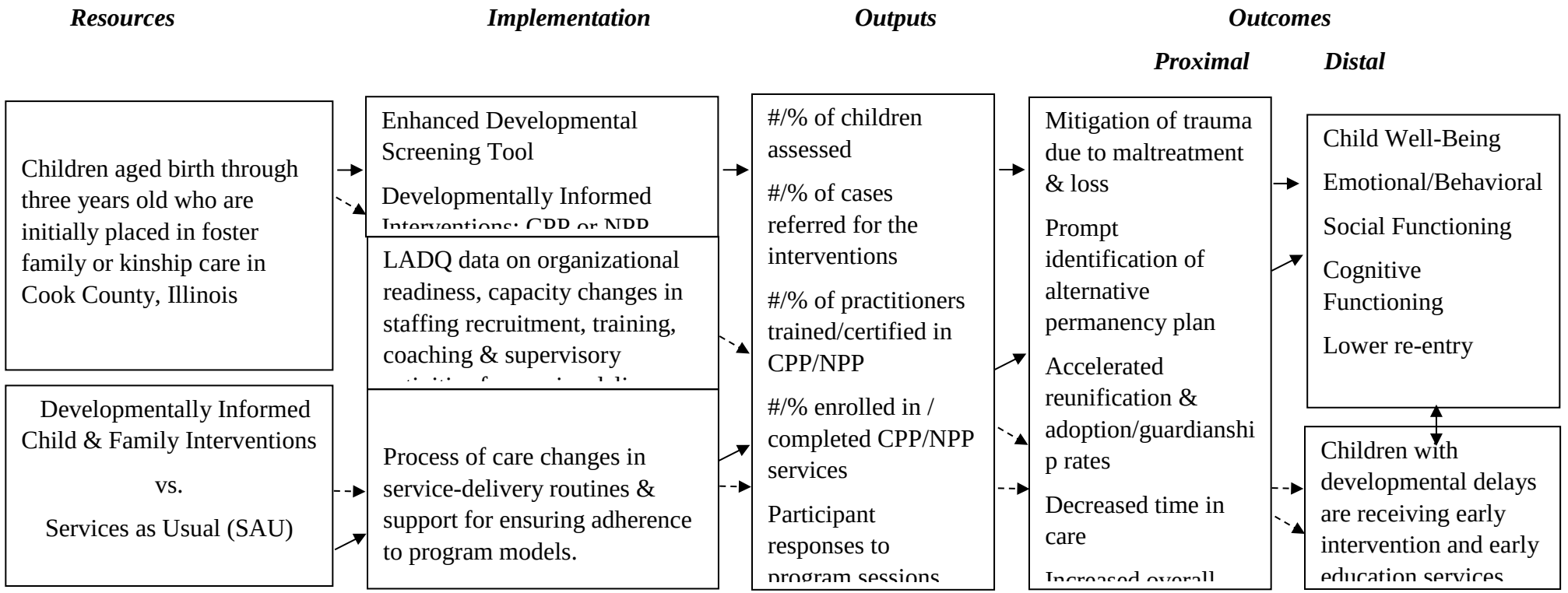
The waiver demonstration tested the following research question: Will Illinois children aged birth through three years old, who are initially placed in foster care in Cook County, experience reduced trauma symptoms, increased permanence, reduced re-entry, and improved child wellbeing if they and their parents (birth and foster) are provided CPP or NPP programs compared to similar children who are provided IV-E services as usual?

Based on the research question, the theory of change can be summarized as follows: Traumatic events that led to out-of-home placement hinder children's development into healthy, caring, and productive adults. If providers can provide immediate access to EBIs to alleviate the distress experienced by children, they will be better supported to mitigate the developmental disruptions resulting 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.

The logic model and theory of change are illustrated in Figure 3 below. There are a variety of formats for constructing logic models. The format utilized for the IB3 demonstration adheres to the model developed by Testa (2010), which elaborates on the PICO framework presented above.

Figure 3 overlays on top of the PICO question the hypothesized mediating casual pathways that link populations (**P**), interventions (**I)**, and comparison (**C**) services as usual (SAU) to the services, procedures, and outputs that impact the proximal and distal outcomes (**O**). Immediately below the causal model are placeholders for the description of the problems, historical background, and policy context examined during the Identify & Explore phase. These external conditions are not under the direct control of change agents, but nonetheless influence the implementation of programs and constrain their capacity to achieve the desired outcomes. Next are the theory of change and relational assumptions that are posited to effectuate the desired changes. Finally, there are the general end values for reconciling diverse outcomes for evaluating the ultimate worth of the change.

There are two noteworthy changes to the Logic Model that was originally proposed in the IB3 Evaluation Plan. The number and percentage of practitioners certified in EBIs replaces the number and percentage of practitioners rated as adequate on NIRN Implementation Tracker instrument. Also, the central role of the Cook County juvenile court in effecting permanency plans is highlighted as an external condition that moderates the capacity of child welfare agencies to attain waiver demonstration goals. The programmatic components/services identified under Implementation in the Logic Model are described more fully below in the findings from the process study.



External Conditions

Reductions in numbers of Cook County children entering foster care.

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

Juvenile court has ultimate responsibility for permanence.

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

End-Values

Child and family well-being

Family autonomy

Readiness for school

Evidence-based policy making

Figure 3. Illinois Birth through Three Logic Model

Overview of the Evaluation

The IB3 project was a 5-year randomized control trial and included a process evaluation of the integrity of program implementation, an outcome evaluation, and a cost analysis that examined the costs of the key elements of services received by children and families assigned to receive IB3 services and a comparison of the costs of services received by those who were not assigned to received IB3 services.

All three components of the evaluation were built on the rotational assignment system that IDCFS uses to assign foster care cases to IDCFS teams and private child welfare agencies under performance contracting. Rotational assignment helps ensure that every team and agency receive a "representative mix" of children as new referrals so that no team or agency has an unfair advantage through creaming of the "easy" cases.

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 identical family receives an experimental treatment in one world and services-as-usual (SAU) treatment (or control group) 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 all that 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.

The outcomes study utilized a two-tier unbiased allocation procedure for assigning cases to intervention and comparison conditions: 1) randomization of DCFS offices and voluntary agencies to treatment clusters; and 2) rotational assignment of child cases to intervention and comparison agencies. With unbiased allocations, systematic differences between the two groups should occur only by chance and, if the number of cases is sufficiently large, with a very low probability. If the assumption of statistical equivalence between groups holds, the observed differences in outcomes between intervention and comparison cases can be confidently attributed to the casual effect of the assignment rather than to any preexisting differences at baseline (selection bias), changes that would have occurred in any event (maturation bias), or happenings that unfold over time (history bias). Details of how new cases were rotationally assigned are described in the "Sampling Plan" (see below).

Data Sources and Data Collection Methods

After the Identify & Explore phase, the next phase ("The Develop & Test") began with baseline data collection on the intervention and comparison agencies using the Local Agency Director Questionnaire (LADQ) to gather detailed information on agency structure, service delivery, agency expenditures and staff resources, staff and caregiver training, parenting training, trauma treatment, agency relationships, trauma-informed practice, evidence-based programs, director background, and local economic conditions.

A major source of data on implementation integrity and program outputs comes from quarterly extracts of administrative data that were supplied by IDCFS to Chapin Hall at the University of Chicago. Chapin Hall links the data at the child level to the IB3 database that is maintained by IB3 Continuous Quality Improvement (CQI) teams.

The major source of primary data for the Outcomes Study was originally intended to come from the Research Triangle Institute, International (RTI), which was commissioned by IDCFS to administer the caregiver and caseworker modules of the National Survey of Child and Adolescent Well-Being (NSCAW). The Illinois Survey of Child and Adolescent Well-Being (ISCAW)—was intended to answer a range of questions about the service use of children, parents, and caregivers who come in contact with the child welfare system. Contracting problems prevented acting on these original intentions. Baseline primary data collection was impossible, and resources were devoted to funding the Survey Research Lab at the University of Illinois-Chicago to conduct a follow-up survey drawing from the Child Wellbeing Survey it conducted for IDCFS in 2005.

A major source of data on proximal safety and permanency outcomes also comes from quarterly extracts of administrative data that were supplied by IDCFS to Chapin Hall at the University of Chicago. Chapin Hall linked the data at the child level to the IB3 database that is maintained by IB3 Continuous Quality Improvement (CQI) teams. Additional data on the distal outcomes come from the IDCFS Mindshare Dashboard and the survey that was conducted by the Survey Research Lab (SRL) at the University of Illinois-Chicago.

Sampling Plan

The sampling plan was designed to optimize the representativeness of the target population of infants and toddlers in foster care in Cook County, Illinois (external validity) and to permit valid inferences to be drawn about the impact of the intervention on safety, permanency and wellbeing outcomes (internal validity). The external validity of the samples was ensured by assigning all eligible children in Cook County to the demonstration. The sample includes infants, toddlers and preschoolers who entered foster care between July 1, 2013 and June 30, 2017 and stayed in state custody for at least 45 days. Excluded from the demonstration were children who were discharged prior to 45 days or were assigned to agencies that were not allocated to the intervention or comparison agency clusters.

The internal validity of the study was supported by utilizing a two-stage unbiased allocation procedure that assigned children and families to the intervention and comparison groups.

The waiver demonstration attempted to approximate the ideal but impossible experiment by utilizing a two-tiered unbiased allocation procedure to assign children and families to the intervention and comparison groups. First, IDCFS teams and private agencies in Cook County were randomly allocated to an intervention or comparison cluster. Second, children and families were assigned to a specific cluster based on the rotational assignment system that IDCFS routinely uses to allocate foster care cases to IDCFS teams and to private child welfare agencies for case management services.

First-Tier Selection: Agency Cluster Assignments

IDCFS teams and private agencies were randomized to waiver services and SAU clusters. Table 1 shows the results of the first-tier randomization of agencies, which have been adjusted slightly to minimize treatment diffusion and to balance the distribution of agencies with respect to special foster care contracts according to the following procedures:

- Each private agency was paired-up with its nearest neighboring match based on each unit's percentage of referral opportunities (PROs) for traditional and home of relative care.[4]
- The two IDCFS Central and North Regions and Children's Home + Aid were purposely placed in the cluster opposite to IDCFS South in order to achieve a better balance on agency size and PROs.
- The remaining matched pairs of private agencies were randomly ordered by the "flip of the coin."
- Two of the three agencies with prior training in CPP landed in one of the clusters and the third landed in the opposite cluster. This third agency with prior CPP training was reclassified and grouped with the other two to form the Waiver Services Cluster. Its matched pair was changed to the SAU cluster.

The cluster totals displayed in Table 1 show that the sums of the number of foster children, IV-E claimable children, and PROs are well balanced among the two clusters. Also, the number of agencies with specialized foster care contracts is fairly well distributed between the two clusters.

Table 1. Assignment of Agencies to Intervention and Comparison Clusters

Services As Usual Group	N	Col. %	IB3 Group	N	Col. %
DCFS Cook South Region	96	9.64%	DCFS Cook North Region	39	3.92%
Lutheran Social Services	151	8.02%	DCFS Cook Central Region	94	9.44%
Lakeside Community	48	2.55%	Children's Home & Aid	181	9.61%
Child Link	93	4.93%	UCAN	28	1.48%
ABJ Community Services*	0	0.00%	Association House	45	2.38%
ChildServ	102	5.42%	Lutheran Child & Family Services	116	6.16%
Unity Parenting and Counseling	81	4.29%	Shelter, Inc.	12	0.64%
Lydia Home Association	43	2.28%	One Hope United	101	5.36%
Volunteers of America	137	7.28%	Ada S. McKinley	56	2.97%
Lawrence Hall Youth	48	2.55%	Centers for New Horizons*	4	0.21%
Aunt Martha's Youth Services	37	1.96%	Universal Family Connection	59	3.13%
Other Agencies**	14	1.41 %	Other Agencies**	10	1.12%
Total	992	52.51%	Total	891	47.16%

*Closed agencies
** Other agencies (Not surveyed):

- Alliance Human Services
- Children's Place Association
- Jewish Child & Family Services
- Kaleidoscope
- Omni Youth Services, Inc.
- United Cerebral Palsy Sequin

Second-Tier Selection: Rotational Assignment of Families

Initial entries into foster care were allocated to rotating IDCFS teams and to private agencies with performance contracts for traditional foster family and home of relative care. The 'Rules Determination' (RD) window in the mainframe Statewide Case Assignment (SCA) system helped the Case Assignment/Placement Unit (CAPU) staff identify if the child was an initial entry. RD reviewed past placement histories to determine if the child had a prior case closing and allocated child cases as follows:

- If the child had a prior relationship with the IDCFS or with a private agency, the assignment process assigned the child case to the agency that had prior case management responsibility for the case (reopening).
- If the RD determined that the child's removal was an initial placement but he or she was a sibling of the child of an existing open child case, he or she was referred to the agency that currently serves a sibling of the child (add-on).

- If RD confirmed the child represented a new case opening, the child was rotationally assigned to the next available provider, which determined whether the families receive the experimental or comparison services (standard).

The rotational method of allocation is what statisticians call the alternation procedure (Chalmers, 2011). It was the gold standard for allocating subjects to study groups in medical research prior to World War II (Hart, 1999). Even though the use of random numbers has since superseded the alternation procedure as the preferred method for forming statistically equivalent groups in medical trials, the alternation procedure is still widely used in child welfare administration because of the ease of programming and simplicity for distributing workloads. Randomization replaced the alternation method not so much because the former provided a less biased allocation sequence than the latter, but because alternation was thought to be less easily concealed from the implementers of the unbiased sequence. Randomization offers a surer method than alternation for concealing the allocation schedule from those involved in enrolling subjects so that the division of subjects really does ensure a random selection (Chalmers, 2011). Checking the extent to which the alternation procedure results in an unbiased allocation to the intervention and comparison groups was one of the key objectives of usability testing and formative evaluation (the process study).

Table 2 shows the quarterly count of all age-eligible children in Illinois who entered DCFS custody before July 1, 2017. After correcting for data-entry lags, the total count of 8,910 infants and toddlers is 1,132 children more than the total reported in the prior semiannual report due primarily to the inclusion of children enrolled during the last 6 months of FY17. Of the total children removed from their homes, 6,481 were outside the demonstration site of Cook County or placed under the case management of Cook County agencies not involved in the demonstration. Of the 1,889 children assigned to the waiver demonstration, 894 were rotationally allocated to IB3 intervention agencies (47%) and 995 were allocated to comparison agencies (53%).

The Evaluation Plan dated February 15, 2014 projected that approximately 2,080 children would have been enrolled by the end of June 2017. The shortfall of 193 children from projected enrollments (9%) arises from lower than projected entries into foster care in Cook County.

The CONSORT diagram displayed in Figure 4 aligns the flow of the actual 2014 and 2015 enrollments with corresponding data sources (vertical left-hand column). Initially, the two-stage allocation procedure randomly assigned a total of 19 voluntary agencies and three IDCFS Cook County regions into the waiver (intervention) and services-as-usual (comparison) clusters. As indicated in the CONSORT diagram, two of the agencies ceased operations during the early phases of the demonstration, which reduced the number of voluntary agencies to 17. Fortunately, the agencies were assigned to different demonstration clusters, so the balance of referrals was not adversely affected by their attrition from the demonstration. All but one of the 17 voluntary agencies completed the LADQ. The results of the LADQ are briefly summarized under “The Process Study”. The full LADQ report is attached as Appendix A.

Table 2. Quarterly Enrollments in the Demonstration

Fiscal Year	Quarter	State of Illinois	Not Eligible for Demonstration		Assigned to Demonstration	
			Balance of State	Cook County	SAU	IB3
FY14	2013 3	561	407	34	50	70
	2013 4	507	375	28	48	56
	2014 1	528	399	24	47	58
	2014 2	554	378	35	57	84
FY15	2014 3	638	442	37	76	83
	2014 4	574	392	40	84	58
	2015 1	577	426	27	69	55
	2015 2	580	405	41	76	58
FY16	2015 3	582	411	36	72	63
	2015 4	490	351	34	63	42
	2016 1	503	367	29	70	37
	2016 2	581	446	40	51	44
FY17	2016 3	564	442	35	44	43
	2016 4	529	391	30	59	49
	2017 1	543	405	38	61	39
	2017 2	599	440	36	68	55
	Total	8,910	6,477	544	995	894
	Percentages	100%	73%	6%	11%	10%

The assessment tools used in the demonstration support critical decisions for all children under the age of 4 in Cook County. The tools were used to make two crucial determinations: 1) the category of risk assigned to the child (high, moderate or low); 2) services, if any, needed to address the trauma and attachment issues. Both the Infant Toddler Symptom Checklist (ITSC) and the Devereux Early Childhood Assessment (DECA) served to assess the child's trauma symptoms. The Child and Adolescent Needs and Strengths (CANS) assessment was used to assess trauma experiences and history. The parent and caregiver's level of stress was determined by the Parenting Stress Index (PSI).

Based on the risk determination, one or more of the following IB3 service recommendations were made based on the level of support needed to achieve enhanced caregiver responsiveness: CPP, NPP-PV, or NPP-CV.

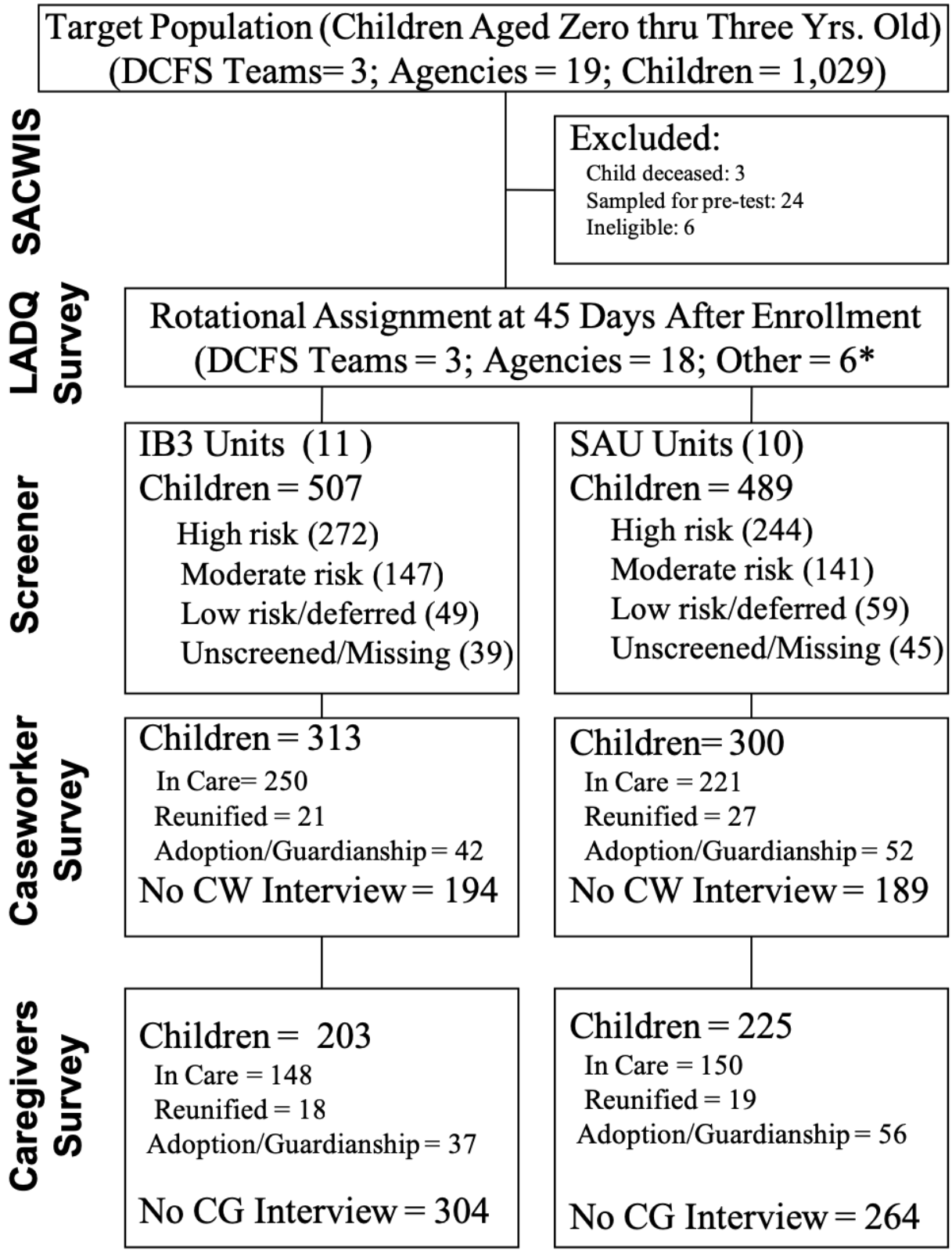


Figure 4. Consort Diagram

Trauma Experiences (as measured by CANS)	Symptoms (As measured by DECA, ITSC)	Parent Stress (As measured by PSI)	Risk Level Determination	Service Determination
High Trauma Experiences As indicated by any score of 3 Or two or more scores of 2Normal in interpersonal trauma areas	Any symptom profile (IE no Area of Need on DECA, ITSC, or any combination scores on DECA and ITSC	Elevated or not	HIGH	CPP
Moderate Trauma Experiences As indicated by one or more score of 2 in any trauma area	High symptom profile As indicated by two or more Area of Need scores on DECA, OR One Area of Need and Deficient on ITSC	Elevated or not	HIGH	CPP
Moderate Trauma Experiences As indicated by scores of 1 or 2, Including one Score of 2 in one interpersonal trauma area	Moderate symptom profile As indicated by one Area of Need score on DECA OR Deficient on ITSC	Elevated or not	MODERATE	NPP-PV/CV
Moderate Trauma Experiences As indicated by scores of 1 or 2, Including one Score of 2 in 0ne interpersonal trauma area	Low symptom profile As indicated by scores on DECA Typical or Strength, scores on ITSC Normal	Elevated or not	MODERATE	NPP-PV/CV
Low Trauma Experiences As indicated by scores of 0 Or 1 (excluding Sexual Abuse)	Moderate symptom profile As indicated by one Area of Need score on DECA OR Deficient on ITSC	Elevated or not	MODERATE	NPP-PV/CV
Low Trauma Experiences As indicated by scores of 0 or 1 (Exc. Sexual Abuse)	Low symptom profile As indicated by scores on DECA Typical or Strength, scores on ITSC Normal	Elevated	MODERATE	NPP for parent With elevated PSI
Low Trauma Experiences As indicated by scores of 0 Or 1 (exc. sexual abuse)	Low symptom profile	Not Elevated	LOW	NPP-PV

Figure 5: The IB3 Assessment Grid

Data Analysis Plan

The data analysis plan assessed both the integrity of the demonstration's implementation and the validity of two family-centered, trauma-informed interventions in improving the family permanence and social and emotional well-being of infants, toddlers, and preschoolers taken into foster care. The success of any waiver demonstration is a product of the integrity with which a demonstration is implemented and the validity of the implemented interventions in attaining the desired outcomes. Failure to obtain the desired results may result from deficiencies in implementation integrity or lack of intervention validity, or both (Klein & Sorra, 1996).

Thus, the IB3 evaluation involved two complementary studies: a study of implementation integrity (process) and a study of intervention validity (outcomes). Even though there is incomplete agreement on the scope of implementation integrity, there is general acknowledgement (Berkel et al., 2011; Dane & Schneider, 1998) that integrity can be measured along at least several of the following dimensions:

- **Coverage:** the extent to which study subjects and conditions are representative of the target population and setting.
- **Program Differentiation:** the extent to which the subjects in each intervention condition received only the assigned treatment.
- **Exposure:** the extent of client participation and the level of service dosages received.
- **Adherence:** the extent to which specified program components were delivered as prescribed by training, certification, or program manuals.
- **Participant Responsiveness:** participant response to program sessions, such as levels of satisfaction.

The first dimension is primarily a matter of sampling design. Because nearly all children aged birth through three years old, who were placed into foster care, were enrolled in the demonstration, both the sample subjects and conditions were representative of the intended target population and settings. The next two dimensions were measured with referral and service utilization data entered into the IB3 database. Adherence was assumed because all therapists and group facilitators have been certified or trained for the delivery of program components. Finally, participant responsiveness was assessed through focus groups and interviews conducted with samples of service providers, program staff, and intervention participants.

The focus groups and interviews were conducted by researchers at Chapin Hall at the University of Chicago and Juvenile Protective Association. The research focused on the experiences of key professional staff involved in the implementation of the IB3 program as well as on individual birth parents and foster parents who were enrolled in the IB3 demonstration. The focus groups and interview discussions were organized around the following questions:

- Did the respondents understand IB3 and how the services were relevant to them?

- Did the respondents understand key processes such as the integrated assessment and family team meetings?
- What steps were taken to help communicate the importance of IB3 services?
- What challenges hinder the uptake of IB3 services?
- What aspects of IB3 are working well?

The outcomes study measured the validity of the interventions along the following dimensions:

- **Statistical Validity:** the extent to which there is a statistically significant association between the interventions and the desired outcomes.
- **Internal Validity:** the extent to which there is confidence that the statistical association results from a causal relationship between the interventions and the outcomes.
- **External Validity:** the extent to which the causal relationship is generalizable across variations in different populations and settings (e.g. voluntary child welfare agencies and IDCFS offices).
- **Construct Validity:** the extent to which the causal relationships correspond to their higher-order theoretical constructs as specified in the Logic Model.

Based on the Framework described above, these four dimensions symbolize "tollgates" the evaluation has to pass through in order to qualify the intervention as evidence-based. Passing through successive tollgates from statistical to construct validity contributes to the generalizability of the results. The Outcomes Study applied this process to answering the following specific questions and hypotheses derived from the demonstration's PICO question:

- *Do children in the intervention services group exhibit positive improvements in early childhood development, behavior problems, cognitive functioning, and adaptive/pro-social behavior as compared to similar children in the comparison group?*

The null hypothesis (H_o) can be stated as follows: The proportions of children with clinically significant scores at follow-up in the intervention group are equal to the proportions in the comparison group. The expectation is that this hypothesis will be rejected.

$W_i = W_c$

- *Do children in the intervention group experience fewer placement changes as compared to similar children in the comparison group?*

H_o: The proportion of children with two or more placement changes at the conclusion of the study in the intervention group is equal to the proportion in the comparison group. The expectation is that this hypothesis will be rejected.

$S_i = S_c$

- *Are a higher proportion of children in the intervention demonstration group reunified within 2, 3 and 4 years from removal compared to children in the comparison group?*

H_o: The proportions of children reunified from the intervention group are equal to the proportions from the comparison group. The expectation is that this hypothesis will be rejected.

$R_i = R_c$

- *Do children in the intervention group spend fewer average days in foster care from placement to permanence than children in the comparison group?*

H_o: The average days of foster care from placement to reunification, adoption and guardianship in the intervention group is equal to the average days of foster care in the comparison group. The expectation is that this hypothesis will be rejected.

$LOS_i = LOS_c$

- *Do more children with developmental delays in the intervention services group receive appropriate early intervention and early education services than similar children in the control group?*

H_o: Reports from caseworkers and caregivers at the 18-month follow-up will show the same levels of needed service receipt for children with developmental delays in the intervention services group compared to similar children comparison group. The expectation is that this hypothesis will be rejected.

$D_i = D_c$

- *Do children reunified or placed permanently in an adoptive or guardianship home in the intervention services group experience fewer repeat maltreatment reports and re-enter foster care at a lower rate than children in the comparison group?*

H_o: The re-abuse and re-entry rates of children in the intervention demonstration group are equal to the re-entry rate in the comparison group. The expectation is that this hypothesis will be rejected.

$Re_i = Re_c$

Cost-Neutrality Calculations

Because rotational assignment is intended to provide an unbiased estimate of differences in outcomes, the total sum of costs for both groups can be used for cost neutrality and IV-E claiming calculations. The amount of title IV-E funds the State was reimbursed under the demonstration was based on an analysis of the costs of cases within the comparison group and was determined by application of the cost-neutrality formula. The calculation described below was performed separately for maintenance and administrative payments on a quarterly basis.

Step 1. Calculate the cumulative title IV-E costs for the comparison group, including title IV-E foster care, adoption assistance and guardianship assistance maintenance, and associated administrative expenses. Any non-IV-E-eligible costs must be excluded from this calculation and from title IV-E claims.

Step 2. Calculate the average title IV-E cost per comparison group case by dividing the cumulative title IV-E costs for the comparison group (per Step 1) by the number of ever assigned comparison cases (including both title IV -E and non-title IV-E eligible cases).

Step 3. Multiply the average derived in Step 2 above by the number of ever assigned intervention cases (including both title IV-E and non-title IV-E eligible cases). The result is the cumulative cost-neutrality limit for the intervention cases.

Step 4. Calculate the cumulative costs for the intervention group, including title IV-E foster care, adoption assistance and guardianship assistance maintenance, and associated administrative expenses, the costs of the demonstration early intervention services provided to all intervention group children, and the costs of specialized training necessary to implement the interventions.

Step 5. Compare the result of Step 3 with the result of Step 4. If the result of step 4 (cumulative intervention costs) is greater than the result of step 3 (cumulative cost neutrality limit), the difference represents costs in excess of the cost neutrality limit for which the State may be responsible. If the State chooses to file claims for such costs, reimbursement will be pended until a quarter in which cost neutrality is not exceeded or the completion of the project. If Step 4 is less than the cost-neutrality limit calculated in Step 3, then the difference represents ***savings*** that the State may claim for expenditures for any child welfare purposes allowable under titles IV -B or IV-E of the Act. Total savings available for expenditure (including amounts calculated for past periods) is subject to recalculation each quarter until the completion of the project.

Any net improvements in permanence, reduced length of stay, and lower re-entry rates for the intervention group compared to the comparison group would translate into higher average maintenance and administrative costs per comparison case group compared to the average costs per intervention case. Because the IV-E claims for the intervention group are not based on actual costs but on the average cost per comparison case, substantial savings can accrue to the State if the net improvements in permanence are substantial enough to exceed the actual maintenance and administrative costs of the intervention group including the costs of the CPP/NPP programs.

Federal title IV-E payments to the State for this demonstration were made quarterly based on State estimates of demonstration expenditures for the next quarter and the reconciliation of actual expenditures to the amount of funds the State had already received for the demonstration. If the State cost estimates are higher than actual expenditures, the State reconciles actual amounts on a quarterly basis. At the completion of the demonstration, the State will notify the Administration for Children and Families (ACF) when a final claim for operational costs has been filed. Any unspent savings will be available for claiming in accordance with Federal regulations for costs incurred during the project period.

Substudy

Because of the high proportion of children with more than one caseworker, a substudy was conducted to test the impact of having multiple caseworkers on family unification and on the average days children spent in foster care. Specifics regarding the key research questions, evaluation design, findings, and other issues are provided in a subsequent section ("Substudy"; see below).

Limitations

Despite the amount of missing data from caseworker and caregiver interviews and data entry lags, the evaluation did not conduct multiple imputation to account for the missing data. Missing data are a common problem in survey research. It is no longer considered acceptable practice to ignore missing data when the proportion of missing cases exceeds 5%. Therefore, the results using survey data and assessment data should be interpreted with caution because of the large proportion of cases with missing information on process indicators.

Evaluation Time Frame

The independent evaluator provided services and deliverables over a performance period of sixty (60) months commencing on or about January 1, 2013.

Schedule and List of Deliverables

January 1, 2013 – September 30, 2018: The independent evaluator provided expert consultation and technical assistance on implementation of the waiver demonstration through membership and participation in work groups, teleconferences, conferences, and other related activities.

February 1, 2013 – March 30, 2013: The independent evaluator submitted an evaluation plan to IDCFS within 45 days after the evaluation contract was awarded that included a power analysis and development of a logic model that specified the intervening implementation activities that transformed population and intervention resources into measurable service outputs that produced the proximal and distal outcomes the waiver demonstration was intended to improve.

July 1, 2013 – June 30, 2018: Survey data collection commenced on children and with caregivers at baseline.

December 1, 2013 – June 1, 2018: The independent evaluator submitted bi-annual written summaries of project status to IDCFS reporting project activities and accomplishment of deliverables.

January 1, 2015 – June 30, 2018: Survey data collection commenced with caregivers and caseworkers at 18 months.

February 1, 2016 – March 30, 2016: The independent evaluator submitted an interim evaluation report to IDCFS no later than 30 days after the conclusion of the 10th quarter following the demonstration's implementation date.

July 1, 2018 – December 30, 2018: The independent evaluator submitted a final evaluation report to IDCFS that integrates the process, outcome and cost components of the evaluation.

THE PROCESS STUDY

The IB3 demonstration was predicated on the formula that programmatic success is a product of intervention integrity (i.e., the fidelity with which the program is implemented) and intervention validity (i.e., the efficacy of the program in achieving its intended objectives).

Key Research Questions

Much of the quantitative data for the process study of IB3 implementation comes from the IB3 database. The information from the database allowed for the tracking of referrals, enrollments, and completion rates for the signature IB3 programs: CPP, NPP-PV, and NPP-CV. Thus, the process study addressed the following research questions:

- What was the number or percentage of children who were assessed with screening protocols?
- How many children were enrolled in or completed CPP/NPP services?
- What are the differences in the 2-year follow-up LADQ as reported by local agency directors?

Overall, the questions refer to the amount of program content received by children and families and the features of the interventions that were distinguishable from the usual services.

Key Outputs/Implementation Measures

The outputs and their indicators (identified in the Logic Model) describe the children in the demonstration who were assessed using the Integrated Assessment tool.

Table 3 — Description of Key Outputs for the Process Study.

Output	**Measure/ Indicator**	**Data Source(s)**	**Collection Interval**	**Organization Responsible**
Children will be assessed with screening protocols	#/% of children assessed with screening protocols	CANS, PSI, DECA, ITSC, Denver II, Ages & Stages	Baseline, 6, 12 & 18 months	• IDCFS • Chapin Hall • Erikson Institute
High, moderate & low risk status	PSI, DECA, ITSC, Denver II, Ages & Stages	IDCFS IA/Early Education data systems	Baseline, 6, 12 & 18 months	• IDCFS • Erikson Institute
Parents and caregivers will be referred to appropriate interventions	#% of cases referred for CPP & NPP interventions	IB3 Database	Quarterly	• IDCFS • Chapin Hall • Erikson Institute

Output	Measure/ Indicator	Data Source(s)	Collection Interval	Organization Responsible
based on screening assessment.				
Caregivers will be enrolled & complete CPP/NPP services as assigned.	#/% referrals that completed CPP/NPP services	IB3 Database	NPP-PV (16 weeks) & NPP-CV (8 weeks) CPP (18 months)	• IDCFS • Chapin Hall • Erikson Institute
Participant responses to IB3 implementation	Qualitative assessments of participant perceptions of and satisfaction with IB3 implementation.	Interviews with parents & caregivers and focus groups with staff	Fall 2015	• Chapin Hall • JPA
Permanent Primary Caregiver (PPCG) will receive parenting training and support services	% referred to or offered any training in parenting skills; support groups; services	ISCAW-Section SR	One time	• UIUC • SRL
Worker will refer CHILD for developmental, special education, AODA recovery, mental health and physical health services.	Developmental, trauma, psychological, health assessments; medications; service referrals; special education; service receipt inventory	ISCAW-SC Section	Onetime question about the services child may have received in the last 12 months.	• UIUC • SRL • Erikson Institute • IB3 agencies
Practitioners trained in CPP/NPP	#/% of practitioners trained/Certified in CPP/NPP	IB3 program staff	One time	• IDCFS

Data Collection & Data Sources

A major source of data on implementation integrity and program outputs comes from quarterly extracts of administrative data that were supplied by IDCFS to Chapin Hall at the University of Chicago.

The Erikson Institute DCFS Early Childhood Project and UIUC were responsible for referrals and monitoring the service needs of children in the project. They administered ongoing screenings using the assessment tools for the comparison and intervention groups to determine if service needs or the risk classification changed.

Scores from the CANS, PSI, DECA, ITSC, Denver II, and Ages & Stages questionnaire were used to determine how many children were assessed in the study and their risk levels. These tools were part of the Integrated Assessment Program (IA), which is a comprehensive front-end assessment program that supplements and supports the casework process of child and family assessment through the early identification of child and family strengths and needs. Children entering foster care are expected to be assessed every 6 months.

The number or percentage of cases referred for CPP and NPP were collected quarterly and entered in the IB3 database. The IB3 database also tracked the number of cases that completed CPP/NPP services. Chapin Hall at the University of Chicago linked administrative data at the child level to the IB3 database, which is maintained by IB3 Continuous Quality Improvement (CQI) teams.

The tools used to collect data on the key proximal measures are briefly described below:

Local Area Director Questionnaire (LADQ)

Baseline data were collected on the intervention and comparison agencies using the LADQ to gather detailed information on agency structure, service delivery, agency expenditures and staff resources, staff and caregiver training, parent training, trauma treatment, and other characteristics of the agency. The LADQ is a paper-and-pencil interview that was completed by the DCFS team supervisor or private agency director, or their designee. The baseline data were used to assess intervention agencies' readiness to implement the EBIs. The second LADQ was administered at the end of the second year of the waiver demonstration.

Child and Adolescent Needs and Strengths (CANS)

The CANS is designed to be a comprehensive trauma-informed and strength-based assessment and includes a series of items measuring trauma experiences and trauma symptoms. It measures psychological well-being, need for services and intervention, and strengths. Information gathered

from the tool can help with decision making, treatment planning, and outcome management (Lyons, 2004).

Parenting Stress Index (PSI)

The PSI is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioral and emotional problems, and parents who are at risk for dysfunctional parenting. It can be used with parents of children as young as one month.

The PSI is particularly helpful in:

- Early identification of dysfunctional parent-child systems.
- Prevention programs aimed at reducing stress.
- Intervention and treatment planning in high-stress areas.
- Family functioning and parenting skills.
- Assessment of child-abuse risk.
- Forensic evaluation for child custody.

Devereux Early Childhood Assessment for Infants and Toddlers (DECA)

The DECA is a standardized, strength-based assessment with two parts: (a) infants and (b) toddlers. It assesses protective factors and screens for social and emotional risks in young children between the ages of 4 weeks to 36 months. Some of the protective factors include children's ability to use independent thought and actions, ability to manage emotions, and sustain attention.

Infant Toddler Symptom Checklist (ITSC)

The ITSC is a tool used with children from 7 to 30 months of age and items vary based on specific age groups (e.g., 7-9 months). The checklist focuses on infant's responses in the areas of (1) self-regulation, (2) attention, (3) feeding, (4) sleep, (5) dressing, bathing, and touch, (6) movement, (7) listening, language, and sound, (8) looking and sight, (9) attachment and emotional function. It aims to identify infants and toddlers who are at risk for sensory integrative disorders, attention deficits and emotional/behavioral problems.

Denver II

The Denver II is a developmental screening tool used to identify developmental problems in infants (birth to 4 months). It focuses on four domains: personal-social, fine motor and adaptive, language, and gross motor skills. This tool directly tests the child.

Ages & Stages (ASQ)

ASQ is another developmental tool that measures children's developmental performance, but is completed by the children's parents or caregivers.

Focus Groups & Interviews with Key Personnel

Because only a limited perspective on implementation integrity is obtainable from quantitative tabulations alone, the University of North Carolina at Chapel Hill subcontracted with the Chapin Hall Center at the University of Chicago to conduct focus groups and interviews with key professional staff involved in the implementation of the IB3 program as well as on individual birth parents and foster parents who were enrolled in the IB3 demonstration.

Sample

According to program data, between the enrollment period of July 1, 2013 and June 30, 2017, 8,910 age-eligible children were taken into DCFS custody. The process study followed that cohort through September 30, 2018. The cohort was restricted to the enrollment period that ended in June 30, 2017 so that we would have at least a fifteen-month follow-up period for the evaluation. Of the total children removed from their homes, 6,477 children were outside the demonstration site of Cook County. Another 544 children had exited care within 45 days of case opening or were placed under the case management of Cook County agencies not involved in the demonstration. Of those taken into custody, 1,889 children were assigned to the waiver demonstration, which accounted for 21% of all age-eligible children entering legal custody in Illinois during the observation period.

The waiver demonstration utilized a two-tiered, unbiased allocation procedure to assign children and families to the intervention and comparison groups. First, IDCFS teams and private agencies in Cook County were randomly allocated to an intervention or comparison cluster. Second, children and families were assigned to a specific cluster based on the rotational assignment system that DCFS routinely uses to allocate foster care cases to DCFS teams and to private child welfare agencies for case management services. Rotational assignment resulted in a balanced allocation of the assigned cases: 894 children to intervention agencies (47%) and 995 children to comparison agencies (53%).

Even though rotational assignment typically results in the allocation of add-on, sibling cases (i.e., siblings born or removed after an earlier case opening) to the same treatment group as their older siblings, case transfers among agencies can sometimes result in siblings' being assigned to different treatment groups. Fortunately, the number of sibling groups with mixed assignments was rare: 22 (1.6%) out of 1,352 family clusters. The results of analyses are essentially the same whether these mixed-assignment cases are included or excluded from the analyses.

The sample frame for the process study consisted of 1,029 children who were enrolled in the IB3 program between July 1, 2013 and June 30, 2015 (SFY 2014 and 2015). Children in the sample

frame were either still in the legal custody of the state as of July of 2017 or had been reunified with their birth parents, adopted, or discharged to the permanent guardianship of their foster caregivers. Any case that had been closed for longer than six months was excluded from the caseworker survey because of the likelihood of missing or erroneous case information due to staff turnover.

Survey Completion Rates

Prior to interviewing caseworkers, the UIC-SRL sent e-mails, which contained an internet link to a screening instrument. The e-mail explained that one or more children in the sample frame were on their caseload. The purposes of the screener were: 1) to confirm that the child had been in the foster care system within the last six months, (2) to verify that the caseworker was the current or immediate past caseworker for the child—and if not---to get updated caseworker name and contact information, and (3) to schedule a convenient day and time to conduct the telephone interview. If caseworkers did not respond to the e-mail screener, field staff attempted to call them to complete the screener by phone. After no response to the screener and seven unsuccessful attempts at telephone contact, UIC-SRL sent up to two reminder emails that included a date by which their response was needed.

Caseworkers for 100 of the 764 children eligible for caseworker interviews did not respond. An additional 17 caseworkers who responded to the screener did not complete the instrument, and the caseworkers of 34 children, who did not respond, made it known the case was closed for longer than six months, which made them ineligible for the caseworker interview. Subtracting these 34 children from the 764 children presumed eligible for the caseworker survey yielded a caseworker survey completion of 84%.

In terms of the caregiver survey, the UIC-SRL first attempted to reach the caregivers of the 232 children who were ineligible for the caseworker survey because their case had been closed for longer than six months. Whereas 40% to 50% of cases discharged to adoptive or guardianship homes had completed caregiver interviews, only 6% of reunified cases had completed interviews. Reaching birth parents whose children were discharged within 6 months of case closing proved easier: 43% of reunified cases had birth parent interviews compared to 46% of finalized guardianships and 48% of adoptions. Caseworkers were able to verify contact information for most of these families, which facilitated reaching them.

This criterion resulted in the exclusion of the 232 cases from the caseworker survey, which had been closed for longer than six months as of July of 2017.

All cases were eligible for the caregiver survey. However, in order to minimize the burden on respondents, families with more than three children in the sample frame were limited to reporting on only two of the children randomly selected from the home. This restriction resulted in the exclusion of 18 children from the caregiver survey.

Child Characteristics

Child characteristics were evenly balanced across all four sources of data on children. As shown in Table 4, there was an equal proportion of girls and boys (48% vs. 52%) for all 1,889 children tracked for the Outcomes Study. These proportions varied only slightly for the subset of children that were the focus of the Process Study and the Caseworker and Caregiver Surveys. These similarities, which are true for most of the characteristics in Table 4, give us confidence in the generalizability of the survey data to the full sample that can be tracked with administrative data.

Focusing on the full sample of 1,889 children, 28% of children were less than a month old when they were taken into foster care; 21% were between 1 to 6 months of age, 22% were between 7 and 19 months, and 28% were older than 20 months.

There were equal proportions of children, approximately one-quarter each fiscal year, who were enrolled in the demonstration. The samples for the Process Study and SRL Surveys excluded the more recent fiscal years to allow for adequate follow-up time. Slightly over 50% of the children represented an initial placement case at first contact. The remainder included children who were removed from an intact family case, were add-on siblings to an existing placement case, or were reopened after a prior case closing. There was extensive prior contact of children's families with DCFS. Over one-half of the children had families that had one or more prior contacts prior to the child's enrollment in the IB3 demonstration.

Nearly one-third of the cases were managed by DCFS at 45 days of case opening and approximately one-half of the children in the sample were initially placed with kin. A majority of the cases were opened due to a neglect allegation (80%), whereas 18% were opened because of physical abuse.

The above child characteristics are based on complete information, which was available from administrative data. There are other child characteristics, however, which must be estimated from incomplete administrative data because the information either was not recorded or was not entered into the automated data system. As shown in Table 5, the Latino origins of one-fourth of the full sample could not be determined because the ethnic heritage of the family was not recorded. The absence of information on ethnic origins was higher among the fiscal year 2014 and 2015 cohorts included in the Process Study and SRL Surveys. In spite of the limitations, it is estimated that a majority of the children were black (73%) and a majority were not Latino (61%).

Table 4 — Child Characteristics with Complete Data.

Case Characteristics	Administrative Data		Survey Data	
	Outcomes Study (N = 1889)	Process Study (N = 996)	Caseworker (N = 613)	Caregiver (N = 428)
Child sex				
Male	52%	51%	53%	51%
Female	48%	49%	47%	49%
Age at case opening				
Under 1 month	28%	29%	27%	30%
1 to 6 months old	21%	21%	21%	23%
7 to 11 months old	10%	10%	12%	9%
12 to 19 months old	12%	12%	12%	10%
20 to 35 months old	18%	19%	18%	17%
36 months and older	10%	11%	10%	11%
Fiscal year of case opening				
FY14	25%	46%	42%*	42%
FY15	30%	54%	58%*	58%
FY16	23%	--	--	--
FY17	22%	--	--	--
Case opening status				
Initial placement case opening	53%	52%	51%	52%
Placement from intact family case	24%	26%	26%	24%
Add-on to placement case	18%	16%	16%	17%
Reopened child case	6%	6%	6%	8%
Prior Family Contact with DCFS				
No prior contact	45%	46%	43%	42%
One prior contact	31%	29%	30%	28%
Two or more prior contacts	24%	25%	27%	30%
DCFS case management at 45 days				
No	73%	77%*	74%	78%
Yes	27%	23%*	26%	22%
Initial placement with kin				
No	45%	52%	53%	53%
Yes	55%	48%	47%	47%
Reason for case opening				
Abuse	18%	19%	18%	18%
Neglect	80%	79%	79%	79%
Dependency	2%	2%	2%	3%

Data entry lags accounted for some of the missing data on the 15% of the enrolled children who lacked risk level determinations. The extent of missing data is less of a problem among the children who were the subjects of the Process Study and SRL Survey. In spite of the incompleteness of the information, approximately one-half of the children were determined to be high risk and an additional 28% to 30%% were determined to be at moderate risk given their trauma experiences. It is important to note that children categorized as high and moderate risk had experienced significant trauma in at least one or more types of trauma.

Table 5 — Characteristics with Missing Data.

Case Characteristics	Administrative Data		Survey Data	
	Outcomes Study (N = 1889)	Process Study (N = 996)	Caseworker (N = 613)	Caregiver (N = 428)
Race of child				
Black or African American	73%	73%	72%	73%
White	25%	25%	25%	24%
Other	1%	1%	1%	1%
% Missing	1%	1%	2%	2%
Latino origins of child				
Mexican	6%	6%	6%	6%
Puerto Rican	3%	3%	2%	3%
Other Latino	8%	8%	9%	8%
Not Latino	61%	51%	52%	51%
% Missing	22%	31%	31%	31%
Risk level				
High	48%	52%	54%	52%
Moderate	29%	29%	28%	31%
Low	7%	8%	8%	7%
Deferred	2%	2%	3%	4%
% Missing	15%	8%	7%	7%

Caregiver Characteristics

The characteristics of caregivers differ based on their status as either a foster caregiver or a permanent caregiver, which includes birth parents, adoptive parents, and permanent guardians. There are two sources of data on permanent and foster caregivers: 1) the survey conducted by the SRL with 364 caregivers and 2) the assessment instruments compiled on the 728 caregivers who participated in the NPP program.

Table 6 displays the characteristics of the caregivers from the SRL Survey. The denominators for the percentages under Respondents are the unduplicated counts of caregivers who responded to the survey. The denominators under Children are the 428 children who were the subjects of the survey, some of whom shared the same caregiver.

Table 6 — Caregiver Characteristics by Sample Frame and Caregiver Survey.

Caregiver Characteristics	Respondents		Children	
	Permanent Caregivers (N = 120)	Foster Caregivers (N = 244)	Permanent Caregivers (N = 130)	Foster Caregivers (N = 298)
Race of caregiver				
Black or African American	52%	66%	52%	66%
White	31%	19%	31%	19%
Other	8%	7%	8%	7%
Multiracial	5%	3%	5%	4%
% Missing	4%	5%	4%	4%
Latino origins of caregiver				
Mexican	12%	9%	12%	8%
Puerto Rican	6%	3%	5%	4%
Other Latino	2%	1%	2%	1%
Not Latino	81%	87%	81%	86%
Caregiver age at interview				
Under 35 years old	28%	10%	27%	10%
35 to 54 years old	58%	63%	60%	61%
55 years old and older	13%	26%	12%	27%
% Missing	1%	1%	1%	2%
Caregiver education				
Less than BA degree	76%	61%	76%	62%
BA degree or higher	19%	32%	21%	33%
% Missing	5%	7%	3%	5%

Table 7 — Caregiver Characteristics by Sample Frame and Caregiver Survey (Continued).

Caregiver Characteristics	Respondents		Children	
	Permanent Caregivers (N = 120)	Foster Caregivers (N = 244)	Permanent Caregivers (N = 130)	Foster Caregivers (N = 298)
Occupational status				
Employed full time	53%	49%	53%	47%
Employed part time	18%	13%	18%	13%
Looking for work	8%	5%	9%	6%
Homemaker/Student	14%	17%	14%	17%
Retired/ Disabled	5%	14%	5%	15%
% Missing	2%	2%	1%	1%
Caregiver sex				
Male	15%	6%	15%	7%
Female	85%	94%	85%	93%
Relationship to birth parents				
Paternal kin	--	8%	--	7%
Maternal kin	--	28%	--	29%
Not kin	--	64%	--	64%

Table 7 displays characteristics of all parents and foster caregivers who participated in the NPP program and those who enrolled prior to July 1, 2017.

Table 8 — Characteristics of NPP Participants.

Caregiver Characteristics	All NPP Participants (N = 728)		Enrolled Prior to July 1, 2017 (N = 439)	
	Parent Version (N = 532)	Foster Caregiver Version (N = 196)	Parent Version (N = 314)	Foster Caregiver Version (N = 125)
Caregiver sex*				
Male	33%	23%	32%	17%
Female	67%	77%	69%	83%
Caregiver age at baseline*				
Under 35 years old	80%	18%	80%	14%
35 to 54 years old	19%	57%	19%	58%
55 years old and older	1%	25%	2%	28%
Caregiver education*				
Less than HS diploma	46%	29%	45%	26%
HS diploma/Some college	48%	47%	50%	48%
4-yr college or more	6%	24%	5%	26%
N Missing	6	1	2	1
Employment status*				
Employed full time	26%	53%	22%	52%
Employed part time	19%	13%	19%	12%
Looking for work	45%	21%	50%	21%
Disabled/ Retired	7%	11%	8%	14%
Other	3%	2%	1%	1%
N Missing	14	3	10	2
Income level*				
Not reported	41%	10%	42%	9%
Under $15,000	38%	18%	42%	18%
$15,000 to $25,000	11%	21%	9%	22%
$25,000 to $40,000	7%	14%	5%	14%
$40,000 to $60,000	2%	12%	1%	14%
$60,000 and above	1%	25%	0%	23%

ns: not statistically significant at the .05 level; * $p < .05$, ** $p < .01$, *** $p < .001$

Table 7 — NPP Participant Characteristics (continued).

Caregiver Characteristics	All NPP Participants (N = 728)		Enrolled Prior to July 1, 2017 (N = 439)	
	Parent Version (N = 532)	Foster Caregiver Version (N = 196)	Parent Version (N = 314)	Foster Caregiver Version (N = 125)
Ethnicity of caregiver [ns]				
Black or African American	61%	57%	63%	64%
White	13%	14%	9%	14%
Hispanic	24%	25%	27%	20%
Other	2%	4%	1%	2%
N Missing	13	0	6	0
Number of own children [ns]				
Childless	2%	4%	1%	2%
One child	26%	19%	26%	14%
Two children	23%	23%	23%	22%
Three to five children	39%	41%	40%	49%
Six or more children	10%	13%	11%	12%
Marital Status*				
Married	15%	45%	16%	42%
Unmarried partners	15%	5%	12%	5%
Divorced/separated	7%	13%	6%	15%
Widowed	0%	3%	0%	3%
Never married	63%	34%	65%	34%
N Missing	8	0	3	0
Experienced Abuse in Home*				
Yes	22%	13%	25%	17%
No	69%	80%	67%	77%
Not reported	9%	7%	8%	6%
Experienced Abuse Outside*				
Yes	19%	12%	21%	15%
No	73%	83%	70%	82%
Not reported	8%	5%	9%	3%

ns: not statistically significant at the .05 level; * $p < .05$, ** $p < .01$, *** $p < .001$

Permanent caregivers, who completed the SRL survey, included a slightly smaller percentage of African-Americans (52%) than foster caregivers (66%). Birth parents who participated in the NPP program were more evenly balanced compared to foster caregivers: 61% vs. 57% African-

American. There were similar distributions of non-Latino caregivers in both groups. Permanent caregivers in the SRL survey profiled younger in age: 28% were aged 34 years old and younger compared to 10% of foster caregivers; 13% were aged 55 years old and older compared to 26% of foster caregivers. The age differences were more pronounced among NPP participants, where permanent caregivers were almost exclusively birth parents: 80% were aged 34 years old and younger compared to 18% of foster caregivers; 1% were aged 55 years old and older compared to 25% of foster caregivers. Because only 37 of the permanent caregivers who responded to the SRL survey were birth parents (out of 130 permanent caregivers), the characteristics of NPP participants provide a more accurate portrait of the differences between birth parents and foster caregivers than the SRL survey.

Permanent caregivers in the SRL survey also reported fewer years of education on average: 78% had less than a four-year college education compared to 65% of foster caregivers. Again the differences were more pronounced among NPP participants: 94% of birth parents had less than a four-year college education compared to 76% of foster caregivers. Approximately equal percentages were employed full-time outside of the home (50%) in the SRL survey, whereas only 26% of birth parents were employed among NPP participants. In the SRL Survey, a larger percentage of permanent caregivers self-identified as males (15%) than foster caregivers (6%). There was a similar percentage-point difference among NPP participants, but one third of the birth parents were fathers compared to 23% of foster caregivers.

Focusing only on NPP participants, 15% of birth parents were married compared to 45% of foster caregivers. The differences in family size were negligible: 23% of parents and foster caregivers had two of their own children, approximately 40% had three to five children, and 10 of birth parents and 13% of foster caregivers had six or more of their own children.

The largest difference between birth parents and foster caregivers involved their financial status: 41% of birth parents did not disclose any source of income whereas 10% of foster caregivers failed to report their annual income. Among birth parents who reported an annual income, 64% said it was under $15,000, whereas among foster caregivers who reported an annual income, 20% fit into this income bracket. At the upper range of the income bracket, 25% of foster caregivers reported annual incomes in excess of $60,000. Only one percent of birth parents reported earning this much money on an annual basis.

Information on kinship ties between caregivers and children is available only from the SRL survey. Among foster caregivers, 26% were related to the child on the maternal side and 10% on the paternal side. Most non-kin foster caregivers reported they were licensed foster parents (97%) whereas less than 66% of kinship foster parents reported being licensed.

Data Analysis

Univariate and bivariate analyses were employed to summarize the characteristics of the children in the sample, program exposure and completion status, and to assess the comparability of agency clusters.

Results

Process Study: Local Agency Comparability (LADQ)

The first-tier of randomization was intended to distribute similarly performing agencies into intervention and comparison clusters. The cluster totals showed that the sums of the number of foster children, IV-E claimable children, and PROs were well balanced among the two clusters at time of assignment. In addition, it was hoped that the random assignment of agencies would also balance the two clusters with respect to agency structure, service delivery, agency expenditures and staff resources, staff and caregiver training, parenting training, trauma treatment, agency relationships, trauma-informed practice, evidence-based programs, director background, and local economic conditions.

To assess the comparability of agency clusters, DCFS administered the LADQ during the months of February and March of 2013 and again between the months of February and July of 2017. All but one agency (from the comparison cluster) completed the first round and 16 out of 18 still-active voluntary agencies completed the second round of the pencil-and-paper form.

There were 247 group comparisons between intervention and comparison agencies. Round one findings showed that random assignment mostly balanced the two clusters with respect to agency structure, service delivery, agency expenditures and staff resources, staff and caregiver training, parenting training, trauma treatment, agency relationships, trauma-informed practice, evidence-supported programs, director background, and local economic conditions. The two clusters were unbalanced on the following comparisons in which intervention agencies reported offering more additional post-permanency services (in addition to clinical, support, and financial services), elements of parent training and trauma treatment programs, and reduced funding ($p<.05$):

- Offer of post-permanency services:
    - Support networks after reunification
    - Any other services after reunification
    - Percent adopted/guardianship get services after
    - Financial services after adoption/guardianship
    - Any other services after adoption/guardianship
- Parent training programs:
    - Child development
    - Communication skills
    - Positive discipline
    - Real-life parenting
    - Traumatic triggers
    - Regulation of emotions
    - Ability to understand others
    - Daily, predictable routine
- Reduced funding.

Because of the large number of group comparisons, it is expected that some or all of the significant differences could have arisen by chance. Based on round one data, it can be assumed that the comparison cluster provides an adequate "counterfactual" for estimating the effects of IB3 services on the outcomes observed for families served by agencies in the intervention cluster.

The differences in post-permanency services disappeared during the second round of the questionnaire as intervention and comparison agencies similarly reported about their use of additional services for families after permanence. Also, at round two, while a smaller percentage of intervention agencies (66% vs. 71%; $p<.05$) reported providing support networks after reunification, a larger percentage of intervention agencies (22% v. 16% $p<.05$) provided financial services after adoption or guardianship compared to comparison agencies. These percentages reported were significantly different between the intervention and comparison groups. Moreover, there were no significant differences in parent training programs between intervention and comparison agencies at round two.

The questionnaire also asked questions about respondents' assessment of their agencies' readiness for a new trauma-informed program. There were no significant differences between the clusters at round one, but during the second-round respondents from intervention agencies reported a significantly higher average of readiness (about 75% ready vs. about 50% ready; $p<.05$) to adopt a new trauma-informed program compared to respondents from comparison agencies. These responses were based on agencies having an adequate number of families who could benefit from such a program, staff perceiving the advantage of implementing evidence-supported programs (EBPs), and their agencies' readiness to evaluate them.

Overall, the two clusters were balanced on most questionnaire items describing the characteristics of agencies and their services. Because of the number of tests, the small number of imbalances between the clusters at round one may be due to chance or different respondents between the two rounds rather than true differences. Notable findings at round two include the higher level of preparedness to implement trauma-informed practices and to evaluate evidenced-based programs among intervention agencies compared to comparison agencies. The full table of group comparisons can be found in Appendix A.

Process Study: Implementation Integrity

Output Indicator 1: Number and Percentage of Children Assessed (Coverage I)

The clinical services provided in the waiver included screening of both intervention and comparison cases and provision of evidence-supported interventions for children assigned to the intervention group. Of the 1889 children assigned to the IB3 demonstration, almost 90% of assigned children (N = 1645) were assessed for trauma and other functional impairments as of March 31, 2018 (see Table 8). The remaining 13% (N = 238) were coded as unassessed for a variety of reasons, including a delay in data entry as well as the transfer of case management responsibilities outside of the Cook County service area before screening could commence.

Table 9. Number and Percentage of Children Assessed

Fiscal Year		**Unassessed** (A)	**Assessed** (B)	**Total** (C)
FY14	Count	17	451	468
	Row%	4%	96%	100%
FY15	Count	34	525	559
	Row%	6%	94%	100%
FY16	Count	71	370	441
	Row%	16%	84%	100%
FY17	Count	116	299	415
	Row%	28%	72%	100%
TOTAL	Count	238	1645	1883
	Row%	13%	87%	100%

The assessment processes and the associated algorithm for determining risk resulting from trauma exposure is one of the most substantial innovations of the demonstration. Findings in this report reflect a balanced distribution of risk across intervention and comparison cases, which support the valid implementation of the risk determination processes for the waiver (Table 9). Even though higher than expected proportions of children screened as high risk (56%), which resulted in a waiting list for intensive dyadic (parent-child) interventions, referrals to small group NPP accommodated much of the need for services while caregivers waited for a CPP slot to open up.

There was universal screening of all assigned children within 45 days of case opening. Children were typically re-screened every 6 months. However, 44% (N=730) of the children assigned to the demonstration were not re-screened during the period of observation. Children who were screened more than once (N=915) either had no change in their risk level, a positive change, or a negative change. Of the children who were screened more than once and had known risk determinations, 15% were screened as high risk during their first screening and last observed

screening. Likewise, 16% of children with completed caregiver interviews experienced no change in their high-risk status. Regardless of initial risk status, 68% of children experienced no change in risk status at their last observed screening. Of those whose risk level changed, 12% experienced an improvement (e.g., from high risk to moderate risk) whereas 19% experienced a negative change (e.g., from low risk to high risk). Children in the comparison and intervention groups equally experienced no change or changes in their risk levels.

Table 10. Risk Level by Assignment Cluster

Risk Level		**Cluster**		**Total**
		Comparison	Intervention	
High	Count	438	463	901
	Col.%	55%	57%	56%
Moderate	Count	272	270	542
	Col.%	34%	33%	34%
Low	Count	64	59	123
	Col.%	8%	7%	8%
Deferred	Count	17	15	32
	Col.%	2%	2%	2%
TOTAL	Count	791	807	1598
		100%	100%	100%
Missing	Count	50	43	93

Chi square = .869; 3 *df*; p = .833.

Output Indicator 2: Number and Percentage of Program Participants (Coverage II)

During the first year of implementation, high-risk children were immediately referred to the CPP intervention. After this period, a CPP waiting-list was established due to limited resources. Thus, the parents and caregivers of high-risk children were referred to the NPP programs while waiting for a CPP slot to open up, which shows up in the spike of referrals in NPP-PV during the first quarter of 2014.

Table 10 shows a report of CPP referrals for high-risk children as of June 30, 2018. The percentages in the table come from CPP program data pulled by Chapin Hall in June 2018. Most of the referrals to CPP were for children and their foster caregivers.

Table 11. Referrals to CPP Program for Intervention Children Assessed as High Risk as of June 30, 2018					
Fiscal Year		**Referred to CPP**			
		Biological Father	Biological Mother	Foster Caregiver	Total
FY14	Count	2	17	63	82
	Row%	2%	21%	77%	100%
FY15	Count	3	19	75	97
	Row%	3%	19%	77%	100%
FY16	Count	2	18	21	41
	Row%	5%	44%	51%	100%
FY17	Count	0	1	6	7
	Row%	0%	14%	86%	100%
FY18	Count	0	0	1	1
	Row%	0%	0%	100%	100%
TOTAL	Count	7	55	166	228
	Row%	3%	24%	73%	100%

The number of CPP/NPP certified trainers.

The table below reflects the number of CPP and NPP trainers at the beginning of the implementation and the latest number of trainers available to serve IB3 families. The drop in certified trainers is due to staff turnover during the demonstration.

	Baseline	Current (as of December 18, 2018)
NPP	31	21
CPP	33	17

Referrals to parenting training as reported by caregivers**.**

In order to further assess differences in program referrals between treatment groups, the SRL queried caregivers about offers of and participation in parenting training and completion of NPP, CPP, or both programs sequentially. According to caregiver survey responses, 60% of children in permanent homes had caregivers who were referred or offered training in parenting skills, whereas 53% of children in foster homes were referred or offered parenting training.

Being assigned to the intervention group significantly boosted the chances of receiving an offer of parenting training compared to the comparison group. In the intervention group, 71% of children in permanent homes had caregivers who reported receiving an offer of parenting training compared to 52% of comparison children in permanent homes. Similarly, 62% of

intervention children still in foster homes had caregivers who received an offer compared to 44% of comparison children. The differences are statistically significant at the .05 level.

Table 12. Referred or Offered Training in Parenting Skills by Assignment Cluster

Risk Level		**Cluster**		**Total**
		Comparison	**Intervention**	
Children in Permanent Homes				
Yes	Count	39	39	78
	Col.%	52%	71%	60%
No	Count	36	16	52
	Col.%	48%	29%	40%
TOTAL	Count	75	55	130
		100%	100%	100%
Chi square = 4.727; 1 *df*; $p < .03$.				
Children in Foster Homes				
Yes	Count	66	91	157
	Col.%	44%	62%	53%
No	Count	84	57	141
	Col.%	56%	38%	47%
TOTAL	Count	150	148	298
		100%	100%	100%
Chi square = 9.138; 1 *df*; $p < .003$				

Logistic regression models for permanent caregivers and foster caregivers show that children assigned to the intervention group were two times more likely to receive an offer or referral to parenting training than children assigned to the comparison group.

Table 13. Logistic Regression Models for Offers or Referrals to Parenting Training

	Permanent Caregivers				**Foster Caregivers**			
	Complete		20 Imputations		Complete		20 Imputations	
	Odds Ratio	Sig. 2-tailed	Odds Ratio	Sig. 2-tailed	Odds Ratio	Sig. 2-tailed	Odds Ratio	Sig. 2-tailed
Intervention	**2.484**	**0.031**	**2.524**	**0.024**	**1.919**	**0.013**	**2.116**	**0.002**
Female	2.358	0.162	2.072	0.200	0.441	0.148	0.455	0.156
African American	1.075	0.886	1.132	0.796	1.691	0.163	1.401	0.356
Multiracial	0.606	0.655	0.963	0.969	**8.920**	**0.015**	3.300	0.130
Mexican American	0.857	0.840	0.846	0.813	3.033	0.079	1.721	0.307
Puerto Rican	3.207	0.341	4.996	0.172	0.842	0.821	1.190	0.804
Less than BA degree	0.730	0.551	0.774	0.614	0.813	0.539	0.964	0.912
Less than 35 yrs. old	0.957	0.928	1.117	0.812	0.850	0.725	0.683	0.395
55 yrs. And older	0.685	0.570	0.747	0.650	0.891	0.743	0.885	0.708
Employed part time	0.751	0.604	0.736	0.566	1.164	0.721	1.385	0.399
Looking for work	1.467	0.622	1.246	0.770	2.993	0.065	2.502	0.108
Retired/Disabled	4.588	0.212	2.470	0.413	1.309	0.561	1.154	0.739
Homemaker/student	0.450	0.233	0.412	0.149	0.886	0.748	0.724	0.366
Paternal kin					1.608	0.398	1.270	0.644
Not kin					**1.956**	**0.037**	**2.005**	**0.022**
Constant	0.305	0.264	0.341	0.290	1.557	0.693	1.631	0.656
Total N	121		130		268		298	
% Missing	7%		0.0%		10%		0.0%	

As displayed in the table on caregiver characteristics above (Table 6), a little over one-third of the surveyed children taken into foster care before the age of four resided in homes where the foster caregiver is biologically related to the child's mother or father. Four out of five of these relatives were from the maternal side and 20% from the paternal side.

The logistic regression analysis of referrals to parenting training indicated that kinship caregivers were less likely to recall being offered parenting training services than non-related caregivers. The results displayed in Table 12 show that this disparity is confined entirely to the comparison group. The 19-percentage point difference in the comparison group (31% vs. 50%) diminishes to insignificance (58% vs. 63%) in the intervention group. Thus, not only does assignment to the intervention group significantly increase referral rates across all caregivers. This so-called "interaction effect" also extends to the receipt of any parenting training, where kin caregivers in the intervention are much more likely to receive parenting training than kin caregivers in the comparison group (40% vs. 12%). It also extends to the completion of NPP or CPP services (2% vs. 18%). Table 13 shows the distribution of children whose caregivers reported being offered parenting training by relationship status and assignment group.

Table 14. Referred or Offered Training in Parenting Skills by Relationship and Assignment Cluster

Received		**Caregiver Relationship to Birth Parents**		**Total**
		Related	Not Related	
Comparison Group				
Yes	Count	16	50	66
	Col.%	31%	50%	44%
No	Count	35	49	84
	Col.%	69%	50%	56%
TOTAL	Count	51	99	150
		100%	100%	100%
				Chi square = 5.001, 1 *df*; $p < .025$.
Intervention Group				
Yes	Count	32	58	90
	Col.%	58%	63%	61%
No	Count	23	34	57
	Col.%	42%	37%	39%
TOTAL	Count	55	92	147
		100%	100%	100%
				Chi square = .343; 2 *df*; $p < .558$

Output Indicator 3: Number and Percentage of Program Participants by Assignment Cluster (Program Differentiation)

Despite the waiting list for CPP, only a small number of children were not referred to either CPP or NPP. Less than 10% of high-risk cases and less than 15% of moderate-risk cases in the intervention cluster were not referred to either CPP or NPP. The majority of families were referred to a combination of NPP-PV and NPP-CV or a combination of all three available

programs. Equally important, in regard to implementation integrity, is the near absence of cross-overs of comparison cases from services as usual to enrollment in one or more of the IB3 intervention services. Ninety-nine percent of both high and moderate risk cases have no record of referral to either the CPP or NPP programs. Thus, the magnitude of the potential impact of the IB3 interventions on permanency and well-being outcomes won't be diluted by the lack of program differentiation between services available to intervention subjects and those usual services available to comparison subjects. Of course, it can't be ruled out that the usual services available to comparison cases, such as parenting coaches and regular parent training, offer similar content to NPP and CPP. Based on observations of the programs available to families, there is ample reason to believe that the content of IB3 interventions is substantively different from the content offered with services-as-usual.

Tables 15 and 16 below show the distributions of comparison children in the sample frame whose caregivers received any training on parenting skills and children whose caregivers completed NPP and CPP services. While nearly 30% of permanent and foster caregivers in the comparison cluster reported receiving any training in parenting skills, only few of them reported completing NPP and CPP services.

Table 15. Received Any Training in Parenting Skills

Received		**Cluster**		**Total**
		Comparison	Intervention	
Children in Permanent Homes				
Yes	Count	22	23	45
	Col.%	29%	43%	35%
No	Count	17	14	31
	Col.%	23%	26%	24%
Not Offered	Count	36	16	52
	Col.%	48%	30%	40%
TOTAL	Count	75	53	128
		100%	100%	100%
Chi square = 4.352; 2 *df*; $p < .113$.				
Children in Foster Care				
Yes	Count	42	70	112
	Col.%	28%	47%	38%
No	Count	24	21	45
	Col.%	16%	14%	15%
Not Offered	Count	84	57	141
	Col.%	56%	39%	47%
TOTAL	Count	150	148	298
		100%	100%	100%
Chi square = 12.357; 2 *df*; $p < .002$.				

Table 16. Completed NPP or CPP Training

Risk Level		Cluster		Total
		Comparison	Intervention	
Children in Permanent Homes				
Yes	Count	0	12	78
	Col.%	0%	22%	60%
No	Count	75	43	52
	Col.%	100%	78%	40%
TOTAL	Count	75	55	130
		100%	100%	100%
Chi square = 18.028; 1 *df*; $p < .000$.				
Children in Foster Care				
Yes	Count	13	32	157
	Col.%	9%	22%	53%
No	Count	137	115	141
	Col.%	91%	78%	47%
TOTAL	Count	150	147[a]	297
		100%	100%	100%
Chi square = 9.914; 1 *df*; $p < .002$.				

Output Indicator 4: Services Received (Exposure)

Program data from October of 2018, which contain the latest count of program referrals and completions reported by IB3 program staff, show that there have been 943 referrals to NPP-Parent Version (NPP-PV) and 396 referrals to NPP-Caregiver Version (NPP-CV) throughout the waiver.

Referral to a program does not guarantee that participants receive the full dosage of services as intended. As of October 31, 2018, 38% children and their birth parents in the intervention group referred for the NPP-PV program successfully completed, whereas 44% of children and their foster caregivers referred to the NPP-CV program successfully completed the program.

Assigning the NPP status of completion to all siblings in a family cluster slightly increased the number of comparison cases that have at least one parent who completed the NPP program. However, the amount of cross-over from comparison to intervention would not bias any analysis because it results from siblings being assigned to different agencies for case management services.

The percentage of children with at least one parent who completed NPP treatment rose from 28% in fiscal year 2014 to 44% in fiscal year 2015. The lower percentage of NPP completions (28%)

in FY14 was likely due to more referrals to CPP at the time. The percentage of NPP completions declined to 38% in 2016 and bounced back to 45% in fiscal year 2017 (see Table 17).

Table 17. NPP Status for All 1,889 Children Assigned to the IB3 Demonstration

Fiscal Year of Case Opening	NPP Status	All Siblings		
		As Usual	IB3	Total
Fiscal Year 2014	Completed	2	75	77
		1.0%	28.0%	16.4%
	Not Completed	6	169	175
		3.0%	63.1%	37.2%
	Received No Treatment	194	24	218
		96.0%	9.0%	46.4%
	Total	202	268	470
Fiscal Year 2015	Completed	3	111	114
		1.0%	43.7%	20.4%
	Not Completed	3	120	123
		1.0%	47.2%	22.0%
	Received No Treatment	299	23	322
		98.0%	9.1%	57.6%
	Total	305	254	559
Fiscal Year 2016	Completed	2	71	73
		0.8%	38.2%	16.5%
	Not Completed	7	102	109
		2.7%	54.8%	24.7%
	Received No Treatment	247	13	260
		96.5 %	7.0%	58.8%
	Total	256	186	442
Fiscal Year 2017	Completed	2	83	85
		0.9%	44.6%	20.3%
	Not Completed	3	92	95
		1.2%	49.5%	22.7%
	Received No Treatment	227	11	238
		88.6%	5.9%	53.8%
	Total	256	186	442
Fiscal Years 2014 - 2017	Not Completed	19	483	502
		1.9%	54.0%	26.6%
	Completed	9	340	349
		0.9%	38.0%	18.5%
	Received No Treatment	967	71	1038
		97.2%	7.9%	54.9%
	Total	995	894	1889

Table 18 summarizes program completion status by program type and risk level. However, due to delays in contracts and data entry, data through March 31, 2018 were used to summarize participation in IB3 programs by risk status. According to these data, 24% of children referred to CPP completed the program, 17% completed NPP-CV, and 26% completed NPP-PV.

Majority of referrals to IB3 programs did not complete the full course of treatment. As shown in Table 18, 45% of referrals completed CPP or were still attending CPP, whereas 28% completed or were still attending NPP-PV. Completion rates were highest for birth parents enrolled in NPP-PV. The lowest completion rates were observed among caregivers who were referred to the NPP-CV program.

Table 18. Program Completion Status by Program Type and Risk Level (As of March 31, 2018)

Program Type	Completion Status		Risk Level		Total
			High	Moderate	
CPP	**Completed**	Count	54	11	65
		Col.%	**23%**	**24%**	**24%**
	Attending	Count	44	13	57
		Col.%	**19%**	**29%**	**21%**
	Non-Completion	Count	130	21	151
		Col.%	**57%**	**47%**	**55%**
	TOTAL	Count	228	45	273
		Col.%	**100%**	**100%**	**100%**
NPP-PV	**Completed**	Count	100	35	135
		Col.%	**31%**	**19%**	**26%**
	Attending	Count	9	2	11
		Col.%	**3%**	**1%**	**2%**
	Non-Completion	Count	208	152	360
		Col.%	**66%**	**80%**	**71%**
	TOTAL	Count	317	189	506
		Col.%	**100%**	**100%**	**100%**
NPP-CV	**Completed**	Count	61	34	95
		Col.%	**20%**	**14.5%**	**17.4%**
	Attending	Count	0	0	0
		Col.%	**0%**	**0%**	**0%**
	Non-Completion	Count	250	200	450
		Col.%	**80%**	**85.4%**	**82.5%**
	TOTAL	Count	311	234	545
		Col.%	**100%**	**100%**	**100%**

Completion Status as Reported by Caregivers

The differences in the offer of training carries forward to differences in actual participation rates between treatment groups: 43% of intervention children in permanent homes had caregivers who reported receiving parenting training compared to 29% in the comparison group and 47% of intervention children in foster homes had caregivers who reported receiving training compared to 28% in the comparison group. The group differences for children in permanent homes were not statistically significant; however, the sample of children in permanent homes was too small to rule out sampling error. On the other hand, the group difference highlighted above for children in foster homes was statistically significant ($p<.05$).

According to survey responses, approximately one-half of the caregivers who received parenting training in the intervention group fulfilled their requirements by completing NPP, CPP, or the two programs in sequential order. There were no permanent caregivers in the comparison group who reported completing NPP or CPP, but 9% of foster parents in the comparison group (cross overs) reported completing NPP or CPP training. Overall, 22% of children in the intervention group had caregivers who completed NPP, CPP, or both programs. Even though only one out of every five children assigned to the intervention group had caregivers who reported completing the intended treatment, the odds of completion were five times larger than the odds of cross-over completion from the comparison group.

Output Indicator 5: Participant responses to program sessions (Participant Responsiveness)

In order to assess participant responsiveness to the IB3 demonstration, caregivers in the sample frame were asked how helpful was NPP and CPP. Of the 22% of caregivers in the intervention group who completed NPP or CPP training, 65% of surveyed caregivers found the NPP program to be very or extremely helpful and 67% found the CPP program to be very or extremely helpful. There were no differences in satisfaction levels among participants who completed one or both programs sequentially. Caregivers reported feeling slightly more enthusiastic about NPP than CPP: 33% found NPP to be extremely helpful whereas 17% found CPP to be extremely helpful. This sample size of completers, however, is too small to draw conclusions about the significance of the difference.

In addition to caregivers' survey responses, researchers at Chapin Hall at the University of Chicago conducted focus groups and interviews with selected professional staff and individual parents and foster caregivers who were the referred to IB3 services. The focus groups were conducted separately with the following staff: IB3 continuous quality improvement (CQI) team, intervention agency caseworkers, legal representatives, Integrated Assessment (IA) screeners, CPP providers and NPP providers. These focus group findings were summarized in the interim evaluation report.

Table 19. How Helpful Was NPP and CPP?

Risk Level		Completed Program		Total
		NPP or CPP	Both NPP/CPP	
How Helpful was NPP?				
Not at all helpful	Count	1	0	1
	Col.%	3%	0%	2%
A little helpful	Count	5	2	7
	Col.%	15%	11%	14%
Somewhat helpful	Count	6	4	10
	Col.%	18%	22%	20
Very Helpful	Count	11	6	17
	Col.%	33%	33%	33%
Extremely Helpful	Count	10	6	16
	Col.%	30%	33%	31%
TOTAL	Count	33	18	51
		100%	100%	100%
Chi square = .815; 4 *df*; $p < .936$				
How Helpful was CPP?				
Not at all helpful	Count	1	0	1
	Col.%	17%	0%	4%
A little helpful	Count	1	1	2
	Col.%	17%	7%	8%
Somewhat helpful	Count	1	4	5
	Col.%	17%	22%	21%
Very Helpful	Count	2	10	12
	Col.%	33%	56%	50%
Extremely Helpful	Count	1	3	16
	Col.%	17%	17%	31%
TOTAL	Count	6	18	24
		100%	100%	100%
Chi square = 4.178; 4 *df*; $p < .382$.				

Parents and foster parent interviews were conducted to collect detailed information on the individual experiences of subjects referred to the IB3 programs. Interviews were conducted with parents and foster parents who were identified as eligible for IB3 services. The interviews included both engaged and non-engaged subjects. For purposes of the study, non-engaged subjects were defined as those parents and foster caregivers who were assigned to the intervention group but had not completed IB3 services and were not actively participating in IB3

services at the time of the interview recruitment. A brief summary of overall focus group findings is as follows:

- Core IB3 program services were well-received *when* parents and foster caregivers participated in services.
- Logistics and communication were the primary barriers regarding engagement and participation of both parents and foster caregivers in IB3 services.
- Program communication was the primary issue affecting staff (caseworkers mainly) perceptions of the program and its interventions. The CQI team identified caseworkers to be the most important in terms of communication and creating buy-in amongst the parents/foster parents. However, feedback from caseworkers suggests they knew the least about the services/interventions.
- The CPP waitlist was identified across most focus groups with staff as an issue and cause for concern.
- Birth parents and foster parents expressed general frustration and fatigue with regard to IDCFS service expectations. This seems to significantly impact their follow-up with IB3 as well as other IDCFS services.

Appendix D includes a summary of findings from a focus group conducted with foster caregivers who completed NPP-CV.

Implementation Challenges

The challenge of implementing evidence-based practices in organizations is well established. Within the context of the child welfare system, the Illinois Birth through Three (IB3) Waiver Demonstration Project has engaged in ongoing implementation and continuous quality improvement strategies that have been instrumental in addressing implementation challenges, promoting engagement and participation in the primary evidence-based interventions (NPP and CPP), and achieving positive outcomes. The Appendix E contains two tables documenting a full list of overall implementation challenges and how they were addressed.

Discussion

Although it was projected that 2,080 children would be enrolled in the demonstration by the end of June 2017, the shortfall of 193 children from projected enrollments did not have a significant impact on the evaluation. Between the enrollment period of July 1, 2013 and June 30, 2017, a total of 1,889 children were assigned to the waiver. These children accounted for 21% of all age-eligible children entering legal custody during this time period.

The purpose of the process study was to assess the intervention's integrity (fidelity with which the program was implemented). The two-tiered, random allocation procedure established the comparability of the agencies involved in the demonstration. The random allocation procedure assigned a balanced number of children to the intervention and comparison groups. At baseline, the intervention and comparison agencies were mostly similar with respect to agency structure,

service delivery, agency expenditures and staff resources, staff and caregiver training, parenting training, trauma treatment, agency relationships, trauma-informed practice, evidence-supported programs, director background, and local economic conditions. At the second wave, intervention agencies reported a higher level of preparedness to implement trauma-informed/evidence-based programs.

There were 1029 children who entered foster care between July 1, 2013 and June 30, 2015 who were eligible for caseworker and caregiver interviews. Over 80% of children had information from completed caseworker surveys, and between 43% and 48% of children had interview data from birth parents and foster caregivers. Although there were some child characteristics with incomplete information, most characteristics of the children in the sample were balanced various sources of data.

Majority of the children enrolled were assessed at least once for trauma and other functional impairments. Results of each screening helped determined a child's level of risk and need for service. There was a balanced distribution of risk across intervention and comparison cases. However, there was a higher than expected proportion of children screened as high risk, which resulted in a waiting list for CPP and referrals to small group NPP. Therefore, not all parents and caregivers were able to enroll in the appropriate intervention based on the screening assessment, but they were able to receive a group-based, trauma-informed treatment. Majority of families received a combination of NPP-PV and NPP-CV or a combination of all three programs. Results from the process study showed an expected differentiation between services available to intervention families and those usual services available to comparison families. Thus, differences in any outcomes can be attributed to differences in programs and practices available to intervention and comparison cases.

Moreover, the expectation was for each child to be assessed every 6 months to determine changes in trauma symptoms and developmental capabilities. However, only 40% of children in the demonstration were screened more than once and had known risk determinations. Of those who children, almost 70% had no change in risk status at their last observed screening.

At least half of the caregivers in the sample frame reported receiving an offer of any parenting training; if a child was in the intervention group, the chances of receiving an offer was significantly higher.

According to the most recent program data, an average of 40% of birth parents and caregivers completed an IB3 program. All in all, the IB3 programs were well-received by parents and caregivers who participated in services. It is possible that implementation challenges may have influenced the intervention's integrity. Logistics and communication issues were some of the primary barriers regarding engagement and participation of both parents and caregivers in IB3 services.

OUTCOME STUDY

Key Research Questions

The Outcome Study applies the process outlined by the Framework, described above, to assess the four dimensions of validity:

- **Statistical Validity:** the extent to which there is a statistically significant association between the interventions and the desired outcomes.
- **Internal Validity:** the extent to which there is confidence that the statistical association results from a causal relationship between the interventions and the outcomes.
- **External Validity:** the extent to which the causal relationship is generalizable across variations in different populations and settings (e.g. voluntary child welfare agencies and IDCFS offices).
- **Construct Validity:** the extent to which the causal relationships correspond to their higher-order theoretical constructs as specified in the Logic Model.

Passing through successive tollgates from statistical to construct validity contributes to the generalizability of the results. Using this process, the Outcome Study aimed to answer the following key research questions:

1. Are a higher proportion of children in the intervention group reunified within 2, 3 and 4 years from removal compared to children in the comparison group?
2. Do children in the intervention group spend fewer average days in foster care from placement to permanence than children in the comparison group?
3. Do more children with developmental delays in the intervention services group receive appropriate early intervention and early education services than similar children in the control group?
4. Do children in the intervention services group exhibit positive improvements in early childhood development, behavior problems, cognitive functioning, and adaptive/pro-social behavior as compared to similar children in the comparison group?
5. Do children reunified or placed permanently in an adoptive or guardianship home in the intervention services group experience fewer repeat maltreatment reports and re-enter foster care at a lower rate than children in the comparison group?

It was expected that favorable responses to the research questions would provide evidence of the validity of the IB3 intervention in causing improvements in permanency and well-being outcomes. Failure to achieve the intended outcomes would reflect either a problem with the integrity of implementation or a problem with the validity of the intervention (Klein & Sorra, 1996).

Key Outcomes

Key proximal outcomes of the outcome study include:

- Reunification, adoption, guardianship, and overall permanency rates
- Time in care

The key distal outcomes of the study include:

- Mitigation of trauma and child well-being: Emotional, behavioral, social, and cognitive functioning

These outcomes were derived from the demonstration's theory of change, which states that receipt of evidence-based, trauma-informed programs will increase permanence rates, improve the well-being of children, and prevent re-entry of children into foster care. The outcomes and their indicators are summarized in Table 20 below.

Sample & Comparison/Cohorts

The sampling plan was designed to optimize the representativeness of the target population of foster infants and toddlers in Cook County, Illinois (external validity) and to permit valid inferences to be drawn about the impact of the intervention on safety, permanency and wellbeing outcomes (internal validity). The outcome study used data collected on the total number of enrolled children, including the subset of children who were eligible for caseworker and caregiver surveys. Children eligible for the demonstration were randomly assigned to either the intervention or comparison group using a two-tiered unbiased allocation procedure described above in the Sampling Plan. Children assigned to the services-as-usual cluster received the typical services offered by DCFS and other child welfare agencies. Thus, it was possible for children in the comparison group to have received parenting training. However, it was assumed that the provision of evidence-based, trauma-informed services, such as NPP and CPP, would result in higher proportions of children achieving timely permanence and improved well-being than children receiving parenting training and other services as usual—that may or may not be trauma-informed or evidenced-based.

The characteristics of the full sample (N=1889) and the survey sample (N==996) were described above in the Process Study (See Tables 4-7).

Data Sources and Data Collection

Child Well-being: Information on child well-being (as reported by children's caregivers and caseworkers) were collect by the Survey Research Lab. The survey was designed to answer a range of questions about the needs and service use of children, parents, and caregivers who come in contact with the child welfare system.

Permanency: Data on proximal safety and permanency outcomes were provided by IDCFS to Chapin Hall, who linked the data at the child level to the IB3 database that is maintained by IB3 Continuous Quality Improvement (CQI) teams.

The permanency outcomes were tracked with existing administrative data from the Statewide Automated Child Welfare Information System (SACWIS) and related information from Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System State Level Data (NCANDS) as reported biennially to the Administration on Children, Youth and Families (ACF).

Federal law and regulation require state child welfare agencies to collect case-level information on all children for whom the agency is responsible for placement, care, or supervision, and on children adopted under the auspices of the agency. AFCARS includes information on children in care, as well as on children's foster and adoptive parents. These data were obtained and entered by local child welfare staff members. State child welfare agencies compile and submit these data to the federal government every six months. AFCARS is considered to be the "official record" and is used by the ACF for many purposes, including monitoring, reporting, and fiscal determinations.

NCANDS is currently a voluntary data collection and analysis system created in response to the requirements of the Child Abuse Prevention and Treatment Act. States submit NCANDS data annually. NCANDS includes a compilation of key aggregate child abuse and neglect statistics, as well as case-level information from child protective service agencies. Although NCANDS is a voluntary system, states must submit certain aggregate statistics to the federal government. NCANDS includes data on child abuse and neglect reports, child victims, and child perpetrators.

AFCARS and NCANDS data were merged at the child and family case level. In addition to establishing measures of case-level entry characteristics, such as child age and foster care placement history, AFCARS data (e.g., removals, length of placement, discharge dates) were used to assess proximal and distal outcomes on permanency and time in foster care.

Table 20 below describes the outcomes, their indicators, data sources, collection interval, and organization responsible for providing or managing the data.

Table 20 — Key Proximal and Distal Outcomes

Outcome	**Measure/ Indicator**	**Data Source(s)**	**Collection Interval**	**Organization Responsible**
Placement Stability	% with 2 or more moves within 12 months	Integrated Data Base	Quarterly	UNC, UWM, Chapin Hall
Reunification, adoption, guardianship	Days in foster care; hazard rate; # of reunifications, adoptions, and guardianships	Integrated Data Base	Quarterly	UNC, UWM, Chapin Hall
Re-entry	% re-enter foster care within 24 months	Integrated Data Base	Quarterly	UNC, UWM, Chapin Hall
Social/emotional functioning	DECA	ILSCAW	Onetime follow-up	SRL
Trauma & Mental Health Problems	CANS	North-western University	Baseline, 6, 12 & 18 months	IA Screener
Parenting and Child Rearing Attitudes	Adult-Adolescent Parenting Inventory (AAPI-2)	NPP Only ILSCAW	Baseline, 8 weeks & 16 weeks (Intervention Group Only) Onetime follow-up (Both Groups)	NPP Trainer SRL

Data Analysis

Using the Framework described above, the data analysis plan followed the "tollgate" approach to test the validity and generalizability of the intervention. First, to test for statistical validity, standard models of linear, logistic, and hazards regression were used to assess whether intervention effects were statistically disguisable from no difference. Next, the characteristics of the children assigned to intervention and comparison groups were analyzed for statistical equivalence within the bounds of chance error. It was assumed that if statistical equivalence between the intervention and comparison groups is successfully achieved through rotational

assignment, each of the study's hypotheses can be tested by comparing the simple means or proportion differences in outcomes between the intervention and comparison group. Statistical equivalence was checked by regressing the binary assignment indicator (0=comparison, 1=intervention), expressed as log odds, against a set of covariates that were potentially important predictors of the primary outcome of timely permanence. Any serious imbalances in the distributions of predictors between the intervention and comparison groups were addressed by following appropriate steps to adjust for the imbalances in the regression models. The data analysis plan also included modeling change in well-being trajectories of children in the survey sample. The third tollgate involved testing for interaction effects between assignment group and several key population characteristics and settings that were potential moderators of the intervention effects. The last tollgate of construct validity involved data analyses to assess the extent to which causal effects are actually transmitted through participation in IB3 programs: assignment to the intervention could still have an effect on outcomes, which is not transmitted exclusively through full participation in IB3 interventions. Children in the intervention group, for example, who are not referred to IB3 services may be perceived as less problematic and hence safer bets for reunification than children in the comparison group who aren't subjected to the same level of scrutiny and comparative assessment.

Results

Statistical Conclusion Validity: Is The Association Between Proximal Permanency Outcomes And Assignment Group Statistically Significant?

Table 21 displays the cross-tabulations for measures of family permanence. Overall, analyses show that the IB3 intervention group had substantially higher rates of family unification (reunification and kinship guardianship) than the comparison group. Nearly one-third of children in the intervention group were reunified or discharged to the guardianship of kin compared to 22% in the comparison group. The difference of 7 percentage points for the full sample and 9% percentage points for the survey sample are statistically significant.

Because adoption rates were higher in the comparison group, the difference in overall permanency rates between intervention and comparison groups were narrowed to nearly 4 percentage points. Findings showed, for children in the FY14 and FY15 cohorts who were eligible for the caregiver survey, there were equivalent proportions of children who remained in long-term foster care in the comparison group compared to the intervention group.

The collection of caseworker and caregiver information on these children offers a unique opportunity to compare the child well-being differences for statistically equivalent samples of infants and toddlers who experienced somewhat different pathways to family permanence.

Table 21 — Permanency Outcomes for Full Sample and for Children Eligible for Caregiver Surveys as of September 30, 2018.

		Full sample (FY14-FY17)		**Survey Sample (FY14, FY15)**	
		Comparison	Intervention	Comparison	Intervention
Reunification					
Yes	Count	186	213	106	140
	Col. %	18%	24%	22%	28%
No	Count	809	681	383	367
	Col. %	82%	76%	78%	72%
Total	Count	995	894	489	507
	Col. %	100%	100%	100%	100%
		Chi2=7.44; 1 df; **p<.01**		Chi2=4.71; 1 df; **p<.05**	
Guardianship					
	Count	32	48	27	42
Yes	Col. %	3%	5%	5%	8%
No	Count	963	846	462	465
	Col. %	97%	95%	95%	92%
Total	Count	995	894	489	507
	Col. %	100%	100%	100%	100%
		Chi2=5.38; 1 df; **p<.05**		Chi2=2.94; 1 df; p=.08	
Adoption					
Yes	Count	188	135	155	118
	Col. %	19%	15%	32%	23%
No	Count	807	759	334	389
	Col. %	81%	85%	68%	77%
	Count	995	894	489	507
	Col. %	100%	100%	100%	100%
		Chi2=4.78; 1 df; **p<.05**		Chi2=8.87; 1 df; **p<.01**	
Family Unification					
Yes	Count	218	261	133	182
	Col. %	22%	29%	27%	36%
No	Count	777	633	356	325
	Col. %	78%	71%	73%	64%
Total	Count	995	894	489	507
	Col. %	100%	100%	100%	100%
		Chi2=13.20; 1 df; **p<.001**		Chi2=8.71; 1 df; **p<.01**	
Permanence					
	Count	406	396	288	300
Yes	Col. %	41%	44%	59%	59%
	Count	589	498	201	207
No	Col. %	59%	56%	41%	41%
	Count	995	894	489	507
Total	Col. %	100%	100%	100%	100%
		Chi2=2.34; 1 df; p=.12		Chi2=.00; 1 df; p=.92	
Total		1889		996	

A logistic regression model was also used to test whether there is a relationship between family unification and group assignment. Results from this model showed that group assignment was statistically associated with family unification and that the odds of reunifying with a parent or family member (e.g., grandparent) were 46% higher for children in the intervention compared to children in the comparison group ($p<.01$).

Based on these findings, the demonstration passes the first tollgate of statistical conclusion validity: the intervention is associated with higher family unification rates for children assigned to the intervention group.

Internal Validity: Are The Intervention And Comparison Groups Statistically Equivalent?

Although there is evidence that the intervention is associated with higher family unification rates, rotational assignment can lead to imbalances in the composition of the treatment groups, which could threaten the internal validity of inference that the IB3 intervention is the "cause" of the improvement. However, rotational assignment resulted in a well-balanced allocation of all children enrolled in the demonstration to intervention and comparison conditions according to indicators of risk, age at case opening, reason for case opening, and gender. Differences in the local ecologies of communities served by intervention and comparison agencies and DCFS offices resulted in some systematic imbalances with respect to ethnicity, case management by DCFS offices, year of case opening, IV-E eligibility, and whether the child's case was an add-on from an intact family case. For example, there was a larger proportion of Hispanic children who were served by intervention agencies than comparison agencies. This imbalance is due to Cook County's Central region, which serves many of the predominately Latino communities in the city of Chicago and fell into the intervention cluster.

These imbalances necessitated the inclusion of indicators of these differences as statistical controls into data analyses in order to minimize the threats of selection and history bias to the internal validity of the findings.

Table 22. Statistical Equivalence of the Intervention and Comparison Groups at Baseline

Case Characteristics	Cluster	
	Comparison	Intervention
Child sex		
Female	47%	48%
*Child ethnicity****		
Black or African American	79%	68%
White	20%	32%
Hispanic*	13%	23%
Other	1%	2%

Note: *$p<.05$**;** **$p<.01$**;** ***$p<.001$

Table 22. Statistical Equivalence of the Intervention and Comparison Groups at Baseline (Continued)

Case Characteristics	Cluster	
	Comparison	Intervention
Age at case opening		
0-1 month	30%	27%
1-6 months	21%	21%
7-11 months	9%	11%
12-19 months	12%	11%
20-35 months	18%	19%
36+ months	10%	11%
*Case opening status**		
Initial child case opening	53%	52%
Add-on to family case	19%	16%
Add-on from intact family case	22%	26%
Reopened child case	6%	6%
Prior Family Contacts		
None	44%	47%
One	31%	29%
Two or more	25%	24%
Initial placement with relative		
No	54%	56%
Yes	46%	44%
Risk level		
High	55%	57%
Moderate	34%	33%
Low	8%	7%
Deferred	2%	2%
*IV-E eligibility ****		
Yes	66%	57%
No	34%	43%
*DCFS case management at 45 days***		
No	76%	69%
Yes*	24%	31%
Maltreatment		
Neglect	81%	80%
Abuse	17%	18%
Dependency	1%	2%
*Year of case opening****		
FY14	20%	30%
FY15	31%	28%
FY16	26%	21%
FY17	23%	21%

Data collected from caseworkers and current caregivers offer another check on the similarity of the intervention and comparison groups at baseline (not shown in table). The two groups were statistically similar with respect to type of case opening and risk assessment. Approximately one-half of the children in both groups were taken directly from their parents' custody and placed into foster care as an initial case opening. Another 15-16% were add-on cases to previously opened cases. These were primarily newborns of parents who already had children in state custody. The remainder were children taken from intact or reunified family cases where family preservation or reunification service proved insufficient to protect the children from harm. Approximately one-half of the children assessed at baseline scored in the high-risk range. These included children who scored high on trauma experiences and in the clinical range on the DECA or ITSC scales. The two groups were also evenly balanced on the proportions of children who fell into the moderate, low, and deferred risk groups. SRL asked caseworkers if any of the problems listed in Table 23 were active at the time of investigation. As shown in the Table 23, comparison and intervention groups were mirror images of each other with respect to the problems identified at investigation.

Table 23. Caseworker Reported Problems at Time of Investigation

Problems at Investigation		**Cluster**		**Total**
		Comparison	Intervention	
Alcohol Abuse	Count	80	84	164
	Col.%	26%	26%	26%
Other Drug Abuse	Count	148	153	301
	Col.%	49%	48%	48%
Serious Emotional Problems	Count	179	186	365
	Col.%	59%	59%	59%
Domestic Violence	Count	151	159	310
	Col.%	50%	50%	50%
TOTAL	Count	304	318	622

*No statistically significant differences at the .05 level

Internal Validity: Is There A Causal Relationship Between The Interventions And Outcomes?

RESEARCH QUESTION 1: Are a higher proportion of children in the intervention demonstration group reunified compared to children in the comparison group?

Several logistic regression models were estimated using permanency data through September 30, 2018. Simple logistic regression models with the intervention assignment as the only predictor showed that the odds of reunification with birth parents for children assigned to the intervention group were 36% higher than for children not assigned to the intervention group. The odds ratio increases to 46% higher when children who were placed under the permanent guardianship of

kin or fictive kin are combined with reunifications (family unification). The results are similar for the survey sample. The odds ratio for family unification further rises to 57% higher when the sample is restricted to children who were removed from their parents' custody after 6 months of age. There was only a marginally significant intervention effect for children removed at birth or before 6 months of age.

Table 24. Permanency Outcomes for Children Assigned to the Intervention Group as of September 30, 2018

Permanency Outcome	**Total Enrolled (N=1889)**		**Survey Sample (N=996)**	
	Odds Ratio	Sig. 2-tailed	Odds Ratio	Sig. 2-tailed
Reunification	1.36	**.006**	1.37	**.030**
Family Unification	1.46	**.000**	1.49	**.003**
Adoption	.76	**.029**	.65	**.003**
Permanent Home	1.15	.125	1.01	.929

On the other hand, the odds ratio for adoption was 24% lower for children assigned to the intervention group than for children not assigned to the intervention group. This adoption difference was significant only among children removed at birth or before 6 months of age. There was no difference in adoption odds among children removed after 6 months of age. Therefore, the impact of the IB3 intervention is best understood as shifting permanency outcomes towards family unification away from adoption rather than boosting overall permanency rates. When all three permanency outcomes of reunification, guardianship, and adoption are combined, the difference in permanency outcomes narrows to statistical insignificance.

Arguably family unification is the more relevant outcome than overall permanency rates because the IB3 interventions are intended primarily to engage and improve the parenting attitudes and practices of birth parents and secondarily those of foster and relative caregivers. An important policy issue that the variation in types of permanency outcomes raises is the extent to which reasonable efforts at family unification are adequately being addressed under usual permanency planning practices in Cook County. Rates of family unification were higher for children assigned to IB3 agencies (29% vs. 22%, $p<.001$). Because agencies were randomly selected to offer IB3 services and children were rotationally assigned to intervention and comparison agencies, it may be reasonably inferred that the availability of IB3 services influenced the observed differences in the types of permanency outcomes. The emphasis placed by IB3 on clinical services for birth parents might have encouraged IB3 agencies to unify children with their families, who otherwise might have been adopted under permanency planning practices as usual.

When analyzing the subset of children in the sample whose parent(s) completed the NPP program, results showed a 20% increase in the odds of family unification. Thus, a child has a greater chance of reunification or kin guardianship if any one of their parents complete NPP than a child whose parent(s) do not complete NPP. Also, results suggest that children who are referred and complete NPP are twice as likely to unify with family compared to children who are not referred and do not complete NPP. However, the subset of children and their caregivers who are able and willing to complete the NPP program are not a random sample of the total sample of

children enrolled in the demonstration. It is possible that several child, family, and agency factors play a role in determining who ultimately completes the intervention. Nevertheless, the availability or offer of IB3 services is associated with an increased likelihood of family unification and those who comply with referrals and complete the intervention have an even greater likelihood of family reunification than children whose parent(s) do not complete NPP.

Similar results were found for the 996 children who were eligible for the caregiver survey. Among the 996 children, there were equivalent proportions who remained in long-term foster care in the comparison group (43%) compared to the intervention group (43%). Thus, family unification is the more relevant outcome for the IB3 evaluation than overall permanency rates considering that the primary goal of the IB3 interventions is to preserve primary attachments by unifying children with their birth or extended families without terminating parental rights. A secondary goal is to improve the developmental and well-being outcomes for the children who remain in long-term foster care.

When child age and other important predictors of family unification are added to the logistic regression model, the intervention effect remains significant for the total enrolled but falls above the .05 threshold using a two-tailed test for the survey sample. However, the impact of intervention assignment on family unification is **significant** using a one-tailed test (p=.037). The odds ratio for both samples are similar (1.26 vs. 1.23). Failure to achieve a significant result using a two-tailed test for the survey sample is largely due to the 50% drop in sample size.

Table 25. Permanency Outcomes for Children Assigned to the Intervention Group as of September 30, 2018

Family Unification	**Total Enrolled (N=1889)**		**Survey Sample (N=996)**	
	Odds Ratio	Sig. 2-tailed (p<.05)	Odds Ratio	Sig. 2-tailed (p<.05)
Intervention	1.263	0.013	1.233	0.073
IV-E eligibility	0.835	0.062	0.710	0.004
Abused	1.472	0.000	1.472	0.004
Initially placed with kin	1.317	0.006	1.468	0.002
Prior family contacts	0.759	0.000	0.878	0.105
Age at removal				
Birth to 1 month	1	-	1	-
Ages 1 to 6 mos	1.165	0.307	1.361	0.098
Ages 7 to 11 mos	0.879	0.490	0.841	0.471
Ages 12 to 11 mos	1.237	0.205	1.513	0.043
Ages 20 to 35 mos	1.125	0.444	1.228	0.289
Ages 36 mos plus	1.245	0.208	1.372	0.150
Year of case opening				
FY14	1	-	1	-
FY15	1.248	0.056	1.252	0.062
FY16	1.183	0.229	-	-
FY17	1.105	0.595	-	-

RESEARCH QUESTION 2: Do children in the intervention group spend fewer average days in foster care from placement to permanence than children in the comparison group?

The differences in permanency pathways can be further refined by taking into account variations in both permanency type and time to family permanence. Figure 6 illustrates how the family unification differences unfold over time. Two years after removal, 12% of children assigned to services as usual had been unified with their families compared to 14% of children assigned to IB3 services. Four years after removal, 32% of children assigned to services as usual had been unified with their families compared to 38% of children assigned to the intervention group. Thus, children in the IB3 group are more likely to be unified with their parents or placed under the guardianship of kin without severing parental rights than children in the comparison group.

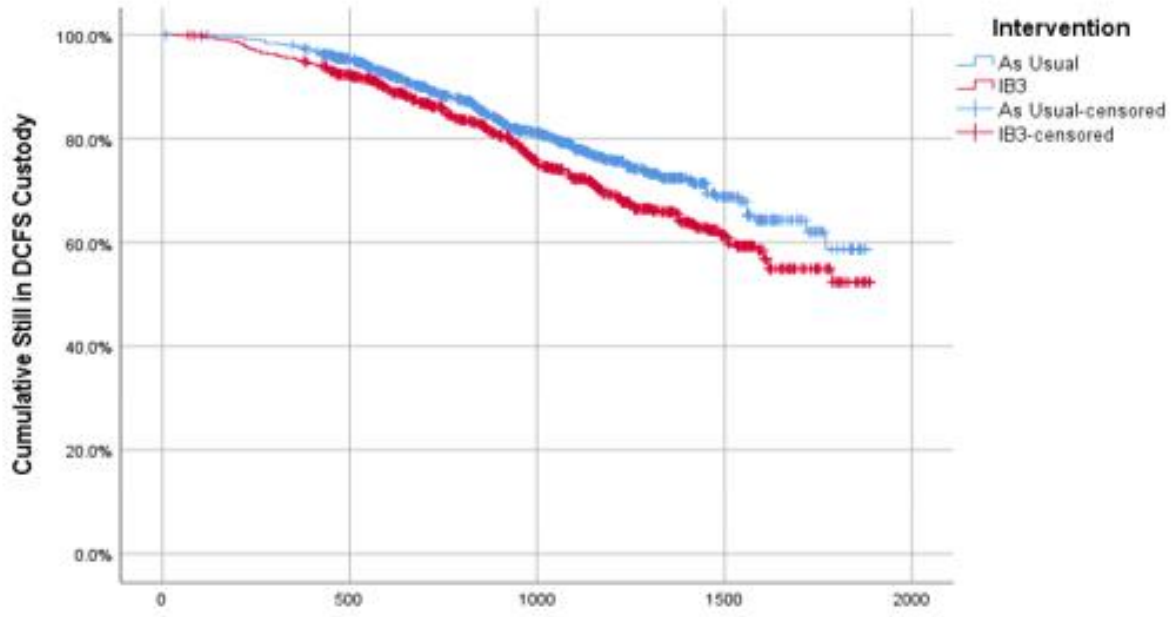


Figure 6. Cumulative Proportion Unified with Birth Parents or Permanent Kin Guardians

Family Unification					
Group	Children	Family Unified	% Unified		
			2 years	3 years	4 years
Comparison	995	218	12.2%	22.2%	32.0%
Intervention	894	261	14.5%	28.8%	38.3%

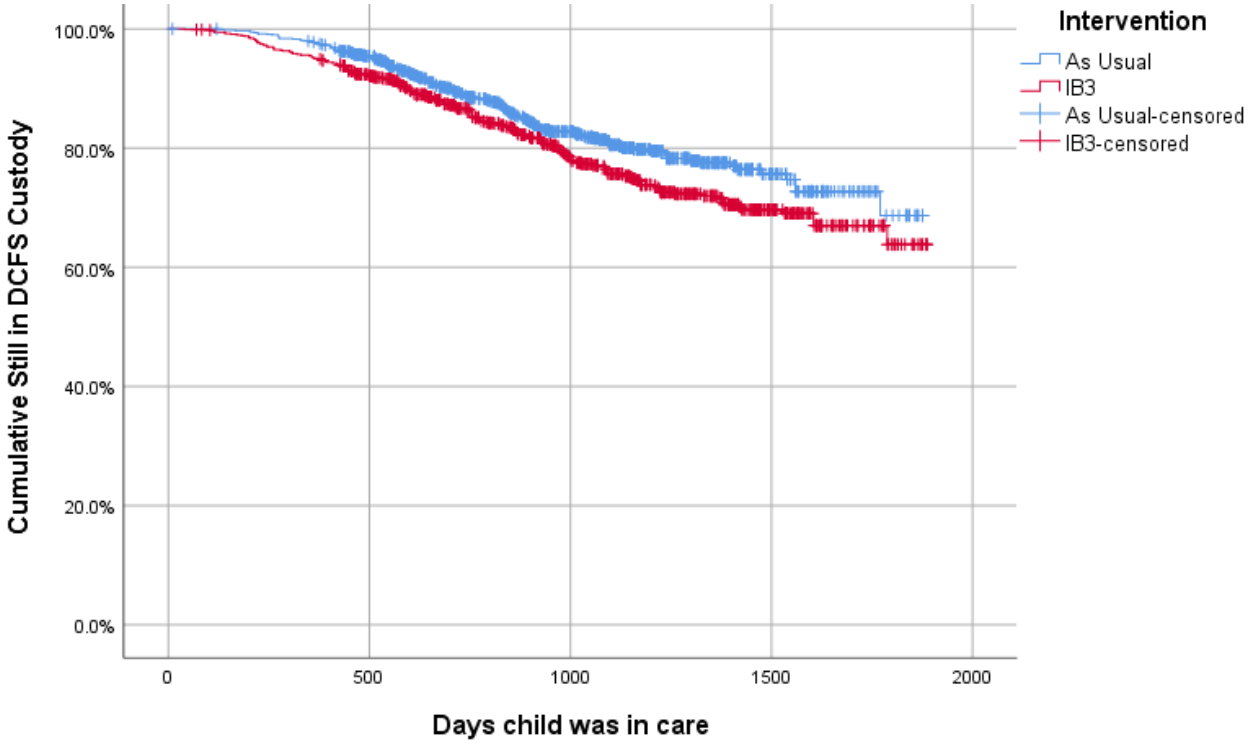


Figure 7. Cumulative Proportion Unified with Birth Parents

Reunification					
Group	Children	Reunified	% Reunified		
			2 years	3 years	4 years
Comparison	995	186	11.2%	19.8%	25.4%
Intervention	894	213	14/0%	25.3%	31.1%

Taking days since removal into consideration, the simple hazards model with intervention assignment as the only predictor showed that the transition rate to family unification at any duration after removal was 27% higher for children assigned to the intervention group than for children not assigned to the intervention group ($p<.01$). Similar results hold for the 996 children who were eligible for the caregiver survey ($p<.05$).

The transition rate rises to a 31% difference when the sample is restricted to children who were removed from their parents' custody after 6 months of age. Again, there were no significant intervention effects for children removed at birth or before 6 months of age. This result likely reflects the difficulty of fostering meaningful attachment relationships with birth parents when children are removed at birth or taken shortly after they are born**.** As was true with the simple odds model, children assigned to the intervention were 30% less likely than children in the comparison group to transition to adoption at any time period after removal ($p<.01$). As a

consequence of the higher rate of adoption in the comparison group, the difference in the overall transition rate to family permanence between the two groups diminished to zero.

When statistically controlling for child-level characteristics[5] and using a two-tailed test, findings continued to show a significant intervention effect as well as higher likelihoods of achieving family unification among children with the following characteristics: primary reason for case opening was physical abuse, were 12 months of age or older, and were of Mexican-American descent. Limiting the analysis to the 996 children in the sample frame yielded similar results.

As mentioned previously, including additional covariates, which contain missing information for some children, reduced the analytic sample size and the model's statistical power. However, Table 26 also displays results from using multiple imputation to handle the missing data in the multivariate analysis.

Table 26. Hazards Regression Models for Family Unification Outcomes

	Total Enrolled				**Sample Frame**			
	Complete		5 Imputations		Complete		20 Imputations	
	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed
Intervention	**1.330**	**0.020**	**1.317**	**0.004**	**1.306**	0.079	**1.283**	**0.037**
Female	1.224	0.089	1.185	0.073	1.268	0.110	1.199	0.120
African American	0.894	0.248	0.987	0.781	0.949	0.587	1.004	0.936
Mexican American	**1.631**	**0.010**	**1.478**	**0.014**	**1.554**	**0.048**	**1.510**	**0.036**
Abuse	**1.656**	**0.000**	**1.676**	**0.000**	**1.588**	**0.005**	**1.653**	**0.000**
High Risk	0.880	0.348	0.878	0.276	1.088	0.623	1.000	1.000
Under 1 month	1		1		1		1	
1 to 6 months old	1.335	0.131	**1.469**	**0.015**	1.421	0.144	**1.744**	**0.005**
7 to 11 months old	1.181	0.494	1.288	0.197	1.054	0.868	1.234	0.402
12 to 19 months old	1.509	0.059	**1.692**	**0.003**	**1.698**	**0.047**	**2.019**	**0.001**
20 to 35 months old	**1.494**	**0.050**	**1.624**	**0.004**	1.342	0.252	**1.722**	**0.010**
36 months and older	1.484	0.111	**1.749**	**0.003**	1.591	0.125	**1.792**	**0.016**

[5] Covariates included child sex, initial placement with kin, abuse reason, type of case opening, child screened as high risk at baseline and Mexican-American descent.

Table 27. Hazards Regression Models for Family Unification Outcomes (Continued).

	Total Enrolled				Sample Frame			
	Complete		5 Imputations		Complete		20 Imputations	
	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed	Hazards Ratio	Sig. 2-tailed
New placement	1		1		1		1	
Add-on placement	0.867	0.471	0.989	0.942	1.033	0.894	1.198	0.344
Disrupted family case	0.778	0.119	0.825	0.114	0.821	0.314	0.840	0.234
Re-opened placement	0.680	0.154	0.773	0.214	**0.412**	**0.036**	0.655	0.119
Fiscal 2014	0.730	0.227	0.806	0.942	1		1	
Fiscal 2015	0.948	0.831	1.108	0.114	1.308	0.083	**1.374**	**0.011**
Fiscal 2016	0.954	0.854	1.136	0.214	--	--	--	--
Total N	1,237		1,889		627		996	
% Missing	34.5%		0.0%		37.0%		0.0%	

RESEARCH QUESTION 3: Do more children with developmental delays in the intervention services group receive appropriate early intervention and early education services than similar children in the control group?

In the survey sample, equivalent proportions of children in permanent homes and in foster care had been tested for learning problems or special needs at least once in their lives. Similar proportions of children had been told by school or health professionals that the child has a learning problem, special need, or developmental disability. Permanent caregivers and foster caregivers equally reported that the child in their homes were enrolled in a special education program. These children represented 71% of the survey sample.

There was a marginally significant difference between the intervention and comparison groups with respect to enrollment in special education programs. A larger proportion of children in the comparison group were reported by their caregivers as being currently enrolled in a special education program at the time of survey administration compared to children in the intervention group (75% vs. 67%; p=.064). Moreover, approximately 42% of children who had been told by a school or health professional that they have a learning disability reported being enrolled in special education services. Among those who had been told they have a learning disability, equal proportions in the intervention and comparison groups were receiving special education services (see Table 27).

Table 28. Group Differences in Receipt of Special Education Services

Received Special Education Services		Comparison	Intervention
No	Count	13	10
	Col %	15%	15%
Yes	Count	71	58
	Col %	84%	85%
	Total	84	68
		Chi2=.017; 1 df; p<.895	

RESEARCH QUESTION 4: Do children in the intervention services group exhibit positive improvements in early childhood development, behavior problems, cognitive functioning, and adaptive/pro-social behavior as compared to similar children in the comparison group?

The Impact of Assignment to IB3 services on Children's Emotional/Behavioral problems

One of the aims of the demonstration project was to alleviate the trauma experienced by children so that they would have improved prospects of recovering in a supportive environment from adverse childhood experiences. Thus, the evaluation focused on the impact of the intervention on children's emotional and behavioral problems, trauma symptoms, and developmental growth.

Table 28 displays differences in how caregivers in the comparison and intervention groups responded to the survey question "In your opinion, does the child have emotional, behavioral, learning, or attentional problems?" Within the intervention group, a greater proportion of unrelated caregivers than kin caregivers endorsed problems (60% vs. 26%; p<.001).

A simple regression model, using the sample of children with completed caregiver interviews, showed no significant intervention effect on children's emotional/behavioral problems. However, post-hoc analyses showed the intervention effect varied according to the relationship of the caregiver to the child. While there were no differences among caregivers assigned to the comparison group, kin foster caregivers assigned to the intervention were significantly less likely to report child emotional/behavioral problems than non-kin foster caregivers. This finding suggests that either children placed with kin experience fewer emotional/behavioral problems as a result of the offer of parenting training than their counterparts in the comparison group or are less likely to perceive children's behaviors as problematic as a result of the training.

Table 29. In Your Opinion, Does Child Have Emotional, Behavioral, Learning, or Attentional Problems?				
Received		**Foster Caregiver Relationship to Birth Parents**		**Permanent Caregiver**
		Related	Not Related	
Comparison Group				
Yes	Count	23	49	29
	Col.%	45%	50%	40%
No	Count	28	50	44
	Col.%	55%	50%	60%
TOTAL	Count	51	99	73
		100%	100%	100%
	Chi square = 0.686; 1 *df*; $p < .408$			
Intervention Group				
Yes	Count	14	55	69
	Col.%	26%	60%	40%
No	Count	41	36	33
	Col.%	74%	40%	60%
TOTAL	Count	55	91	55
		100%	100%	100%
	Chi square = 16.834; 1 *df*; $p < .000$			

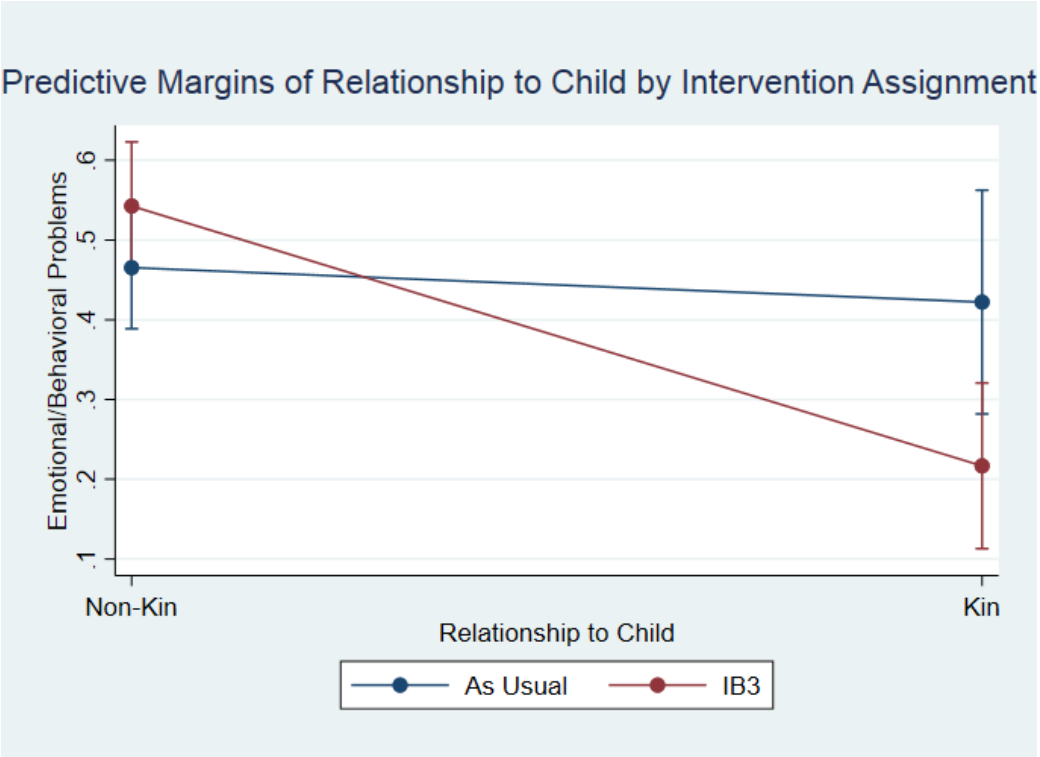


Figure 8. Predictive Margins of Relationship to Child and Intervention Assignment

Changes in Children's Social/Emotional Functioning Over Time

A multilevel growth curve approach was used to investigate change trajectories in children's scores on the Devereux Early Childhood Assessment (DECA), which is administered to parents and caregivers as part of the integrated assessment. This multilevel growth curve approach is particularly useful for yielding insights into patterns over time, even when sample sizes vary at different screenings (i.e., unbalanced data). For the current analysis, we focused on children with four DECA outcomes—attachment, initiative, self-regulation, and total protective factors—measured repeatedly at four consecutive screenings. Information from four screenings were used to measure trends in children's social and emotional functioning over time. Thus, children with 3 or fewer DECA outcomes were excluded from the analysis. Although some children have more than 4 screenings, analyses were limited to the first four screenings because of the smaller sample sizes at later screenings.

Sample

Because each caregiver was only screened up to the time of permanence or last day of observation, the longitudinal data (repeated DECA measures) have varying sample sizes ($N_{Screening1}$ = 1,702, $N_{Screening2}$ = 916, $N_{Screening3}$ = 395, $N_{Screening4}$ = 148). Table 29 breaks down the sample sizes for all four DECA outcomes for the four consecutive screenings. The table also shows the extent of reduction in sample sizes after each assessment of the intervention and comparison groups. The overall trend in percentage drop in the sample sizes over time is similar for both groups.

Table 30. Sample Size Distribution Based on DECA Assessments

DECA outcomes	Screening period	Overall Sample		Comparison Group		Intervention Group	
		Sample size	% drop from prior screening	Sample size	% drop from prior screening	Sample size	% drop from prior screening
Attachment	1st	1702		885		817	
	2nd	916	46%	408	54%	508	38%
	3rd	395	57%	172	58%	223	56%
	4th	148	63%	59	66%	89	60%
Initiative	1st	1701		884		817	
	2nd	916	46%	408	54%	508	38%
	3rd	395	57%	172	58%	223	56%
	4th	148	63%	59	66%	89	60%
Self-regulation	1st	609		310		299	
	2nd	485	20%	194	37%	291	3%
	3rd	307	37%	127	35%	180	38%
	4th	146	52%	57	55%	89	51%
Protective factor	1st	1642		851		791	
	2nd	858	48%	406	52%	452	43%
	3rd	342	60%	168	59%	174	62%
	4th	123	64%	59	65%	64	63%

Growth Trajectories in DECA Scores

Appendix B presents the average trajectories (growth curves) of children's DECA outcomes, and Figures 9 to 11 illustrate the typical (average) DECA profiles for the intervention and comparison groups and the entire sample.

Overall trends

The predicted DECA scores (intercept) at the first screening is around 50 points (initiative, b = 50.79, attachment, b = 48.59, and self-regulation, b = 46.72, $p < .001$). Overall, the entire sample experienced an upward rate of change for all outcomes over time. This rate of change (linear slope) is faster for the attachment outcome (b = 4.42, $p < .001$) followed by self-regulation (b = 3.62, $p < .05$), with initiative experiencing the slowest rate of upward trajectory (b = 2.87, $p <$ .01). However, it is worth noting that the rate of upward change fluctuates over time, except for the self-regulation trajectory. In other words, children start off doing better on several of the subscales, but the progress slows down, and children start to backslide at different rates. The deceleration in the growth trajectory is more rapid for attachment (b = -0.9, $p < .001$) compared to initiative (b = -0.59, $p < .001$) and self-regulation outcomes (b = -0.51, p = .08).

Differences in growth trajectories between intervention and comparison groups

As shown in Appendix B, the results of the subgroup analyses reveal varying significance levels in the rates of change between the intervention and comparison groups. Among the intervention group, the initial upward change was only significant for the attachment and self-regulation scores (attachment, b = 2.15, $p < .05$, initiative, b = 0.19, p = .85, and self-regulation, b = -1.04, $p < .05$), while the comparison group experienced statistically significant initial rate of change in all three outcomes (attachment, b = 4.47, $p < .001$, initiative, b = 2.91, $p < .01$, and self-regulation, b = 3.79, $p < .05$). Concerning the long-term downward trend, the comparison group's faster initial upward trajectory was brief because the group also experienced more statistically significant declines in the long-term compared to the intervention group. As shown in Appendix B, none of the subsequent long-term decelerations in DECA scores among the intervention group was statistically significant at the .05 significance level. To the contrary, the comparison group experienced statistically significant long-term downward trends in their attachment (b = -0.95, $p < .001$) and initiative scores (b = -0.61, $p < .01$).

Further analyses reveal that at the first screening, children in the intervention and comparison groups have similar levels of social and emotional functioning. Overall, changes in the DECA scores for the intervention group are characterized by an upward growth trajectory. However, their upward trajectory between the first and second screenings differs from their counterparts in the comparison group. For example, the average DECA attachment score for the comparison group (M = 50.21) was higher than the average score for the intervention group (M = 48.01), although the difference was not statistically significantly (p = .16). This finding suggests that while children in the intervention group are functioning better at their second screening, they are not functioning better than children in the comparison group. Alternatively, the finding may suggest that caregivers in intervention group, as a result of knowledge exposure from participation in IB3 services, can better identify deficits in children's social/emotional functioning compared to caregivers receiving services as usual.

Despite a greater rate of change between the first two screenings, findings suggest that children in the comparison group experience a downward trend in DECA scores after the second screening. In two out of the three outcomes, the comparison group starts at an "advantage" with slightly higher DECA scores than the intervention group, but by the 4th screening, the intervention group's scores are higher than the comparison group's scores. One possible explanation for this downward trend among children in the comparison group is the end of the "honeymoon phase," as caregivers realize at subsequent screenings that children are not functioning as well as they had hoped at the beginning at the child's entry into foster care. Alternatively, the downward trend may be due to a deterioration in child functioning as a result of no provision of trauma-informed parenting training. Overall, the results suggest that offering trauma-informed parenting programs can improve children's social and emotional over time compared to offering no services or services as usual to children in foster care who have experienced one or more traumas.

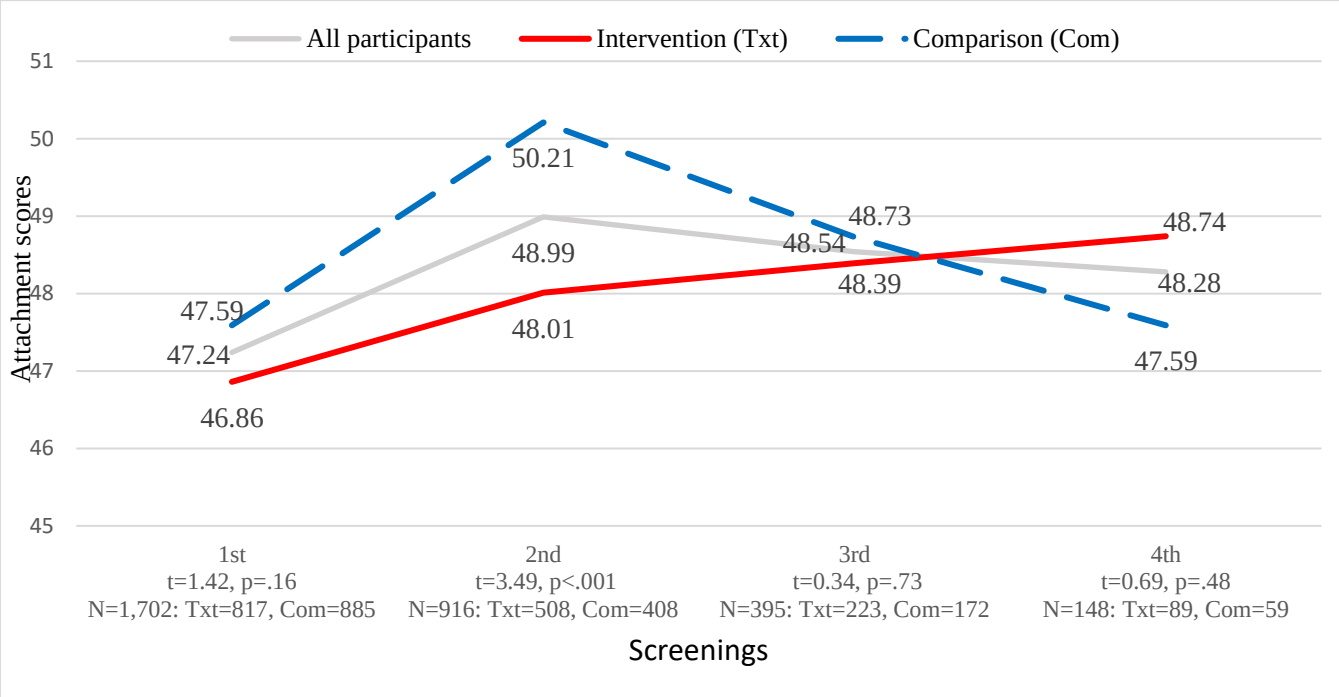


Figure 9. Trajectory Plots of Average Attachment Scores for Intervention and Comparison Groups Based on the DECA Assessment

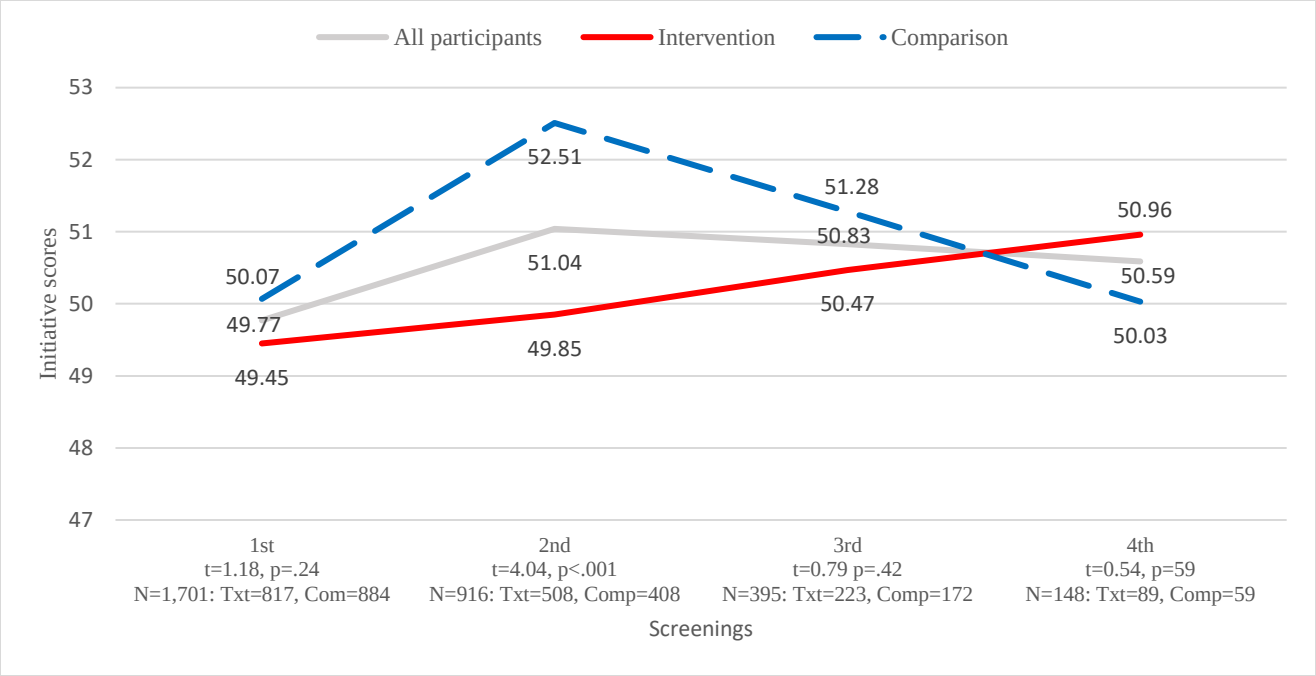


Figure 10. Trajectory Plots of Average Initiative Scores for Intervention and Comparison Groups Based on the DECA Assessment

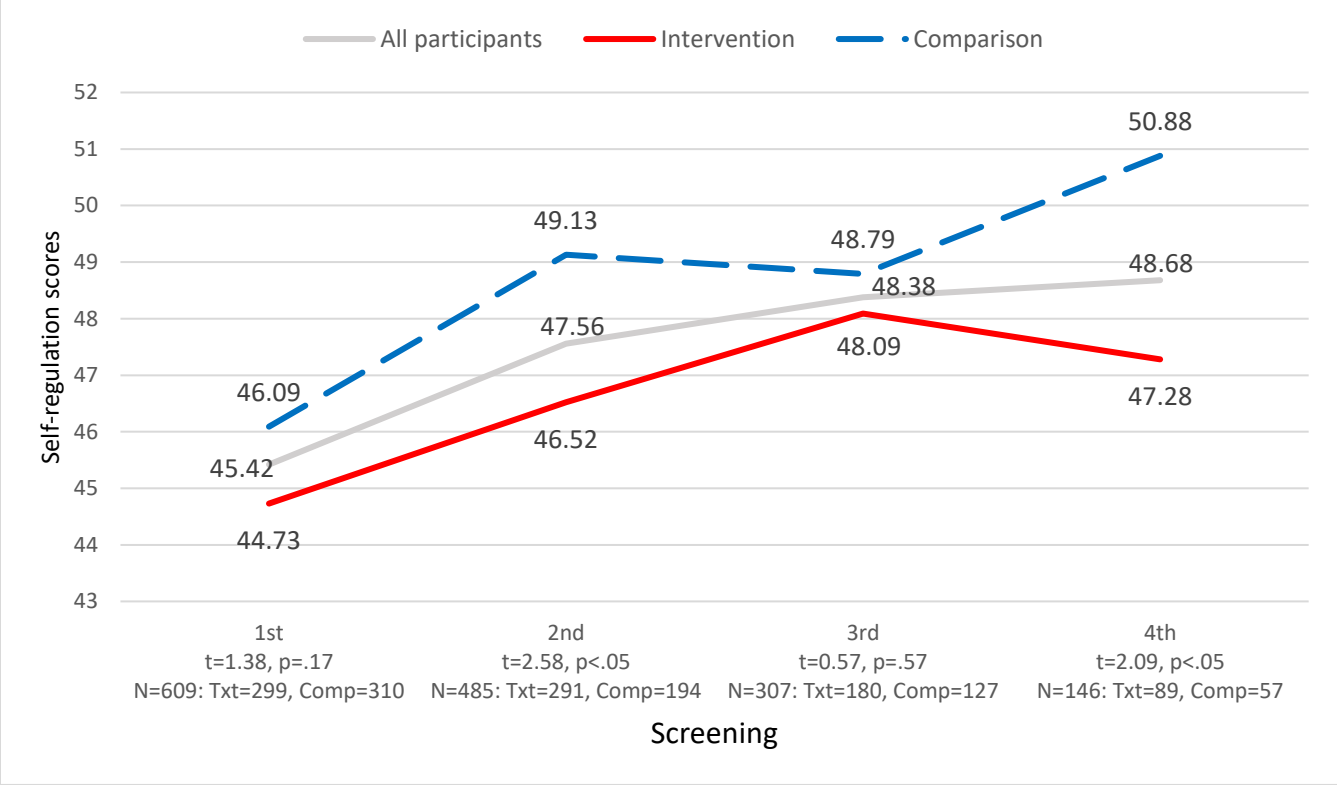


Figure 11. Trajectory Plots of Average Self-Regulation Scores for Intervention and Comparison Groups Based on the DECA Assessment

RESEARCH QUESTION 5: Do children reunified or placed permanently in an adoptive or guardianship home in the intervention services group experience fewer repeat maltreatment reports and re-enter foster care at a lower rate than children in the comparison group?

Because foster care re-entry was a rare occurrence during the study's observation period, no data analyses were conducted to estimate the impact of intervention assignment on repeat maltreatment reports and re-entry rates.

Is Exposure To The IB3 Interventions Improving Parenting Competencies? (Construct Validity)

The IB3 theory of change is predicated on the assumption that improvements in parenting competencies will enhance early brain development and provide a responsive parenting environment that will allow children to be returned to parental custody. One of the mechanisms that is critical to responsive parenting is empathy with the normal developmental needs of children. This can be particularly challenging when caring for pre-verbal children who express their needs by crying or signaling through non-verbal cues. Fortunately, as a species, humans are innately equipped to respond appropriately, but sometimes signals get crossed. Personal trauma experiences, insecure attachments relationships in one's own childhood, and antiquated child-rearing advice, which is no longer valid, can interfere with the proper protection, care, and discipline of children. Both CPP and NPP are evidence-based interventions that attempt to improve caregivers' abilities to interpret, value, and respond sensitively to the normal developmental needs of children.

The IB3 demonstration relies on the Adolescent and Adult Parenting Inventory (AAPI-2) to measure the degree to which such goals are being achieved. The AAPI-2 is the revised and re-normed version of the original AAPI first developed in 1979. The inventory is designed to assess the parenting and child rearing attitudes of adult and adolescent parenting and pre-parenting populations. The AAPI-2, like its predecessor, is a validated and reliable inventory that is predictive of abusive parenting. Responses to the inventory discriminate between the parenting behaviors of known abusive parents and the behaviors of non-abusive parents. The AAPI-2 is used by NPP providers to assess changes in the parenting and child rearing attitudes of programs participants. Responses to the AAPI provide an index of risk assessment in five specific parenting and child rearing behaviors scored from 1 (highest risk) to 10 (lowest risk) as described in Table 30 below.

Table 31. AAPI-2 Subscales

Subscale	Construct	Description
A	Expectations of Children	High risk involves inappropriate expectations that exceed the normal developmental capabilities of children. Tends to be demanding and controlling.
B	Empathy toward Children's Needs	High risk involves low levels of empathy in which the caregiver does not understand or value children's normal developmental needs. Children must act right and not be spoiled.
C	Use of Corporal Punishment	High risk sanctions hitting, spanking, and slapping of children as appropriate and required. A strong disciplinarian who lacks understanding of alternatives to corporal punishment is considered to be high risk.
D	Parent-Child Role Responsibilities	High risk tends to use children to meet self-needs. They expect children to make life better by providing them love, assurance, and comfort.
E	Children's Power and Independence	High risk tends to view children with power as threatening. They tend to view independent thinking as disrespectful.

Even though child welfare policy strives to adhere to the principle that no child should be removed from parental custody for reasons of poverty alone, continuing financial hardship can pose a substantial barrier to reunification after children have been taken into foster care for child protective reasons. The income effect is especially pronounced for women. Figure 12 shows that that the predicted probability of reunification rises steeply for birth mothers from 23% among NPP participants who reported no sources of income to more than 50% for mothers who reported annual incomes of $25,000 of more.

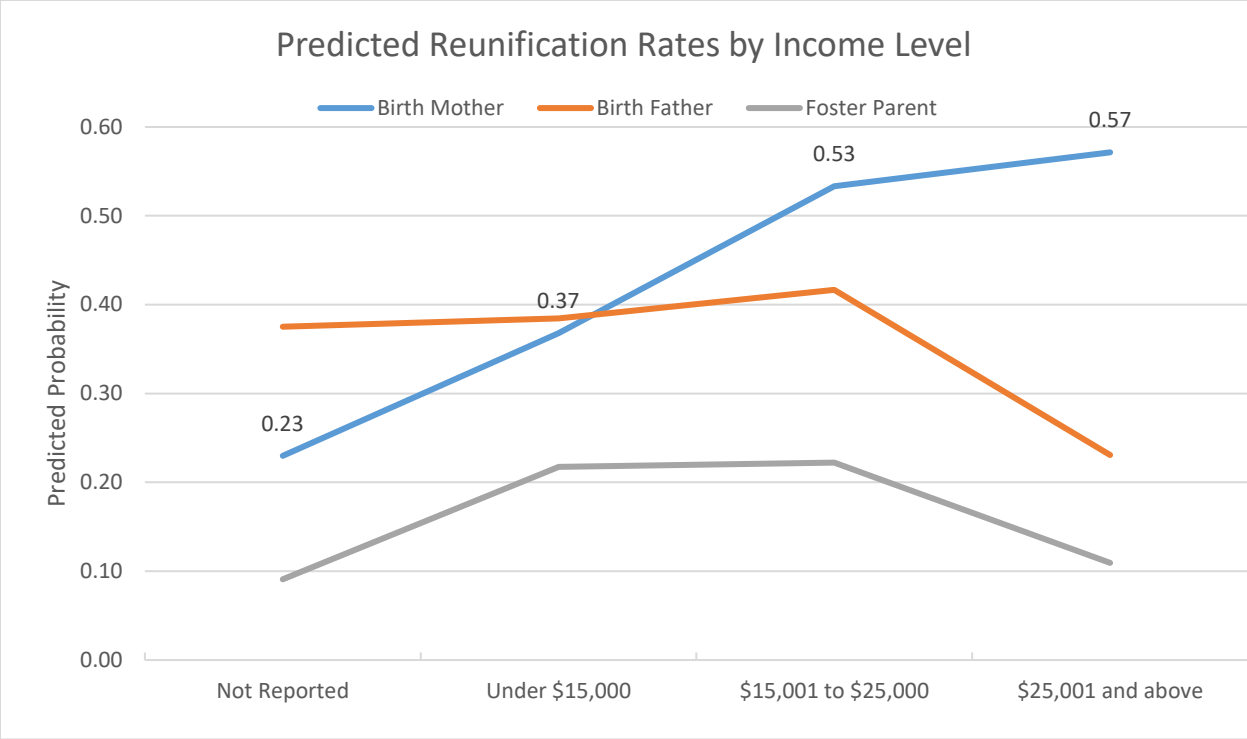


Figure 12. Predicted Reunification Rates by Income Level

Even though financial hardship is an important predictor of reunification for birth mothers, completion of NPP training and parenting competences as measured by the AAPI-2 scale are independently associated with reunification. Approximately 85% of NPP participants who complete an AAPI-2 assessment at baseline complete NPP training and the post-test AAPI-2 assessment at follow-up. As shown in Table 31, the duration of NPP training for birth parents is generally between 3 and 6 months. Because the training is shorter for foster caregivers, 80% completed training in less than 3 months.

Table 32. Completion Rates among Caregivers who Initiated NPP Training

Caregiver Characteristics	All NPP Participants (N = 728)		Enrolled Prior to July 1, 2017 (N = 439)	
	Parent Version (N = 532)	Foster Caregiver Version (N = 196)	Parent Version (N = 314)	Foster Caregiver Version (N = 125)
Completed Post-Test				
No	27%	17%	17%	15%
Within 90 days	16%	81%	11%	82%
Between 90 and 180 days	51%	1%	64%	1%
After 180 days	6%	1%	8%	2%

The distribution of AAPI-2 scores for birth mothers indicate a generally higher level of risk compared to general population norms. Approximately 16% of the general population scored in the high-risk range compared to 32% of birth mothers in the IB3 sample. Birth fathers and foster caregivers, on the other hand, profiled similarly to the general population. There is one exception: More parents and caregivers in the IB3 sample scored in the high-risk range (around 30%) at baseline compared to the general population with respect to feelings of empathy for children.

Even though IB3 participants profile at higher risk on the empathy scale, NPP completers showed the greatest improvement in this area. Table 32 shows the posttest and pretest scores for the birth parents and foster caregivers who completed the NPP program. The posttest subscales indicate substantial improvements in parenting competencies in all five areas. This is particularly true with respect to empathy across the board as indicated by effect sizes in excess of .5.

An effect size measures the standardized difference between posttest and pretest means. Effects sizes greater than .5 are considered medium changes and those greater than .8 are considered large changes. Improvements in four out of the five areas fell into the medium change category for birth fathers and two out of five fell into the medium category for birth mothers and foster caregiver. As a result, 85% of participants who completed NPP training, profiled at posttest the same (birth mothers) or better (birth fathers and foster caregivers) than the general population.

The two AAPI-2 subscales that were most predictive of reunification were appropriate parent-child role relationships and empathic awareness of children's needs. Figures 13 and 14 show that predicted reunification rates trend upwards for birth mothers (blue line) who register lower on the risk scales with regular spikes when mothers complete NPP training. Whereas only 13% of mothers who scored high risk with respect to role reversal and did not complete NPP training reunified with one or more of their children, 43% of mothers who scored low risk and completed NNP training reunified. The same was generally true for birth fathers but the trend line is more erratic due to the smaller sample size. As should be expected, there was no association between role reversal and NPP completion because reunification is independent of the participation of foster caregivers in the program.

Table 33. AAPI-2 Subscale Effect Sizes

Group	Area	Test	Average	N	SD	Correlation	Effect Size
Birth Fathers	Expectations	Posttest	6.55	76	2.10	0.409	0.455
		Pretest	5.53	76	2.02		
	Empathy	Posttest	6.37	76	2.49	0.616	0.695
		Pretest	4.92	76	2.27		
	Punishment	Posttest	7.47	76	1.76	0.478	0.703
		Pretest	6.22	76	1.72		
	Roles	Posttest	6.22	76	2.70	0.639	0.660
		Pretest	4.86	76	2.15		
	Power	Posttest	6.46	76	2.04	0.290	0.525
		Pretest	5.25	76	1.83		
Birth Mothers	Expectations	Posttest	5.50	183	2.02	0.532	0.276
		Pretest	4.97	183	1.95		
	Empathy	Posttest	5.90	183	2.59	0.617	0.572
		Pretest	4.71	183	2.16		
	Punishment	Posttest	6.71	183	1.99	0.497	0.454
		Pretest	5.84	183	1.83		
	Roles	Posttest	5.83	183	2.62	0.626	0.398
		Pretest	4.96	183	2.43		
	Power	Posttest	6.27	183	2.60	0.446	0.404
		Pretest	5.21	183	2.39		
Foster Caregivers	Expectations	Posttest	5.99	106	2.07	0.463	0.238
		Pretest	5.49	106	1.98		
	Empathy	Posttest	6.34	106	2.24	0.626	0.738
		Pretest	4.97	106	2.05		
	Punishment	Posttest	6.67	106	1.89	0.542	0.384
		Pretest	6.03	106	1.59		
	Roles	Posttest	6.72	106	2.25	0.609	0.361
		Pretest	5.98	106	2.39		
	Power	Posttest	6.18	106	2.17	0.381	0.233
		Pretest	5.61	106	2.23		

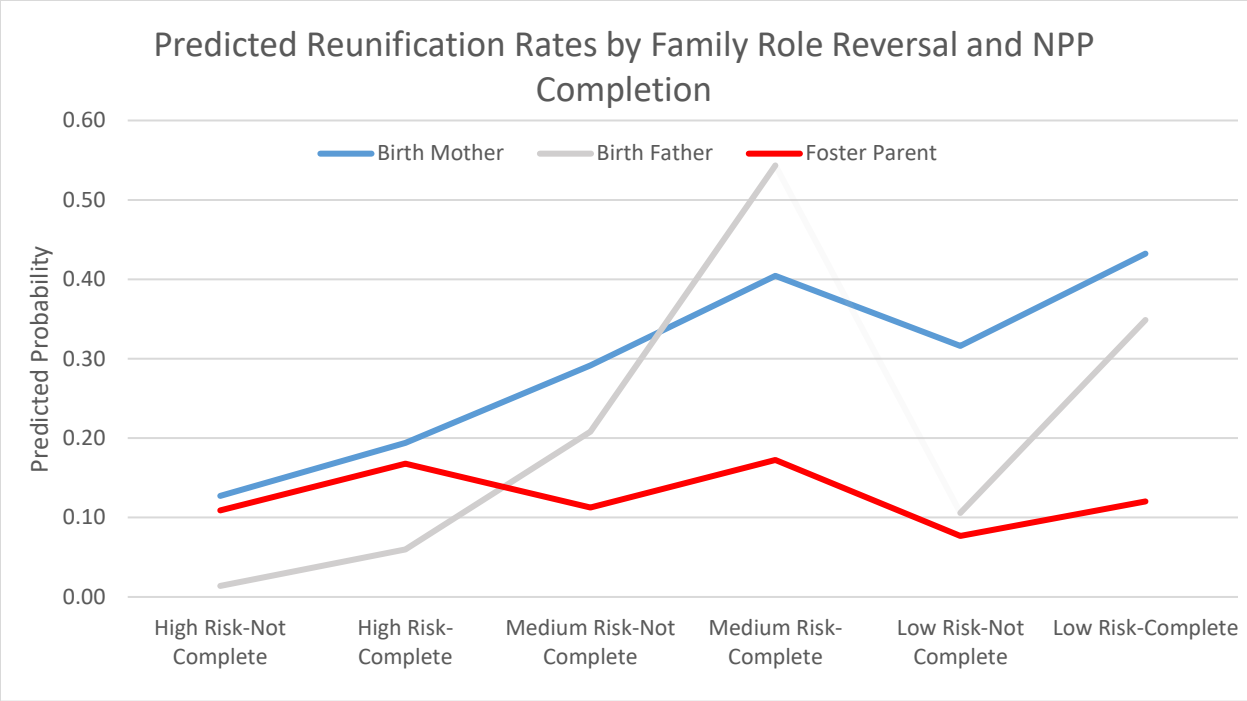


Figure 13. Predicted Reunification Rates by Family Role Reversal and NPP Completion

According to the *AAPI OnLine Development Handbook* (Bavolek & Keene, 2010), appropriate family roles relationships involve parents' assuming the adult roles of protector, authority figure, provider, and advocate. Unless children receive the benefits of "nurturing parenting," the effects of family role reversal can be extremely destructive of a child's healthy development:

> Assuming the role of the responsible parent, children fail to negotiate the developmental tasks that must be mastered at each stage of life if they are to achieve normal development and a healthy adjustment. Failure to perform any of the developmental tasks not only hampers development in succeeding stages, but also further reinforces feelings of inadequacy. Children in a role reversal situation have little sense of self and see themselves as existing only to meet the needs of their parents (Bavolek & Greene, 2010, pp.3-4).
>
> .

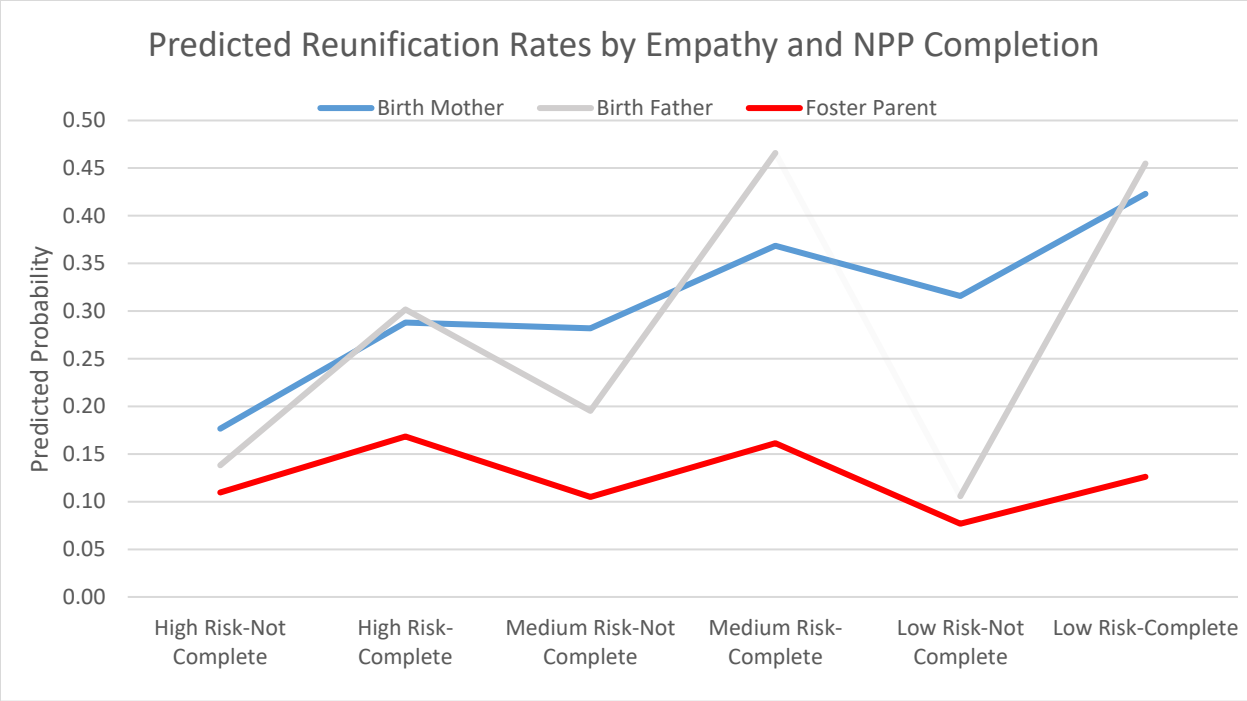


Figure 14. Predicted Reunification Rate by Empathy and NPP Completion

Predicted reunification rates trend similarly with respect to level of empathy. Also as noted by Bavolek & Keene (2010), empathy refers to the parent's ability to be aware of the child's needs and feelings and to place the child's needs and feelings as a priority:

> "Parents lacking sufficient levels of empathy find children's needs and wants as irritating and overwhelming. Everyday normal demands are perceived as unrealistic, resulting in increased levels of stress. The needs of the child come into direct conflict with the needs of the parent, which are often similar in magnitude. Lacking an empathic home life, children often fail to develop a solid moral code of conduct. Right and wrong, cooperation, and kindness are not important because they are not recognized as important values. Others are devalued as "self" takes center stage. The impact of one's negative actions on another is muted as the ability to care about the needs or feelings of another is not important" (Bavolek & Greene, 2010, pp.3-4).

Permanency Planning for Children in Foster Care

For cases in which children were still in care at the time of the survey, caseworkers were asked a set of questions related to reunification. To provide context for these findings, it is important to recognize that the survey was administered between August and November 2017, 2.0 to 4.3 years (mean = 3.1 years, standard deviation = .56 years) after case opening for this sample.

When asked to identify the best option for reunification, caseworkers picked birth mothers three times more often than birth fathers as the more viable candidate. In half of the cases, no viable reunification candidate was identified. Caseworkers identified barriers to reunification for cases in which they had identified a viable reunification option; consistent with the child welfare practice and research literature, the most common barriers to reunification were: parental mental health problems (56%), inadequate or unstable housing (53%), having multiple children in foster care (53%), domestic violence (48%), and parental substance abuse (43%),

When caseworkers identified a reunification option, they were asked to rate the likelihood of reunification using the viability and readiness for reunification (VRR) decision framework that was developed in conjunction with the Collaborative Case Review project (see Appendix C, Budde & Kacha-Ochana). The four VRR categories were identified and presented to caseworkers in this way:

Do you (caseworker) think reunification is:

- Not possible (i.e., *Not Viable/Possible*)[6]
- Possible but unlikely unless major concerns about the motivation or functioning of the parent are addressed (i.e., *Possible But Unlikely*)
- Possible if some specific issues get resolved, or (i.e., *Possible If*)
- Likely when specific issues are addressed? (i.e., *Likely When*)

As shown below, about two-thirds of cases were rated *Not Viable/Possible*, and about one-fifth fell equally into the two middle VRR categories (*Possible But Unlikely* and *Possible If*), which reflect higher levels of uncertainty. In only thirteen percent of cases did caseworkers say that reunification was *Likely When* a specific concern was addressed.[7] At a minimum, these findings suggest that many children were still in care even when caseworkers thought there was little or no chance of reunification.

About one year (on average) after the caseworker survey was conducted, we examined permanency outcomes for the 455 children with caseworker VRR ratings. About two-thirds of the children were still in care, 20% had been adopted, 7% were reunified, and 5% were in formal guardianship. These findings highlight that, at three to five years into the life of these cases, most children remain in care. In addition, during the year since the survey was administered, adoptions occurred much more often than reunifications and guardianships.

[6] In these analyses, the child cases in which no viable candidate for reunification was identified are combined with cases in which a parent was identified as an option for reunification and the caseworker's VRR ratings were still that reunification was *Not Possible*. Permanency outcomes for these two groups of cases (no viable candidate for reunification vs. VRR rating of *Not Possible*) were virtually identical.
[7] In pairwise post-hoc tests, no significant differences were found for the mean number of days in care prior to interview by VRR rating.

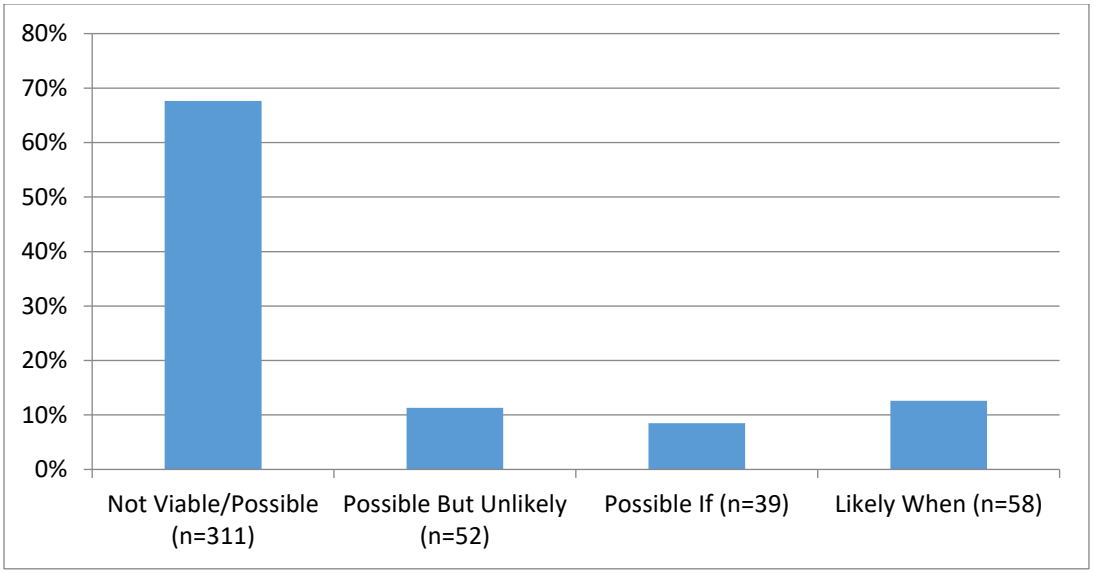


Figure 15 : Caseworker Ratings of Viability and Readiness for Reunification (N=460 children still in care at time of survey, 18 cases had missing data)

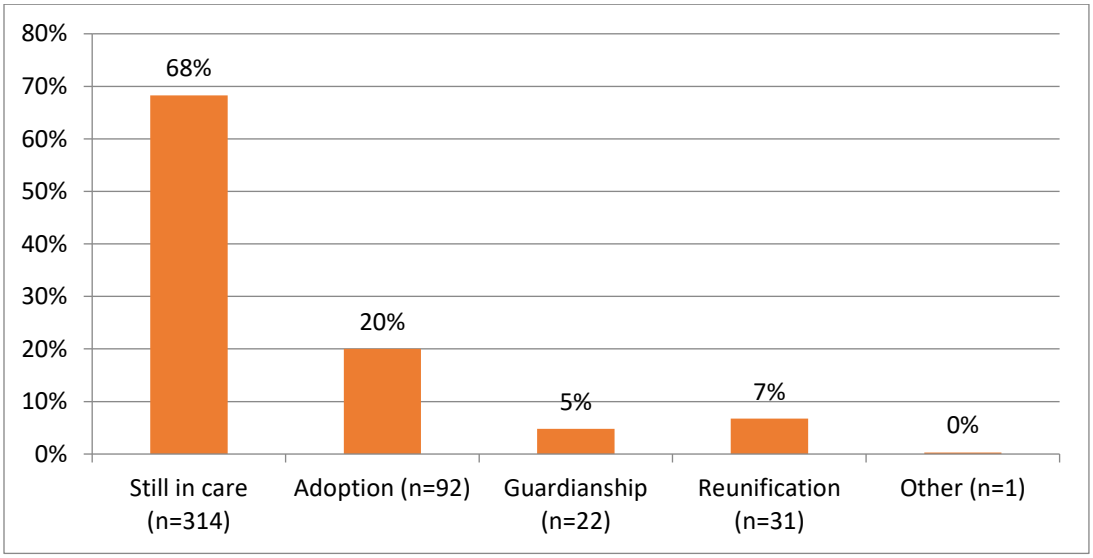


Figure 16: IB3 Permanency Outcomes (as of 9/30/18), One Year after Caseworker Interviews (N=460 children still in care at time of survey, 18 cases had missing data)

To begin to assess the predictive validity of caseworker VRR ratings, we then examined the relationship between their VRR ratings and subsequent permanency outcomes one year later. There were no significant differences in the time from the interview to about a year later on 9/30/18, when the permanency data were pulled.

As shown below, across the four VRR ratings, a large majority of children (64% to 80%) were still in care one year later (3 to 5 years after case opening). Thus, even when reunification was not seen as viable and even when reunification was seen as likely when a specific issue was

addressed, most children remained in care. Overall, caseworker VRR ratings were strongly associated with later permanency outcomes (chi-square=72.55, $p < .001$) and suggested a degree of predictive validity. Consistent with VRR ratings, the likelihood of adoption was highest (30%) for *Not Viable/Possible*, dropped steeply for *Possible But Unlikely* (8%) and dropped to 0 percent for the remaining two categories. Conversely, the likelihood of reunification increased in a linear trajectory from 2 percent for *Not Viable/Possible* ratings to 22% for *Likely When* ratings. Appropriately, rates of guardianship were unrelated to VRR ratings.

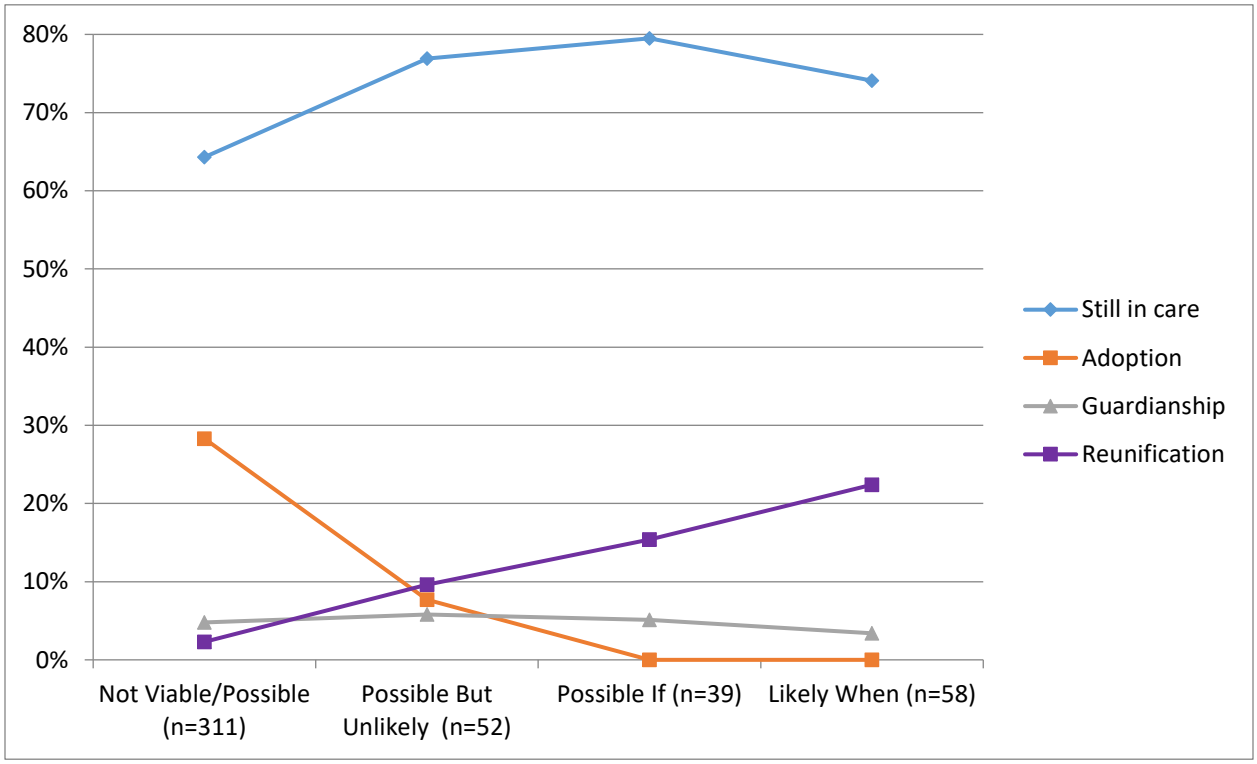


Figure 17: Permanency Outcomes (as of 9/30/18), One year after caseworker interviews by viability and readiness for reunification ratings (n=460 children still in care at time of survey, 18 cases had missing data)

Caseworkers were also asked whether the child's foster caregivers had expressed an interest in adopting or taking subsidized guardianship of the child. The caseworkers reported that for 96% of the children their caregivers had expressed an interest in guardianship or adoption. As of September 30, 2018, 30% of kinship caregivers and 25% of foster caregiver were able to act on those interests. There were no statistical differences between the intervention and comparison groups. An additional 7% were reunified from kinship foster care and 5% were reunified from non-related foster care. The remaining 63% of children in kinship foster care were still under DCFS legal custody as of September 30, 2018, as well as 70% of children in traditional foster care. Again, there were no differences between treatment groups.

Caseworkers reported that adoption or guardianship was always the plan for one-half of the children whereas for the other half, these permanency plans gradually developed over time.

Discussion & Summary

The Outcome Study tested the demonstration's theory of change, which states that receiving evidence-based, trauma-informed programs will increase permanency rates, improve the well-being of children, and prevent re-entry of children into foster care. In order to build confidence that there's a causal relationship between provision of IB3 services and the targeted outcomes, the Outcome Study assessed the intervention's validity in order to rule out other factors that might have influenced the outcomes.

Results showed that there is an association between permanency outcomes and assignment status: children in the intervention group had higher rates of reunifications and guardianships compared to children in the comparison group. However, because adoption rates were higher in the comparison group, there was not a significant difference between the two groups in overall permanency rates. This may be due to the emphasis on clinical services by IB3 agencies for birth parents and, secondarily, for foster and relative caregivers. Notably, the adoption difference was only significant for children removed at birth or before 6 months of age. Because of random assignment, it may be reasonably inferred that the availability of IB3 services influenced the observed differences in the types of permanency outcomes.

Moreover, the odds of family unification were higher for children whose parent(s) completed the NPP program than for children whose parents did not complete.

Results also show that children assigned to the intervention spent fewer average days in foster care than children in the comparison group. Children who were removed after 6 months of age had a higher chance of unifying with family at any duration after removal than children who entered care before 6 months of age. Age differences in the likelihood of timely family permanence may reflect the difficulty of fostering secure attachment relationships with birth parents when children are removed at birth or before 6 months of age.

Caregivers of children assigned to both groups reported similarly on whether the child in their home exhibited emotional problems. However, when considering the caregiver's relationship to the child, within the intervention group, a greater proportion of unrelated caregivers than kin caregivers endorsed emotional problems. This finding suggests that relatives are less likely to perceive children's behaviors as problematic as a result of the parenting training. When examining how children's social and emotional functioning change over time, findings from the outcome study showed that intervention and comparison caregivers reported improvements on several indicators (e.g., attachment, self-regulation, initiative) over time. However, comparison caregivers at earlier screenings reported a higher average of improvements compared to intervention caregivers but over time children in the comparison group had lower reported scores than children in the intervention group. In other words, children in the comparison group started off at an advantage but by the fourth assessment, children in the intervention group were doing better on the above indicators. The results suggest that offering trauma-informed parenting

programs can improve children's social and emotional functioning over time compared to offering the typical family services.

Results from analyzing changes in parenting competencies suggest that completion of NPP is associated with reunification and improvements on parenting competencies (parent-child roles and empathy). Predicted rates of reunification were higher for birth mothers who completed NPP and were considered low risk with respect to parent-child roles and empathy than birth mothers who were considered high risk.

FISCAL/COST STUDY

The IB3 demonstration targets caregivers and children aged 0–3 regardless of their IV-E eligibility for federal reimbursement. The project terms and conditions authorized DCFS to claim federal IV-E reimbursement for innovative programs that are not ordinarily claimable for the 30% of children enrolled in the demonstration who did not meet IV-E eligibility standards. By offering families developmentally appropriate parenting training and support, such as CPP and NPP when indicated, it was anticipated that children assigned to the intervention group would exit more quickly from foster care than children assigned to services as usual. Any federal savings that result from the achievement of timelier family reunification or expedited alternative permanency arrangements compared to services as usual (SAU) are retained and can be reinvested by the state. Additional spending on the intervention group, which is in excess of the average cost neutrality limit for the SAU group, is borne entirely by the state if anticipated permanency improvements are not realized.

The terms and conditions specified that the determination of cost neutrality would rely on an analysis of the costs of cases within the SAU group. The average allowable IV-E costs of a case in the comparison group is assumed to estimate the amount that would have been spent on each intervention case in the absence of the demonstration and is used as the baseline for assessing cost neutrality. The total cumulative title IV-E allowable costs for the SAU group is divided by the number of cases within those groups, and the result is projected to the children assigned to the intervention group to determine the amount the State can be paid in title IV-E funds for the demonstration.

The Illinois Birth through Three demonstration completed five years of full implementation. The cumulative costs savings (maintenance and administration) for IB3 through the June 30, 2018 quarter amounted to $432,568. Thus the demonstration was able to fund the extra costs of delivering evidence-supported services within the pre-established cost-neutrality limits. The demonstration yielded a surplus of hundreds of thousands in federal dollars that would have been forgone in the absence of the waiver demonstration.

Substudy

The high rate of caseworker turnover presented special challenges to collecting reliable data about IB3 services, the whereabouts of current caregivers, and parental experiences while children were in care. The problem of worker turnover is endemic to child welfare. Only 15.4% of the survey children had only one caseworker who was the source of information about the child. The figure below shows that most of the interviews were conducted with workers who were the second or subsequent caseworker assigned to the child's case.

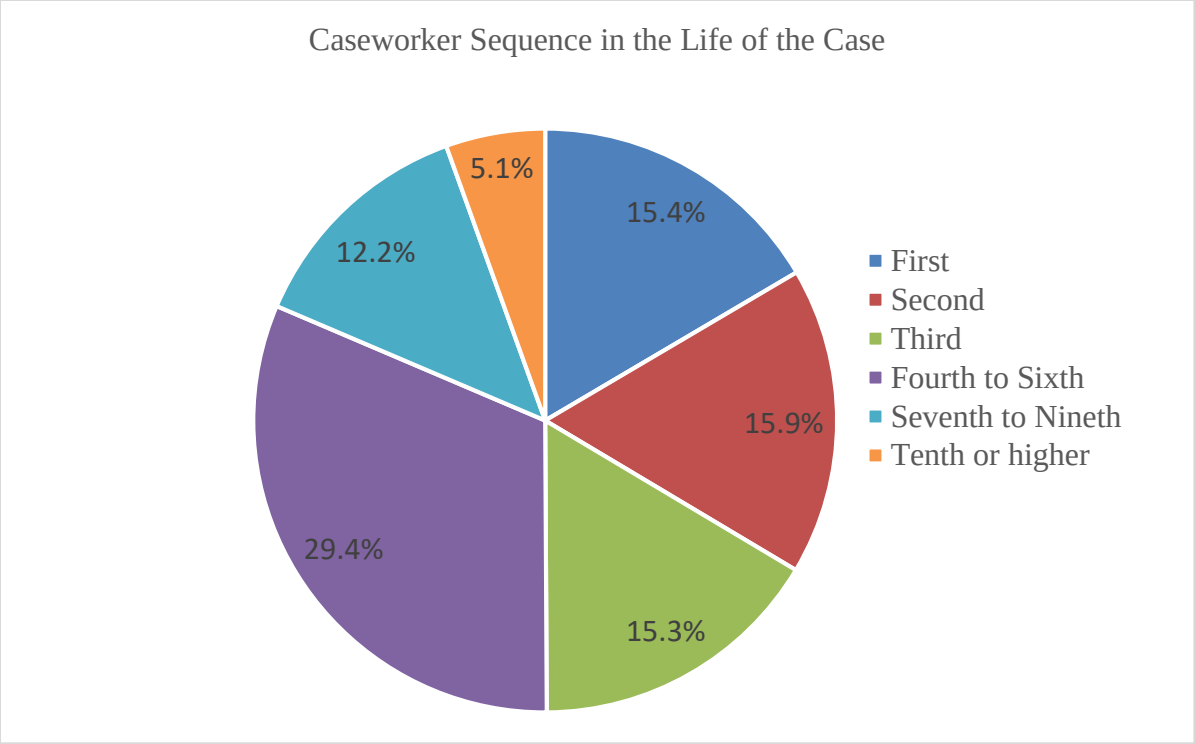


Figure 18: Number of Caseworkers at Time of Survey Administration

Not only do caseworkers who are assigned later in the life of the case lack personal knowledge of the child and their experiences in care, but multiple changes in workers can also put children at a disadvantage when it comes to finding them a permanent home with parents and relatives.

MULTIPLE CASEWORKER ASSIGNMENTS AND TIME TO FAMILY UNIFICATION

Children in the demonstration project experienced several changes in caseworker assignment. Data on caseworkers from April 30, 2017 showed that 17% of the sample (N=1889) had one worker assigned to their case, while 15% had two workers, and 68% had three or more workers assigned over the duration of their time in care. Thus, a variable measuring each child's number of caseworker changes was included in a survival model. After controlling for number of caseworker changes, the magnitude of the intervention effect was slightly reduced, but the treatment effect was still significant using a one-tailed test ($p<.05$). Findings showed children assigned to the intervention group had a 20% higher rate of unifying with a family member than children assigned to the comparison group. However, for each change in worker, the hazard rate reduced by 8% (See Table 34).

Because the number of workers assigned during a child's time in care significantly impacted the rate of family unification, we investigated whether characteristics of workers would also have an impact on rate of family unification. Testing the effects of workers' educational background on time to family unification, we found that children who had a worker with an MSW assigned to them at any point during their time in care had a 24% lower rate of achieving family unification compared to children who did not have a MSW worker assigned to them (see Table 34). This finding suggests workers with a master's degree in social work may have a more conservative approach toward unifying children with family compared to workers without this type of degree.

Moreover, in terms of child age, the hazard rate increased by 14% for every one-unit increase in child age ($p<.001$). While older children generally had a higher rate of unifying, children in the 0 to 2 months age group had the lowest rate of family unification compared to children in older age groups (see figure). Future analyses should extend this model to include more worker characteristics (e.g., work tenure), as well as child and agency characteristics.

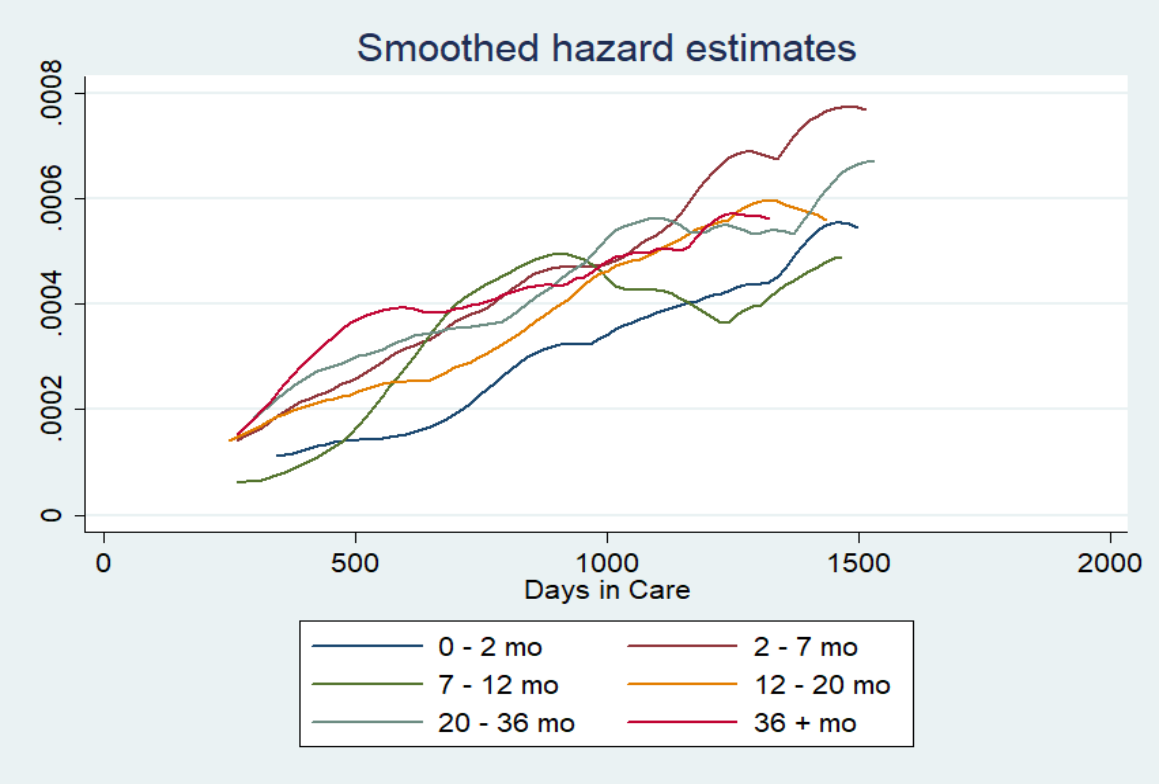


Figure 19: Smoothed Hazard Estimates of Time to Family Unification for FY14-FY17 (as of December 31, 2017)

Table 34. Hazards Regression Models for Family Unification

	Haz. Ratio	Sig. 1-tailed	Haz. Ratio	Sig. 1-tailed	Haz. Ratio	Sig. 1-tailed	Haz. Ratio	Sig. 1-tailed
	Model 1		Model 2		Model 3		Model 4	
Intervention	1.24	0.016	1.20	0.037	1.21	0.031	1.20	0.038
Changes in caseworker			0.92	0.001	0.92	0.001	0.92	0.001
Worker w/ MSW					0.76	0.053	0.76	0.057
Child age							1.14	0.001

Estimating the Effect of IB3 Services on Likelihood of Family Unification

Many children in the demonstration were not clustered under the same higher-level unit (e.g., caseworker) throughout their stay in foster care. Therefore, hierarchical linear modeling (HLM), which assumes lower level units (e.g., children) are nested under one higher level unit (e.g., one worker) during the observation period was determined to be inappropriate for the IB3 sample because of its non-hierarchical data structure. Majority of the children in the sample were nested within multiple higher-level units from the same classification (workers). Therefore, multiple membership multilevel modeling (MMM) was employed to handle this type of complex data structure.

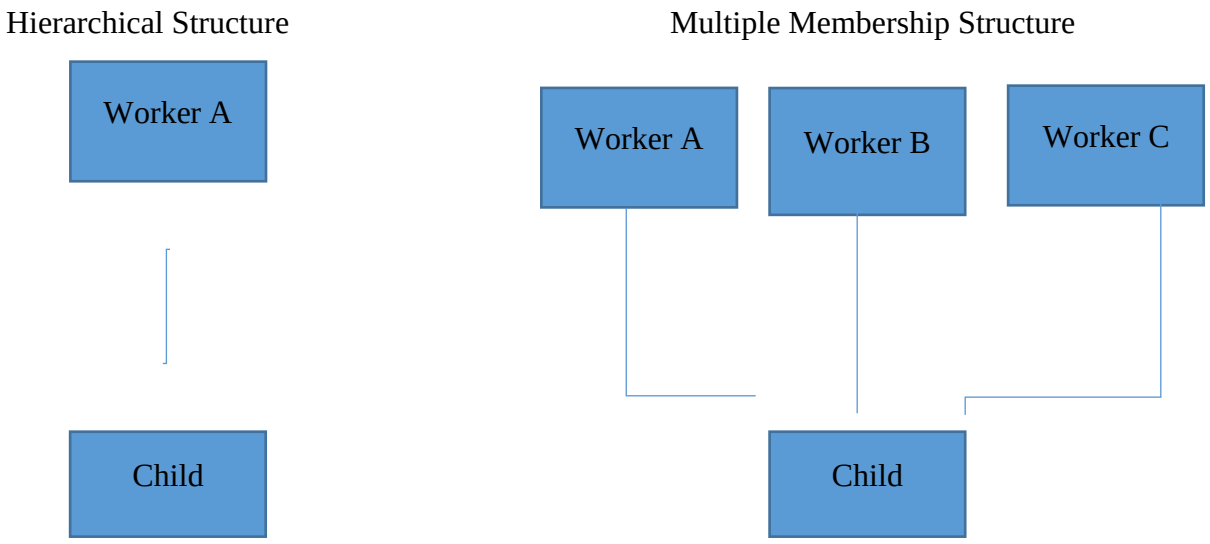


Figure 20. IB3 Data Structures for HLM vs. MMM

MMM can account for the amount of time a child spent with each worker. For instance, a child who had three workers while in care may have spent a greater proportion of his or her time in care with one of the three workers. Multiple membership modeling can account for this variation by using weights to estimate the proportion of time a child spends with each worker. Overall, MMM accounts for number of workers, time spent with each worker, and the weighted average of workers' characteristics in its estimation of the treatment effect. Application of traditional HLM would ignore the potential influences of other workers on permanency outcomes by focusing on only one of the child's workers. Failing to address multiple workers' influences on the outcome would likely run the risk of making incorrect inferences about the relationships between children, workers, and permanency outcomes.

Findings from the MMM analysis showed that children in the intervention group were 62% more likely to achieve family unification than children in the comparison group ($p<.001$). When child age at removal, time spent with workers from different racial groups, and time spent with

workers with an MSW were included in the model, children in the intervention group continued to have at least a 60% greater likelihood of family unification compared to children in the comparison group. Similar to findings from the hazard regression models, findings from MMM also suggest that older children have a higher likelihood of family unification compared to children in the 0 to 2 age group. Children who spent more time with a worker holding an MSW were 67% less likely to achieve family unification compared to children who spent most of their time in care with workers without MSW degrees.

Overall, the current findings show a robust intervention effect, which suggests that assignment to IB3 treatments increases children's odds of returning home to a birth parent or with extended family at a quicker rate than children who are not assigned to IB3 treatments. Moreover, the odds of experiencing family unification were also high for older children who have likely already formed some degree of attachment to caregivers compared to infants. Lastly, these findings suggest children assigned to workers with MSW degrees were less likely to unify with family compared to children whose workers did not possess MSW degrees.

SUMMARY, LESSONS LEARNED, AND NEXT STEPS

Summary

The final evaluation report summarized the IB3 demonstration's background and context, theory of change, target population, interventions, outcomes, and allocation method for approximating the comparison (counterfactual) treatment for evaluation and cost-neutrality calculations. The targeting of infant, toddlers and preschoolers together with the selection of two evidence-supported interventions and focus on the improvement of permanence and well-being led to the demonstrations' primary research question:

> Will Illinois children aged birth through three years old, who are placed in foster care in Cook County, experience reduced trauma symptoms, increased permanence, reduced re-entry, and improved child well-being if they are provided CPP or NPP programs compared to similar children who are provided IV-E services as usual?

The implementation and evaluation of the IB3 waiver demonstration was patterned after *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, which the U.S. Children's Bureau disseminated to support the implementation and evaluation of federally funded programs and innovations. Using The Framework as a guide, the evaluation of the demonstration cycled through the five phases of "increasingly generalizable studies." This process resulted in the selection and adaptation of two well-suited evidence-based programs to address the developmental needs of young children in foster care and to enhance the parenting competencies of the families with whom they are intended to be reunified. A theory of change and logic model were developed and tested to determine whether key elements of the IB3 interventions would result in the desired proximal and distal outcomes. Rotational assignment of child cases to intervention and comparison agencies was successful as children in both groups had similar case characteristics at baseline. Almost all of the children assigned to the demonstration were assessed for developmental risk and service needs, and children in the intervention group were referred to appropriate IB3 services while children in the comparison group received services as usual.

Although children in the intervention group were less likely to become adopted, they were more likely to reunify with a birth parent or relative than children in the comparison group. Those who had any one of their parents complete the NPP training had a greater likelihood of family unification. Results from analyzing changes in parenting competencies suggest that completion of NPP was also associated with reunification and improvements on parenting competencies (parent-child roles and empathy). Moreover, children who entered care at 6 months of age or older were more likely to unify with a birth parent or relative compared to children who entered at birth or less than 6 months of age.

Children in the intervention group also showed a consistent improvement in their social and emotional functioning over time compared to children in the comparison group who started off

with better scores on measures of social and emotional functioning but experienced a deterioration the more time they spent in foster care as evidenced by a lower average of scores on the Devereux Early Childhood Assessment (DECA) at later screenings.

Program/Policy Lessons Learned and Recommendations

The challenge of implementing evidence-based practices in organizations is well established. Within the context of the child welfare system, the Illinois Birth through Three (IB3) Waiver Demonstration Project has engaged in ongoing implementation and continuous quality improvement strategies that have been instrumental in addressing implementation challenges, promoting engagement and participation in the primary evidence-based interventions (NPP and CPP), and achieving positive outcomes.

Many of the important implementation challenges were identified in the mid-term evaluation summary on implementation. At that time, the evaluation team at Chapin Hall noted the following:

General Findings

- Core IB3 program services are being very well-received when parents/foster parents participate in services.
- Logistics and communication are the primary barriers regarding engagement and participation of both parents and foster parents in IB3 services.
- Program communication is the primary issue affecting staff (caseworkers mainly) perceptions of the program and its interventions. The CQI team identified caseworkers to be the most important in terms of communication and creating buy-in amongst the parents/foster parents. However, feedback from caseworkers suggest they knew the least about the services/interventions.
- The CPP waitlist was identified across most focus groups as an issue and cause for concern.
- Interview participants expressed general frustration and fatigue with regard to DCFS service expectations. This seems to significantly impact their follow-up with IB3 as well as other DCFS services.

Source: *Illinois Birth through Three (IB3) Waiver Demonstration Project: Initial Implementation Report.*

The summary provided here describes five key strategies that the program has utilized to support the system, the workforce, and the families who are eligible for the evidence-based services provided through IB3. It also attempts to provide the organization with issues to consider in future implementation and utilization of EBPs within a child welfare context.

1. **Ongoing implementation support is essential to effectively implementing evidence-based interventions in complex systems;**

Utilization of Evidence-Based Interventions requires adoption by the workforce who must have sufficient information regarding the model and ongoing support to effectively promote client engagement and retention in services, testify in court, and address questions or concerns that are identified by the families.

Implementation Support: The IB3 program was designed to support casework processes by facilitating referrals to core IB3 services. Effective implementation requires that the caseworker is knowledgeable about the interventions to support family engagement and to monitor progress. In addition, field coaching is a relationship-based process that is necessary to implement, integrate and sustain organizational practice changes over time while increasing the competencies and effectiveness of the direct service workforce. Coaching and targeted implementation support the Department's mission and goals to integrate and sustain high quality practices and interventions.

During the first two years of implementation, the program conducted in-person trainings with approximately 250 staff. Materials were developed to support knowledge of the interventions including *talking points* when engaging families. The completed IB3 video [https://youtu.be/31WBFDOYItM] is used as a primary communication tool to provide information on the waiver.

By year three the program exclusively relied on monthly in person staff meetings and coaching with supervisors within intervention agencies to increase the knowledge and skills of the workforce about the program. We discovered the adoption of the new information or transfer of learning was best supported as the workforce experienced a true "***felt need"*** for the information. Supervisors within the intervention foster care agencies were the primary target for coaching given their role as the primary teacher and support for their staff. This strategy supports sustainability within the organization.

2. **Data driven processes must be developed and shared with the system to enhance outcomes;**

One of the greatest challenges of this program is the ongoing monitoring of families that have regularly changing circumstances that significantly impact their ability to participate in IB3 interventions. While the case carrying agencies are aware of these changes, it is only through the stable use of our implementation support activities that we can ensure accurate feedback to the program which ultimately results in higher service utilization. The timing of referrals is key to harnessing motivation and maximizing key windows of opportunity.

For the first two years of implementation, the development of a data management system was underway. Interim strategies such as manual tracking and REDCAP were utilized to track outcomes. The IB3 database was not complete until 2015. Once that occurred, our monthly

reporting to agencies included information on IB3 services including status of the referral, IB3 provider agency, service barriers and case closure outcomes. In an ideal world, this information would be available for the caseworker to obtain first-hand since they hold primary responsibility for these interventions. Building data management systems outside of the primary client management systems [i.e. SACWIS] is less than desirable.

During field coaching, implementation staff provide caseworkers and supervisors monthly data reports, including *at-a-glance snapshots* to help focus on performance areas, facilitate clinical discussions on the impact of trauma and placement disruptions, and implement strategies to help agency staff identify family's readiness for the IB3 interventions and/ or permanence. The program developed pre-work before coaching meetings which included communication plans and individually tailored monthly reports to help caseworkers and supervisors focus on specific data points and families. This included implementing a decision strategy (VRR: *viability and readiness for reunification*) to target specific barriers to reunification, promote efficient efforts to support reunification when possible, and inform clinical and legal decisions about how and when to move toward reunification or alternative permanency arrangements.

Provider agencies for the core IB3 interventions also receive outcome data during quarterly provider meetings. For example, Medicaid utilization has been tracked annually by the program for CPP providers. The annual summary of CPP utilization and costs billed to Medicaid for FY'18 indicates 14% of the total contract expenditures were billed to Medicaid which is a 4% increase over the previous fiscal year. There is a significant shift in home-based services. Currently 73% of the services rendered are billed for off-site services and only 27% are billed to in office services. Over 1100 hours were billed to Medicaid servicing 80 unique clients. IN FY' 18 the rate of successful case closures increased by 10% over the previous year.

3. **As barriers to implementation are identified, the program must identify solutions that address these barriers;**

There have been many examples of barriers that have adversely impacted the implementation of this work. They tend to emerge as individual concerns and quickly escalate to a theme across the population. For example, child care was often cited as a barrier to participation for foster parents in the Nurturing Parenting intervention. The team worked with Illinois Action for Children to support child care resources once we established this was not a case level concern.

Determining the projected need for Child Parent Psychotherapy also created the problem of the CPP wait. Initial projections for the service needs of Child Parent Psychotherapy were made prior to the launch of the waiver using available data from the IL Survey of Child and Adolescent Well-Being. Those projections underestimated need and a wait-list began to develop in 2014. The program had to establish a method to serve these families even as we struggled to build CPP capacity. Referrals to NPP services are used as the initial service for biological parents whose children are referred for Child Parent Psychotherapy due to their children being high risk. It has been consistently found that many biological parents are often not yet available for the

psychotherapeutic approach of CPP due to their many other service and concrete needs. This method was adopted to offer the parents and caregivers support and education around the impact trauma can have on young children. Birth parents are first referred for NPP-PV to offer psycho-education and skill development on an array of areas i.e. attachment, infant/ toddler brain development, developmental expectations pertinent to this age group that can support later engagement in CPP interventions.

Starting with NPP services before starting CPP or in conjunction with CPP services has been defined as '*sequential services*'. It is thought that with these sequential services, caregivers and parents will be better prepared to enter CPP and make use of this rich service when it becomes available. This also addressed the service burden identified by families.

At that same time, providers were not meeting contractual obligations. By September 2015 cost data that indicated that CPP providers were billing significantly less than their budgeted amounts. Across the 5 CPP provider agencies, the total for CPP Medicaid and non-Medicaid expenditures for FY '15 was only 29% of the allocation. Most agencies were no longer taking new cases, they were not meeting their quotas for contractual slots, and the waitlist continued to grow. Providers reported that the main deterrent to meeting their targets was the fee-for-service contract structure which is significantly impacted by no-show rates. Fee-for-service contracts do not allow for billing for the intensive engagement work required to get families involved in treatment. This was untenable to the providers and to their boards; in fact, providers have indicated that this only covered 42-48% of their actual costs.

DCFS has made a substantial commitment to supporting CPP as an evidence-based intervention. CPP contracts for FY '17 began to utilize an actual cost model and providers continued to bill Medicaid. These changes went into effect during the final quarter of FY '16 for the months of May and June. CPP capacity for 2017 increase by 66%. We now have contractual capacity to serve 106 families.

The strategic shifts in resource acquisition, contract modifications, or in implementation support never altered the design of the demonstration. Instead, these were the strategies required to effectively implement the demonstration within the context of the system.

4. **Planning for sustainability is essential to maintaining fidelity and for addressing inevitable attrition in the workforce;**

Turnover of clinical staff posed an ongoing challenge. Once trained and certified in CPP, many clinicians seek out potentially more lucrative and less stressful agency contexts. During FY' 16 there was a turnover of 55% of the highly trained CPP clinicians across the provider agencies. While the staff was replaced, the additional strain on the wait-list continued. It should be noted that the initial training process for this model requires an 18-month commitment and like many EBPs, it takes even longer to fully integrate the model into the professional's practice. Illinois is extremely fortunate to have structural capacity to support training, particularly in Cook County

where the waiver is housed. By FY' 17 the Department determined there was a need for an internal CPP consultant to support continuous quality improvement, fidelity, ongoing training implementation and case consultation.

The capacity of the CPP consultant offers the Provider agencies a supportive resource to address their individual concerns as well as providing the project with a better assessment of agency strengths and current needs. The consultant, Lili Gray, is a national trainer for the CPP model was added to the team as a contractual employee in July 2017. Agencies are asked to review annual program data and set targets for enhanced outcomes with the support of the program and the consultant.

Staff attrition has impacted NPP as well. Fortunately, in November 2015 our program completed training-of-trainers with one of the national staff from Family Development Resources. This will support ongoing capacity building for this intervention. Training in this model requires a 3-day initial training. Like CPP [or any EBI] adoption takes more time but having supportive learning communities which we established in ongoing provider meetings for NPP and CPP supports the inevitable dynamic shifts in the workforce. The groups allow the new practitioner to ask questions, learn from their more experienced colleagues and obtain support for the learning process as they develop competency.

5. **The utilization of evidence-based interventions impacts all aspects of the system. All parts of the system must be prepared to accommodate EBIs to strengthen the system of care.**

As we prepared to implement the waiver, there was a communication plan that included agencies, judges, legal professionals, ACR, and Department Leadership. Despite intensive communication efforts, program staff continued to learn of incidents that reflect fundamental misinformation on basic program elements. For example, one of the hallmarks of the Nurturing Parenting Program, NPP, is the availability of an intensive [16-week] group modality ***and*** a home coaching component. These interventions are not typically combined in a single intervention and therefore, the system was challenged to amalgamate the new model.

The failure to understand a discrete intervention is particularly problematic when we consider trying to establish a system-of-care that addresses the needs of the family in a holistic manner. One of our NPP facilitators reported seeing a parent coach arrive as she arrived at a family's home to deliver NPP home coaching.

Given the "lessons learned" from IB3 implementation, the Safe Babies Court Team model was proposed to address systemic factors within the system of care serving families which include the court and court personnel. The Early Childhood Court Team was launched in Cook County on July 1. 2017. Child welfare practice is inherently complex involving multiple systems and providers. Meaningful case coordination is the essential practice of the court team model. Using regular meetings with the family and other providers, collaborative problem solving, enhanced

communication and service coordination occurs. The full scope of the case is contextualized decreasing silos in interventions, unintended burdens, or potential service replication for the family.

Implementation Support

Coaching is still an emerging field of professional child welfare practice and studies have shown that training staff without field reinforcement can result in a loss of up to 80% of the training content within six months of the training event. Field coaching is a relationship-based process that is necessary to implement, integrate and sustain organizational practice changes over time while increasing the competencies and effectiveness of the direct service workforce.

Implementation Support has been in place for four years, the framework developed to help with the organizing of goals, approaches and ways to think about the process of implementation support is consistently utilized. The four areas of the implementation support framework include (1) monitoring of client status (2) CQI (3) IB3 practices and (4) Permanence. In discussing how each of the categories applies to the individual supervisor or team the goal is to identify specific practice strategies supervisors and caseworkers can do, to take specific action steps to enhance performance and thereby improve linkage to IB3 interventions and ultimately positively impact permanency and child well-being.

The implementation support team continues to model effective engagement skills and support the supervisors and caseworkers in implementing practice strategies with children and families in the IB3 program. Over the 4 years there has been a noted enhancement in the quality of relationships between the implementation support team (IST) and agency caseworkers, supervisors, and licensing staff The Implementation Support Team consistently provides monthly on-site coaching to IB3 intervention agency staff. Over the past 6 months, IST engaged 230 agency administrators, supervisors, caseworkers, and licensing staff. IST conducted 1,585 IB3 case status reviews.

Retention of agency staff is an ongoing challenge to engagement. As staff turnover became an increased reality for some intervention agencies, implementation support expanded its strategies to engage new agency caseworkers and supervisors and to sustain the relationships already established. In addition to the monthly on-site coaching, IST utilized the strategy of distance coaching or phone coaching and electronic technology to support coaching in real time with caseworkers and supervisors. This immediately increased communication regarding the readiness and engagement of parents and caregivers in IB3 interventions. The increased communication has also led to the implementation support team receiving critical updates on families' progress toward permanence and case closures in court.

The Impact of Implementation Support on Well Being and Clinical Issues: The Implementation Support Team (IST) continues to enhance the education of agency leaders, supervisors, caseworkers, licensing staff and caregivers as it relates to understanding the long-term effects of trauma, toxic stress, and adversity on children birth through three. Direct psychoeducation is

provided on the urgency of the developmental periods for infants and toddlers. IST continues to receive ongoing request for support through participation in IB3 consultations and clinical staffing for children and families identified as clinically complex.

These consultations have primarily been focused around engagement and coordinated care challenges. IB3 has been able to coordinate and facilitate staffing's to include intervention providers, caseworkers, supervisors, birth parents and caregivers. During these staffing IB3 could utilize facilitation and coaching to increase communication between providers and caseworkers. Caregivers and birth parents were able to gain a better understanding of the interventions and the positive impact they may have on their children.

The Implementation Support Team has received increased invitations to Child and Family Team Meetings (CFTM). The practice-based coaching prior to the CFTM has focused on supporting caseworkers and supervisors to reflect on the assessment of the needs and well-being of the child and family. The support has included participation in CFTM's; support with coordination of CFTM's when there are engagement and communication challenges between agency staff; and skill building coaching in the practice area of facilitation.

The Impact of Implementation Support on Reports of Permanency: The Implementation Support Team conducts regular monthly case status reviews for children in the IB3 program. During field coaching, IST provides caseworkers and supervisors monthly data reports, including at-a-glance snapshots to help focus on performance areas, facilitates clinical discussions on the impact of trauma and placement disruptions, and implements strategies to help agency staff identify families' readiness for the IB3 interventions and permanence. The Implementation team has integrated the viability for readiness and reunification (VRR) tool in the coaching process during this reporting period.

While the case status review helps the IB3 program with understanding a parent or caregiver's readiness for an intervention, the primary focus has been on really promoting a more focused discussion on permanence planning. During case status reviews the VRR framework promotes discussions on the progress a family has made toward the identified permanence goal. Agency supervisors reflect on the decision making and case activities needed to maintain the current permanency goal. Given that caseworkers and supervisors must report to court the status of parent's engagement and progress in an intervention, IST provides talking points for agency staff who continue to enhance their capacity to discuss the recommended interventions with parents, caregivers and attorneys.

The Impact of Implementation Support on Outlier Agencies: There continues to be a population of "Intervention" assigned children who have been transferred from their initially assigned agency to another agency to meet their unique needs. To date there are approximately 212 children and 148 families who are designated Intervention, but are placed with agencies that are not a part of the Waiver. In April 2018, IST facilitated two Outlier Agency Engagement workshops titled, "What is IB3 Anyway?" The purpose of the workshops was to enhance staff

understanding of the IB3 program, the recommended interventions, the effects of trauma exposure and its impact on the well-being of young children, and to strengthen their ability to articulate client readiness. Both workshops were delivered in person; outreach was made to 55 Outlier agency workers with at least one open IB3 case. Eleven agency staff participated in the workshops offered. IST will continue to provide ongoing field coaching as there are 58 families recommended for NPP-CV, 63 families recommended for NPP-PV, and 29 families recommended for CPP among the 41 outlier agencies.

The need for supporting the workforce to implement evidence-based interventions and educating on trauma exposure in early life and child development remains prevalent. Ongoing educational support focusing on early exposure, and the components of the IB3 program to new staff are conducted at each intervention agency due to attrition in the workforce. Thus, staff retention continues to plague agencies and ultimately impacts the engagement of birth parents and foster parents in program interventions.

The Environmental and Cultural Context of Parenting

Culture and environmental context are essential factors to consider when examining child rearing practices. Culture also influences all aspects of child maltreatment from symptom formation to help seeking behaviors (Cohen et.al., 2001). When observing parenting interactions, what is seen in the moment by the observer may hold different meanings from the participants within a particular cultural group. Each person views and makes assessments from their own perspective which is influenced by their unique lived experiences. Even with advanced training and education, it's highly unlikely that a professional is fully able to avoid being influenced by their own experiences. It is through these experiences or "lens," that one examines behavior and other people that they encounter. It is possible that professionals can become more aware of the lens through which they observe and also be able to challenge the beliefs that have been developed throughout their lives.

When examining social and emotional development, the assessor determines that toddlers who are "on target" are ones who can regulate their emotions, display enough curiosity to explore their environments and to be able to establish quality relationships. These hallmarks are the standard behaviors expected of all children during late infancy and toddler years. If a child were to not display curiosity, for instance, in the way similarly aged peers do, the assessor could interpret that perhaps the home environment lacked enough stimulation to allow safety and curiosity to be achieved. The assessor may conclude that parents have failed to create an environment where the child feels safe enough to explore the environment and as a result, there are now concerns about the child's development and the child rearing practices. These beliefs/ issues are routinely processed in reflective supervision with the assessment team from the Erikson/ DCFS project.

Historically and currently, physical safety remains a profound concern among African-American families who have experienced more than their fair share of threats to physical safety,

discrimination and disenfranchisement. Many African-American parents dissuade their young children from moving too far away from them, especially early in life to assure they are not injured. And once the child is older, continued efforts to "keep an eye on them" means that more intentional efforts to contain their movements are employed. In this case such behaviors may be observed as problematic to the child's sense of initiative.

From the parent's perspective, the most important task is to keep their child physically healthy and safe which means that limiting exploration is essential to survival. There may lie many safety risks in their home that could lead to injury. Therefore, containing their child to a small space is necessary. The parents' behaviors in monitoring the child become reasonable in this case if one were to consider the environment in which this family lives and the context of their lives.

These are the types of considerations that have been a part of the IB3 program since its inception. By bringing a cultural lens to ongoing provider meetings, implementation support and in-service training, the program has tried to support the cultural competence of the workforce

References:

Cohen, J., Deblinger, E., Mannarino, A., and Arellano, M. (2001). The importance of culture in treating abused and neglected children: An empirical review. Child Maltreatment, 6(148). DOI: 10.1177/1077559501006002007.

Evaluation Lessons Learned

Additional analyses need to be conducted to better understand which children are more likely to achieve permanence and show improvements in well-being. Based on findings from the outcome study, several factors such as age at removal and relationship to the child can help explain the observed outcomes. Additional analyses should include a focus on identifying mediators and moderators of child permanence and well-being trajectories, as well as analyses using multiple imputation to address missing data.

APPENDICES

Appendix A: LADQ Group Differences

LADQ Group Differences

	Pretest			Posttest		
	C	IV		C	IV	
Responsible for Appointing director						
State Admin	0	2		0	1	
Board of Directors				0	1	
Other	8	8		7	7	
Describe agency						
Free-standing entity	43.7	56.2		50	50	
Year established	1930.5	1922.3		1909.6	1916.7	
State government control	1.5	1.6		1.71	1.55	
Children MH services	3.7	3.5		3.7	3.3	
Adult MH services	3.3	3.1		3.5	3.1	
Substance abuse	3.2	3.3		3.4	3.2	
Physical health care	4.1	4		3.8	3.7	
Special services for R	57.1	60		57.1	50	
% receive aftercare	87.5	75		58.5	88.3	
clinical services after R	87.5	80		71.4	88.8	
financial services after R	37.5	40		42.8	33.3	
support networks after R	75	100		71.4	66.6	*
any other services after R	12.5	80	**	42.8	44.4	
% adopted/g get services after	3.5	38.8	*	5	5.6	
clinical services after A/G	25	40		16.6	33.3	
financial services after A/G	0	30		16.6	22.2	*
support networks after A/G	25	60		33.3	37.5	
any other services A/G	0	40	*	40	11.1	
One caseworker assigned	62.5	80		66.6	66.6	
Total expenditures	3.7	3.9		4	3.8	
# of FTE positions	4.2	5.6		5	5.4	
Annual turnover rate	24.1	18.5		26.1	25.4	
Degree required for fc workers	100	100		100	100	
Bachelors required	77.7	88.8		100	100	
Masters required	62.5	50		42.8	77.7	
other bachelor's degree	100	100		85.71	100	
other master's degree	62.5	42.8		42.86	77.7	
degree required for a/g workers	100	100		100	100	
Bachelors required	77.7	88.8		100	100	

Masters required	50	55.5		42.8	77.7
other bachelor's degree	100	100		85.7	100
other master's degree	50	42.8		42.8	77.7
Regular foster care program	100	100		100	100
Amount of annual training for fp	2.37	1.66		2.3	2.4
in-house training for fp	87.5	80		85.7	77.7
specialized foster care program	44.4	40		57.1	55.5
Annual training for specialized fp	3	2.5		2.4	2.4
in-house training for specialized fp	50	33.3		80	44.4
program for non-licensed kin	100	100		100	100
Annual training for nonlicensed kin	1.6	1.4		1.5	2.2
in-house training for nonlicensed kin	88.8	60		57.1	55.5
fc program for licensed kin	100	100		100	100
Annual training for licensed kin	1.6	2.5		2.5	2.3
in-house training for licensed kin	88.8	80		100	77.7
% of licensed kin	65.7	59.1		64.7	66.7
in-house parent training	50	60		57.1	44.4
purchase-of-service agreements	77.7	70		66.6	30
none by in-house or POS	11.1	0		11.1	40
parent training: self-esteem	66.6	90		62.5	83.3
parent training: stress/anger	77.7	90		66.6	50
parent training: child develop.	77.7	100	*	66.6	50
parent training: comm. Skills	77.7%	100%	*	66.6%	50%
parent training: social skills	66.6%	80%		44.4%	40%
parent training: pos. discipline	77.7%	100%	*	66.6%	50%
parent training: difficult behaviors	66.6%	80%		66.6%	50%
parent training: school issues	55.5%	70%		55.5%	40%
parent training: infant skills	66.6%	90%		66.6%	40%
parent training: real-life parenting	77.7%	100%	*	66.6%	50%
parent training: role plays	77.7%	70%		66.6%	50%
IH: the incredible years	0%	0%		0%	10%
POS: the incredible years	0%	10%		0%	0%
IH: PMTO	0%	0%		0%	0%

POS: PMTO	0%	10%		0%	10%	
IH: PCIT	11.1%	0%		11.1%	20%	
POS: PCIT	22.2%	40%		44.4%	10%	0.06
IH: TRIPLE P	0%	0%		11.1%	0%	
POS: TRIPLE P	0%	20%		0%	10%	
IH: COS	0%	0%		0%	0%	
POS: COS	0%	10%		0%	10%	
IH: Common Sense Parenting	0%	0%		0%	0%	
POS: Common Sense Parenting	0%	20%		0%	10%	
IH: Parenting Wisely	0%	0%		0%	0%	
POS: Parenting Wisely	0%	0%		0%	10%	
IH: NPP	11.1%	0%		33.3%	50%	
POS: NPP	0%	10%		22.2%	30%	
parent training: other	11.1%	20%		22.2%	20%	
IH: trauma treatment	77.7%	80%		55.5%	50%	
POS: trauma treatment	55.5%	50%		55.5%	60%	
No trauma treatment	11.1%	0%		0%	10%	
trauma & relational history	77.7%	100%		78%	80%	
traumatic triggers	77.7%	100%	*	77.7%	80%	
maladaptive representation	77.7%	90%		77.7%	60%	
creating a narrative	77.7%	80%		66.6%	80%	
regulation of emotions	77.7%	100%	*	77.7%	80%	
reciprocity in relationships	77.7%	90%		66.6%	60%	
ability to understand others	77.7%	100%	*	66.6%	70%	
reflective supervision	66.6%	90%		55.5%	70%	
prosocial, adaptive behavior	77.7%	90%		66.6%	80%	
daily, predictable routine	77.7%	100%	*	77.7%	80%	
IH: TF-CBT	33.3%	40%		55.5%	50%	
POS: TF-CBT	22.2%	30%		22.2%	30%	
IH: CPP	22.2%	20%		33.3%	30%	
POS: CPP	11.1%	20%		22.2%	30%	
IH: TFIPT	33.3%	0%		11.1%	10%	
POS: TFIPT	11.1%	20%		11.1%	30%	
IH: TFC	11.1%	10%		22.2%	20%	
POS: TFC	11.1%	20%		11.1%	0%	
IH: alternatives for families	0%	0%		0%	0%	
POS: alternatives for families	0%	10%		0%	10%	
IH: CSP	0%	0%		0%	0%	
POS: CSP	0%	20%		0%	10%	
other services	0%	10%		55.5%	30%	

priority status: substance abuse	33.3%	50%		44.4%	50%	
priority status: DV providers	22.2%	30%		22.2%	30%	
accrediting bodies: JCAHO	11.1%	0%		14.2%	0%	
accrediting bodies: COA	88.8%	90%		85.7%	100%	
accrediting bodies: CARF	0%	10%		0%	0%	
recruit homes for special needs	77.7%	70%		57.1%	55.5%	
recruit foster-adopt parents	88.8%	70%		85.7%	44.4%	0.09
encourage adoption conversions	100%	100%		100%	100%	
recruit relatives as foster/adoptive	100%	88.8%		100%	88.8%	
encourage relatives to adopt	100%	100%		100%	88.8%	
relatives as LG or adoptive parent	100%	90%		100%	100%	
over/under rep. of minorities	66.6%	60%		100%	77.7%	
ready to screen for trauma symptoms	4.0	4.3		3.7	4.6	
have families who could benefit	4.3	4.5		4.0	4.7	*
actively support TIP	4.6	4.8		4.4	4.7	
have seasoned staff	4.3	4.4		4.4	4.2	
tradition of learning/changing	4.3	4.6		4.2	4.5	
TIP is consistent with leadership	4.5	4.5		4.2	4.6	
interaction with communities	4.0	4.0		3.7	4.1	
staff positive about changes	4.3	4.4		4.2	4.6	
tip consistent with on-going practice	4.4	4.5		4.0	4.5	
staff agree about EBPs	4.4	4.3		4.4	4.6	
staff know the adv. Of EBPs	3.6	4.3		3.5	4.4	*
staff know adv. Of RCTs	3.4	3.8		3.5	3.8	
staff know changes are coming	3.7	4.5		4.0	4.5	
caseload/direct care hours	3.5	3.7		3.7	3.3	
measurement sys. For feedback	3.1	3.7		2.5	3.5	
staff have adequate time for learning	3.1	3.7		2.7	3.4	
provide on-going learning	3.2	4.3		3.5	4.2	
provide financial resources & time	2.6	2.9		1.7	2.5	
staff have access to internet	4.8	4.6		5.0	4.6	
ready to evaluate	3.7	3.7		3.0	4.3	**
years in position-director	10.6	20.2	0.06	4.9	9.5	

highest degree of director	7.1	7.0		7.0	6.8	
degree in social work	71.4%	57.1%		71.4%	44.4%	
sex of director	28.5%	60%		57.1%	55.5%	
Spanish, Hispanic, or Latino	12.5%	0%		0%	0%	
race of director: white	57.1%	70%		71.4%	66.6%	
race of director: black	42.8%	30%		28.5%	33.3%	
increase in agency caseload	12.5%	30%		57.1%	44.4%	
what % increased?	0.03	0.09		0.12	0.09	
reduced funding	37.5%	90%	*	42.8%	77.7%	
what % has been lost: 0-5%	50%	66.6%		50%	42.8%	
5-15%	25%	22.2%		25%	42.8%	
more than 15%	25%	11.1%		25%	14.2%	
loss of staff? y/n	25%	70%	0.05	14.2%	77.7%	*
what % has been lost: 0-5%	66.60%	75%		0%	40%	
5-15%	0%	25%		0%	20%	
more than 15%	33.30%	0%		100%	40%	
workload expectancy	3.10	2.40	0.08	2.10	2.30	

*p<.05

**p<.01

R= reunification

A/G=Adoption/Guardianship

Appendix B: Growth Curve Results for DECA Outcomes

Growth curve results for three DECA outcomes (Attachment, initiative, and self-regulation) for the full, intervention-only, and comparison-only samples

	Attachment			Initiative			Self-regulation		
	Full sample b(SE)	Intervention only *b*(*SE*)	Comparison only *b*(*SE*)	Full sample *b*(*SE*)	Intervention only *b*(*SE*)	Comparison only *b*(*SE*)	Full sample *b*(*SE*)	Intervention only *b*(*SE*)	Comparison only *b*(*SE*)
Fixed effects									
Intercept	48.59 (0.35)***	47.32 (0.35)***	48.63 (0.34)***	50.79 (0.36)***	49.53 (0.36)***	50.82 (0.35)***	46.72 (0.60)***	45.46 (0.54)***	46.79 (0.62)***
Screening$^{\Delta}$	4.42 (1.00)***	2.15 (1.01)*	4.47 (1.03)***	2.87(1.09)**	0.19 (1.01)	2.91 (1.04)**	3.62 (1.48)*	2.99 (1.28)*	3.79 (1.52)*
Screening^2	-0.90 (0.20)***	-0.40 (0.21)	-0.95 (0.22)***	-0.59 (0.24)*	-0.01 (0.21)	-0.61 (0.22)**	-0.51 (0.29)$^{+}$	-0.43 (0.25)$^{+}$	-0.57 (0.30)$^{+}$
Intervention	-1.31 (0.49)**			-1.26 (0.53)*			-1.18 (0.84)		
Screening$^{\Delta}$ x IB3	-2.42 (1.37) $^{+}$			-2.59 (1.48) $^{+}$			-0.87 (1.96)		
Screening^2 x IB3	0.55 (0.27)*			0.57 (0.32) $^{+}$			0.12 (0.38)		
Random effects									
var(Intercept)	41.34(4.20)	25.36(3.967)	21.32(4.13)	41.08(4.51)	32.08(4.33)	28.88(4.56)	69.69(8.53)	43.3(6.71)	72.69(9.86)
var(Residual)	59.93(3.64)	78.74(4.12)	74.42(4.18)	72.03(2.56)	79.93(4.14)	75.41(4.23)	-7.71(3.99)	72.29(5.62)	67.76(7.2)
var(Screening$^{\Delta}$)	83.46(32.88)	1.98(1.30)	0.08(0.99)	5.18(1.87)	1.34(1.14)		1.93(2.28)		
var(Screening^2)	1.50(1.01)								
Model fit indices									
Wald x^2	29.6***	4.99^{+}	19.49***	14.45*	0.37	7.99*	22.43***	9.36*	9.51*
Log Likelihood	-11,859.42	-6,195.06	-17,638.71	-11,965.44	-11,969.32	-5,731.76	-12,055.72	-3,313.99	-2,713.54
ICC	.41	.24	.22	.36	.29	.28	.50	.37	.51

$^{+}p < .10$, $*p < .05$, $**p < .01$, $***p < .001$; $^{\Delta}$All screening variables are centered at time point 1; *b*: coefficients; *SE*: Standard error; IB3: Intervention group

Appendix C: Case Review Project

EXCERPT FROM: ILLINOIS BIRTH THROUGH THREE WAIVER:

DEVELOPMENTALLY INFORMED CHILD AND FAMILY INTERVENTION (IB3)

PROGRESS REPORT

REPORTING PERIOD: 7/1/2016 – 12/30/2016

The IB3 Collaborative Case Reviews were conducted following a preliminary finding several years ago showing no association between parents completing NPP and the likelihood of reunification. We were interested in large part in understanding why reunification had not (yet) occurred following completion of NPP by a parent. While subsequent analyses of permanency outcomes with updated data have revealed a positive association between successful completion of NPP-PV (parent version) and reunification, it remains clear that completion of this evidence-based intervention is only one piece of evidence that informs the permanency decisions in Cook County. Thus, the 2017 findings from the IB3 Collaborative Case Review project continue to provide useful information for policymakers and practitioners about the relationship of clinical interventions to permanency decisions and outcomes.

IB3 Collaborative Case Review Project and Engagement Study

As previously reported, IB3 worked with Dr. Stephen Budde and Akadia Kacha-Ochana of the Juvenile Protective Association (JPA) to examine engagement and permanency outcomes for a sample of IB3 cases. The project summary follows:

Overview and Methods

One question of great interest to IB3 program staff and evaluators has been: What happens after a parent completes IB3 services? This question became particularly important for IB3 staff and evaluators when preliminary quantitative analyses of the IB3 cases showed that there was no association between completing an IB3 service and reunification. While some children are reunified quickly after a parent completes an IB3 service, permanency is delayed for many other children.

As part of IB3's commitment to learning and quality improvement, we sought to develop a better understanding of the relationship between completion of IB3 services and reunification outcomes, and the role of IB3 services in the permanency planning process. In September of 2016, the Juvenile Protective Association (JPA) and the IB3 team designed and conducted an in-depth review of 18 child cases in which at least one parent had completed a specific type of IB3 service.

The sample involved all cases (N = 18 cases) from one agency in which a parent had completed an IB3 service and a child entered care in FY14 (July 2013 through June 2014) or the first half of FY15 (July through December 2014). Thus, we were able to follow the trajectory of permanency

efforts and progress in all cases for more than 18 months after the child entered care. All of these cases were in the treatment group, which means that the cases' parents and caregivers were enrolled in IB3 services. Twelve of the children in the sample were still in care and 6 had been reunified. In all 18 cases, the IB3 service that was completed was the Nurturing Parent Program (NPP) by at least one of the natural parents. While the sample was clearly not representative of all of the children in the IB3 study, well-designed collaborative case reviews nonetheless can help to identify important challenges and concerns, raise questions for further evaluation, develop useful typologies (i.e., categories) by which to classify cases, and inform efforts to address systemic barriers to timely permanency and to improve program implementation.

In preparing for the case review, descriptive analyses of the sample were conducted using existing IB3 data on case characteristics (e.g., demographics, type of placement or living arrangement, number of siblings in care), experiences in care (e.g., length of stay in care), and experiences with IB3 services (e.g., time from NPP completion to either reunification or a fixed date if permanency had not been achieved at the time of the review). A team of 11 reviewers selected from the IB3 staff and DCFS consulting psychologists then completed detailed semi-structured reviews of records (which included records from the SACWIS database and from NPP treatment summaries) and 30-60 minute interviews with the case manager and/or supervisor who were best positioned to be able to tell the story of the case. The cases were selected from one agency, Children's Home + Aid. Both the record reviews and the interviews were structured to procure information about the life of the case, including the parent and child's history of DCFS involvement, findings from the initial Integrated Assessment (IA), service planning, progress of the parent(s) over time, progress of the parent(s) in NPP, the events after NPP was completed, barriers to and facilitators of reunification after NPP was completed, and the current status of the child and parent(s) related to the viability or sustainability of reunification.

Summary of Initial Findings

1) **Completion of NPP was usually only one piece of the permanency planning process**. While completion of and progress during NPP sometimes appeared to affect movement toward reunification (e.g., in supporting the court's decision to change visits to unsupervised or to change the permanency goal back to reunification), there was no clear or direct evidence in any of the cases save two that successful NPP completion was the primary factor in reunification decisions.[8] Instead, the reunification process appeared to be influenced primarily by multiple factors related to the parent's participation, progress, and functioning across a range of concerns that contributed to the child coming into care (e.g., domestic violence, mental health, or substance abuse), or by case-specific circumstances that were unrelated to participation in IB3 services (e.g., fathers stepping up to care for children). Furthermore, in two cases in which the court clearly viewed NPP completion as evidence that

[8] This finding pertains to NPP's role and influence on the decision-making process, not to whether case managers viewed NPP as helpful to parents—which they often did.

the case should move toward reunification, the agency disagreed with the court that NPP completion alone (i.e., compliance with that particular service) was a sufficient indicator of the parent's readiness for reunification.

2) **Other factors affecting permanency processes and outcomes** for cases reviewed included:

   a) **Critical parent risk/safety factors that remained concerns**, including the quality of parenting, mental health issues, substance abuse, domestic violence victimization, and unstable housing or income;

   b) **The level of participation and/or progress in key services in the service plan** in addressing risk and safety concerns, including parents completing NPP without making substantial gains in parental scoring or parents completing NPP but making poor progress in other services;

   c) **Caseworker and supervisors** in some cases clearly helped parents (e.g., by ensuring that services were appropriate and would not burden parents) and voiced support in court for parents who made progress in NPP; however:
      i) Turnover of caseworkers (72% of cases had more than 1 worker, 39% had more than 5) and supervisors was a barrier to permanency in multiple cases (e.g., causing court continuances, impeding service planning with parents);
      ii) New and inexperienced caseworkers sometimes, understandably, struggled to understand and respond effectively to risk issues in cases involving parents with severe and chronic problems (e.g., mental illness and substance abuse) or serious forms of maltreatment of young children (e.g., failure to thrive due to neglect);

   d) **Fathers** who were not involved in previous maltreatment and who were not currently involved with the mother stepped up and were "reunified" with two children. They both completed NPP, and it was viewed as particularly helpful for one father;

   e) **Child factors** such as number of children in a case and children with special needs posed challenges to reunification in some cases;

   f) **Court delays were apparent in multiple cases**, although these delays occurred for a variety of reasons (e.g., caseworker and supervisor turnover) and only rarely appeared to be due to factors that the court itself controlled (e.g., changes in judges). It should be noted that data collection for the case review focused on what had happened since NPP completion and likely contained little if any information about the frequency of and reasons for early delays in the adjudication process.

3) **Parents who *successfully completed* NPP varied in their attendance, progress, and the perceived adequacy of functioning as a parent**. Interestingly, given that NPP completion did not appear to be a pivotal factor in permanency decisions in most cases, there were

pronounced differences between reunified and non-reunified (referred to as Still in Care, or SC) cases in these measures:

a) NPP attendance problems were more common in SC cases (63% of SC vs. 0% of reunification cases);
b) While most parents in SC cases (92%) had summary ratings of either *some* or *substantial* progress in NPP (based on analysis of data from the standardized measure—AAPI, the treatment summary by the NPP facilitator, and interviews with the caseworker), they were less likely to show *substantial* progress in parenting competency by the end of NPP (25% for SC vs. 83% for reunification cases);
c) Parents in SC cases were less likely to have a *low risk* level of functioning at the end of NPP (25% vs. 100%) and more likely to have a *high risk* level of functioning on at least one NPP competency (50% vs. 0%);
d) Additional parenting services (CPP, coaching) were recommended after NPP completion in 75% of SC cases.

4) **Among children still in care, parents varied in their current viability and readiness for reunification (VRR).** The following typologies were created and refined from the information collected, reviewed, and analyzed from the collaborative case review. Based on the "molar labels" that aim to describe the overall viability and readiness in practice-relevant language, SIC cases from this review could be classified into four VRR levels:

   a) **Not viable (n = 4)**: Even when a parent completed a key service such as NPP, there were four cases in which reunification of the target child was simply not viable or advisable. Reasons for non-viability included: extreme maltreatment in which the parent was directly involved; both parents were not available and had disappeared for at least 6 months; the case's target child was going to stay with a relative who had cared for the child since birth while the mother focused on reunifying with a different child; one or both parents' severe and recurrent mental health or drug abuse problems; and repeated failure to attend or comply with services to address critical risk or safety issues—especially related to mental health problems, substance abuse, domestic violence, and/or visitation with the child.

   b) **Possibly BUT unlikely (n = 3):** In these cases, parents usually were compliant with some services or visits, and sometimes there was evidence of modest progress (e.g., in NPP), **BUT** reunification appeared to be highly unlikely. Usually, there were multiple concerns that still existed. Concerns included inconsistencies or problems with:
      i) Participation or progress in some key services or visitation;
      ii) Adequacy of parenting (e.g., a mother with significant cognitive deficits);
      iii) Risk and safety factors.

   c) **Maybe IF (n = 3)**: In these cases, a parent had reliably complied with NPP and other key services and had often made demonstrable progress. The parent also appeared highly

motivated for reunification and able to adequately parent child—even though continued services and support may be needed. But reunification could only occur **IF** specific critical issues were addressed (e.g., paramour gets involved in services or agrees to reunification plan; parent reliably avoids domestic violence exposure; parent obtains adequate housing; parties settle disagreements about the parent's viability/readiness). Reunifying multiple children in care with the same parent appeared to pose challenges in some cases (e.g., the need to find adequate housing or the anticipation of increased parenting stress of reunifying with multiple children including young children)

d) **Likely WHEN (n = 2)**: In a small number of cases, everyone appeared to be planning for reunification. Parents had complied with and made substantial progress in services and had manifested strong motivation to get the child back. Reunification was planned for **WHEN** a small number of important and specific things occurred and there appeared to be confidence these tasks will occur—such as getting appropriate housing for multiple children and starting CPP to support stable reunification with a father.

Discussion and Implications

Understanding the relationship of IB3 service completion to permanency outcomes. Two of the central findings of the case review are in some ways not surprising—that, even among parents who completed NPP (1) permanency outcomes were affected by multiple factors rather than just completion of one therapeutic parenting service and that (2) there was variation in the amount of progress parents made in NPP and in their level of parental functioning at discharge from NPP. These seemingly simple and straightforward findings can nonetheless help us begin to understand and explain the initial quantitative findings showing a lack of association between completing an IB3 service and reunification outcomes. The assumption that completing high quality clinical services will affect child permanency outcomes by increasing the relatively low rates of reunification in Illinois is central to the IB3 theory of change and, indeed, to the cost-effectiveness outcomes of the waiver. The collaborative case review findings suggest that even for NPP completers, the relationship of service completion to permanency outcomes is likely mediated by factors unrelated to IB3 and the parent's progress in NPP. The IB3 team is actively exploring ways to better understand and address systemic barriers and challenges related to the referral and linkage process for IB3 services, as well as the need to monitor client involvement in services more closely and improve communication in court about IB3 services and the progress of parents in treatment.

It is important to note that IB3 service completion may begin to show an impact on reunification rates (both within the treatment group and relative to the control group) as permanency outcomes are tracked over longer periods of time. Furthermore, and farther down the child's trajectory of permanency outcomes, it is also possible that reunifications that do occur will be less likely to be disrupted if parents have participated in IB3 services. Whether or not such findings emerge, the strong association in this small sample between reunification status and nuanced indicators of

participation in NPP and change over time in parenting competencies offers hope that future quantitative analyses will be able to identify cases in which NPP made a difference in both parenting and permanency outcomes.

Two alternative explanations of the lack of association between service completion and permanency outcomes are worth identifying. First, what appears to be progress in NPP or high levels of post-NPP functioning may stem more from certain intrinsic or pre-existing characteristics of those parents or cases rather than from the intervention itself. For example, making progress in NPP or high levels of post-NPP functioning might be explained by the fact that these parents were highly motivated toward reunification and would have made progress in any parenting services regardless of the quality of services. While this explanation is difficult to rule out, clinical interventions like NPP and CPP can and do help to address this issue by articulating how these specific interventions nurture parental motivation and understand the process and indicators of therapeutic change.

Another competing explanation for the lack of association between NPP completion and reunification is that IB3 interventions are insufficient to produce the types of parenting outcomes that will actually influence reunification. The current plan for implementing NPP in IB3 focuses on the 16 weeks of group sessions, which may be insufficient for some or many parents who experience chronic or severe trauma in their own lives. NPP therapists noted in multiple discharge summaries that parents needed to work on applying the parenting competencies they had learned in their actual interactions with children. It may be that 16 weeks of primarily supportive and psychoeducational interventions can yield important changes in parenting attitudes (as measured for example by the AAPI), but many parents with children in care in Illinois need additional and potentially longer term hands-on support and coaching in order to make substantial changes in their actual parenting behaviors and relationships with young children. This type of longer term dyadic clinical intervention is available through CPP, which is often designed to follow NPP. In addition, the IB3 team is exploring strategies for augmenting NPP group sessions with home coaching for some parents and for effectively targeting these services.

It is important to recognize more broadly that it is often difficult to assess the adequacy and reliability of parenting when children are in care and not living at home. Graduated visitation plans and creative co-parenting strategies provide useful opportunities to promote parent-child attachment and can offer some limited opportunities to assess actual parenting. In addition, multiple discussions of quality improvement in IB3 have emphasized the need to provide support for many parents during and after the reunification event. For many parents, intensive clinical services and support are most needed during and after reunification. One way to improve reunification outcomes (and time to reunification) is to identify those cases more quickly in which reunification is viable and provide IB3 services more quickly in order to support and sustain reunifications. The often implicit assumption that intensive clinical services for parents

should stop before reunification has occurred is a fundamentally flawed model for clinical and casework programs that aim to improve reunification outcomes.

Viability and Readiness for Reunification—a framework for improving permanency outcomes for young children. Intervention strategies (decision-making, clinical & supportive services, and policies) designed to ensure timely permanency should respond to (1) an understanding of the viability and readiness for reunification (VRR) status of each case and (2) the associated challenges that contribute to delays in seeking reunification, ruling out reunification, or pursuing adoption or subsidized guardianship. Timely permanency is especially critical for very young children in care given the centrality of early attachment relationships to their well-being and brain development. The attached table, which articulates the four levels of the VRR framework including the common challenges and potential strategies of each level, offers a clinically appropriate and developmentally sensitive framework for potentially decreasing time to permanency and increasing permanency stability for cases involving young children in care.

At a minimum, the VRR categories and framework appear to some people who have reviewed them to provide a potentially useful tool for discussing cases, organizing information, and planning differential intervention and systemic response strategies. As such, they could help practitioners and systems to move away from relatively undifferentiated processes and practices that sometimes appear to be the default response to young children and parents. Below we offer brief illustrations of the potential utility of this framework with the understanding that broader implementation of such a framework would require considerable planning and evaluation.

Cases in which reunification is clearly *not viable* can be identified through both formal and clinically individualized criteria for expedited permanency. In these cases, caseworker agencies, DCFS, mental health providers, and the courts should grapple with procedures, inertia, and contextual and interorganizational patterns that inhibit efforts to meet the psychological and physical needs of young children with permanency.

Similarly, in some cases where reunification is *possible but unlikely*, in spite of substantial evidence about current and longstanding safety issues, inconsistent attendance, and lack of actual progress in key services or visitation, providers and the court sometimes appear to value simple compliance by a parent with some services as sufficient reason for giving parents multiple chances to make necessary changes or simply not moving quickly toward exploring alternatives to reunification. We suspect that these children will tend to linger in care even when reunification is not realistic and warranted. In these cases, starting concurrent planning quickly is critical and practitioners in all professions should undertake the challenging task of distinguishing between parental compliance with some services, the actual progress made by the parent(s), and the adequacy of their level of functioning, especially with regard to parenting. In the service of meeting the child's developmental needs, procedural changes can focus on determining quickly whether parents can make meaningful gains in functioning.

For *maybe when* cases, it is often hard to know whether specific issues that appear to impede reunification (e.g., need to find adequate housing, paramour is not willing to participate in services) are reflective of bigger concerns (e.g., parental ambivalence about reunification, safety issues such as domestic violence). In these cases, especially because the parent appears motivated and has made some progress toward addressing concerns that brought the child into care, practitioners and courts may be inclined to keep children in care for longer periods of time even when important concerns do not get resolved. To determine the actual viability of reunification, parents, practitioners and collaborative intervention modalities (e.g., child and family teams, court mediation) should aim to identify and resolve specific barriers to reunification as quickly as possible while also actively pursuing concurrent planning. If the parent does not work actively with others to resolve these barriers or other barriers pop up after one barrier is resolved, the reunification may not be as viable as had appeared. Conversely, active parent involvement in resolving barriers would support movement toward reunification.

In those cases in which reunification is *likely WHEN* specific issues are resolved, concurrent should not be pursued. All efforts should be focused on resolving pressing issues as quickly as possible, returning child(ren) home, and ensuring that parents have the clinical, case management, and social support needed to help the parent and child(ren) make a successful and sustainable transition.

The IB3 evaluation team is exploring the potential utility of the VRR framework. Questions about the VRR status of cases have also been added to the upcoming IB3 surveys with case managers. This will help us to examine the potential utility of the VRR categories for research and evaluation purposes—for example, whether VRR status predicts the likelihood and timeliness of reunification.

Reunification with parents, especially fathers, who were not involved in the initial maltreatment. In two of the six reunification cases and for one child moving toward reunification, previously uninvolved fathers stepped up and assumed primary responsibility for children. While the fathers were not involved in the initial maltreatment or current safety concerns pertaining to the mother, for at least two of the fathers, NPP appeared to provide them with necessary support and guidance. For one of these fathers, CPP is scheduled to start in order to provide continued therapeutic support after reunification occurs. It is unclear to us how often these types of scenarios occur when viable fathers emerge. Consistent with much advocacy for fathers in child welfare, we should track this subpopulation more carefully and consider how intervention and decision strategies can be responsive to their strengths and needs.

Consequences of worker turnover. Caseworker turnover is a common challenge in private child welfare agencies in Illinois. Systematic issues (e.g., low pay relative to the public sector, high levels of stress related to external pressures on the frontline staff) likely contribute to high levels of turnover. While it is beyond the scope of this inquiry to address these underlying causes, it is important to acknowledge them and to highlight some of the potential consequences of worker

turnover that we observed. There were several cases in which worker turnover contributed to permanency-related delays in court and examples in which stable trusting relationships with committed caseworkers appeared to help parents take steps toward reunification. That said, given our small sample, it is unclear if turnover is actually influencing time to reunification (or other permanency outcomes). The qualitative findings support the need to examine the relationship of turnover to IB3 permanency outcomes in upcoming quantitative analyses. Such analyses are also warranted given the surprising paucity of research on this and mixed findings in the existing literature. For example, while Flower, McDonald, and Sumski (2005) found, as expected, that high rates of turnover increased time to permanency, Goerge (1993) found that worker turnover was associated with *increased likelihood of* reunification. Since the continuity and quality of the caseworker's relationship with parents may also contribute to parent and foster parent decisions to participate in and complete IB3 services, we also encourage analyses of the possible effect of turnover on proximal service engagement and participation outcomes.

Not surprisingly, reviewers learned during interviews that new caseworkers sometimes knew little about the cases in question. In addition, as noted earlier, new and inexperienced caseworkers struggled to understand and respond effectively to risk issues in some complex and challenging cases. These findings highlight the need for systematic efforts to help new caseworkers manage the challenging process of starting each case, including learning about the history, progress, and current status of cases while also beginning to build a constructive collaborative relationship with parents, foster parents, and children. The fact that this transition occurs in the context of a loss and a relational disruption (i.e., the former caseworker leaving) certainly complicates the relationship-building process. With regard to helping new workers, reviewers learned firsthand about how difficult and time-consuming it was to learn enough about the history, progress, and status of each case to be able to give accurate and thorough answers to many of the questions posed in the case review process. Reviewers expressed considerable empathy for new caseworkers who have to get up to speed quickly on 15 to 20 cases. For each case transition, new caseworkers need ongoing clinical supervision and support. We suggest that systematic procedures for reviewing cases could also contribute to helping new caseworkers learn about each case, including case challenges to be addressed and opportunities for relational engagement.

IB3/JPA Collaborative Case Review: *Viability of and Readiness for Reunification (VRR)* Framework for Improving Permanency & Well-Being Outcomes for Young Children

For young children in care, permanency strategies (decision-making, clinical & supportive services, policies) should respond to our understanding of VRR in each case

VRR	Description/Criteria/Examples	Types and Causes of delays	Decision, Clinical, and Policy Strategies
Not viable	Even if parent completes a key service (e.g., NPP) other factors make reunification not viable. Examples: • Extreme maltreatment/parent directly involved • Parent disappears • Child lived w/relative since birth, parent focused on reunifying w other child • Repeated failure to attend key services (especially MH, substance abuse, DV, housing) related to safety/risk factors or comply with visitation plans • Level of functioning as parent is not minimally adequate—children would not be reliably safe	• Infrequent use of expedited permanency, even with cases involving very young children • Initial IA assessment & prognosis often ignored in court (by practitioners too?) • Emphasis on giving parents *multiple chances* even when this is detrimental to development/attachment for young children • Bureaucratic inertia, difficult to act quickly • Delays in adjudication	• Articulate (update) criteria for expedited permanency given young child's developmental time frame or special needs of child(ren) • Try to identify viability concerns more quickly (initial IA and first 3 months) and move to TPR • Identify later points in process when expedited procedures can kick in given changes in viability • In some cases, offer intensive clinical interventions quickly to try to give parents their best chance • Actively find fathers or start SG/adoption processes ASAP
Possible BUT Unlikely	• Parent complied with (i.e., attended/completed) *some* services/visits or made *some* progress • BUT participation and/or progress in services are limited or inconsistent • BUT major or multiple concerns still exist related to safety/risk factors or progress in visitation (e.g., problematic visits, slow or no movement to unsupervised visits)	• Hard to resolve dilemma: compliance vs. major concerns remain • Compliance with services tends to be primary focus of service planning/assessment but progress and level of functioning are critical • Emphasis on *multiple chances*, even with very young children in	• Identify and assess competing evidence in direct and transparent way in ACR, CFT, court • Tighter time frames for starting to make progress in services and addressing risk & safety concerns, including providing clinical services (NPP coaching, CPP) and supports if needed • Avoid narrow focus on compliance in casework practice and court decision making—increase awareness of distinction between *compliance*,

		care and importance of reliable and early attachment experiences	*amount of progress*, and *level of functioning*, especially related to parenting or addressing key risk factors • Urgent concurrent planning to move toward two possible options—reunification or adoption/SG
Maybe IF	• Parent reliably complied with key services, usually has made some or substantial progress, & no major concerns about level of functioning as a parent • Parent appears highly motivated for reunification and able to adequately parent child (even though further support may be needed) • Child could come home if specific critical issues are addressed (e.g., paramour gets involved in services or agrees to reunification plan; parent reliably avoids DV exposure; obtains adequate housing; disagreements among parties about readiness for reunification) • Multiple children in care in some cases	• Waiting for some critical issue to be addressed or some disagreement to be resolved • Hard to know if specific issue (e.g., housing) is really the barrier or if it represents other concerns • May wait longer if parent appears motivated and has made progress (*without resolving issue*)	• Try to resolve specific parent/family risk/safety issues quickly through CFT, mediation, or other mechanisms • Avoid narrow focus on compliance in casework practice and court decision making—increase awareness of *progress and functioning*, especially related to parenting • Use targeted concrete supports (e.g., Norman funds) if applicable • Request independent assessments when parties can't agree on readiness for reunification • Urgent concurrent planning to move toward two possible options—reunification or adoption/SG • If warranted, move case to Likely WHEN and suspend concurrent planning

Likely WHEN	• Parent complied with and made substantial progress in services, AND high level of motivation to care for child • Small number of important and specific things need to occur, but it appears that they will/should occur, such as getting appropriate housing for multiple children and starting CPP • Father with no involvement w mother or maltx steps up • May still need post-reunification support (e.g., CPP, NPP coaching) and/or casework/monitoring	• Hard to know if specific issue (e.g., housing, paramour) is really the barrier or if it represents other concerns • Bureaucratic inertia, difficult to act quickly • May be hard to identify some of these cases quickly • Reunification of young child, special needs child, or multiple children will likely increase parental stress.	• Identify VRR status early and on ongoing basis (need criteria), including identifying motivated fathers • Aim to facilitate successful transition and long-term stability • Provide post-reunification clinical services (e.g., NPP coaching or CPP, individual therapy), casework support/monitoring, and concrete support (e.g., Norman funds, other support for housing)

Feedback welcome: Stephen Budde, PhD, sbudde@jpachicago.org

Appendix D: IB3 focus group study on the experiences of foster caregivers who completed NPP-CV through IB3

Overview

Over the past several years, IB3 program staff have heard multiple anecdotal reports about two types of responses caregivers (foster parents) often have to the Nurturing Parenting Program (NPP-CV): that were not sure why they needed to participate and that those who chose to participate really enjoyed and benefited from NPP. IB3 program staff wanted to better understand and articulate the experiences of foster caregivers who have completed NPP-CV through IB3. Focus group discussions were conducted with a sample of these caregivers in order to gather information directly from the caregivers related to the following research questions:

1. What worked well with NPP-CV for foster caregivers who completed the group?
2. What needs still remained for those caregivers?
3. How did NPP-CV affect how caregivers care for themselves and for their children across the five constructs measured by the Adult-Adolescent Parenting Inventory (AAPI)?

Methods

The foster care agencies and any licensing staff of foster caregivers in IB3 who are NPP-CV completers were informed about the study purpose and about recruitment of their foster parents for focus group participation. NPP-CV training staff mailed letters about participation in the focus group to approximately 160 caregivers who had completed the class; follow-up was requested either by email or phone. Letters translated in Spanish were mailed to Spanish-speaking NPP-CV completers in order to ensure their representation in the study. A total of 23 participants had expressed interested in attending the focus group study. On the night of the focus group, only 9 foster caregivers were able to attend, one of them a Spanish-speaker. Others who had initially expressed interest but did not attend may have been deterred by a thunderstorm warning that night or the unavailability of child care during the study. The 9 caregivers who attended were divided into two groups of 4 and 5, each group facilitated by a researcher from the Juvenile Protective Association (JPA) with IB3 program staff taking notes. In one of the groups, Spanish-speaking therapists from JPA were available to translate to and for the Spanish-speaking caregiver as needed. Caregivers were asked questions about the following: their experiences with NPP-CV—including how they learned about it, initial impressions, thoughts on their class facilitators and other caregivers taking the class, home visits, AAPI scores, and homework assignments; the type of support they had while taking NPP-CV and what resources they wished they had; and what they learned in NPP—with regard to taking care of their children and taking care of themselves, the trauma their children experienced, the content of what they learned, and how what they learned affected their parenting. The duration of each of the focus groups was about 2 hours. After the focus groups, notes taken during the discussion were reviewed among JPA and the IB3 program staff supporting the focus groups. IB3 staff provided additional quantitative information about each case. Main themes were summarized and are presented here

Summary of Findings

Quantitative Findings

The foster caregivers were divided into two groups: Group A had 5 foster caregivers (one of them Spanish-speaking) who had completed NPP-CV in IB3 and Group B had 4 foster caregiver completers. Below is a table of some of the characteristics of the participants. All of the caregivers were female. In Group A, 60% of the caregivers were fostering children not related to them, whereas all caregivers in Group B were foster parents to children with whom they had no biological relation. All of the caregivers in both groups had either adopted the child (and one had subsidized guardianship) or were on the road to adoption or subsidized guardianship—illustrating the commitment of the caregivers to the children they're fostering regardless of their biological relations. The commitment was further highlighted throughout the focus group discussions, in which foster parents would use the possessive "my children" in referring to the children they were fostering. For 60% of the caregivers in Group A, two or more years had passed from the time they completed NPP-CV to the time of the study, similar to half of the caregivers in Group B. Despite the length of time that had passed from the time the caregivers in both groups completed NPP-CV to the time of the study, the participants were able to recall their experiences with the class during the focus group discussions.

	Group A (N=5 participants)	Group B (N=4 participants)
Sex	n=5 females	n=4 females
Race	n=4 (80%) were African-American n=1 (20%) was Hispanic	n=4 (100%) were African-American
Placement type	n=3 (60%) home of relative placements n=2 (40%) foster home placements (no relations to child)	n=4 (100%) foster home placements (no relations to child)
Permanency status	n=2 (40%) adopted children n=1 (20%) has subsidized guardianship (of related child) n=2 (40%) goal of adoption or subsidized guardianship	n=1 (25%) adopted children n=3 (75%) goal of adoption or subsidized guardianship
Estimated time from NPP-CV completion to study	n=1 (20%) less than 1 year n=1 (20%) 1.0-2.0 years n=2 (40%) 2.1-3.0 years n=1 (20%) more than 3 years	n=2 (50%) 1.0-2.0 years n=2 (50%) 2.1-3.0 years

Key Qualitative Findings

I. While caregivers expressed reluctance when first referred for NPP-CV, their overall experiences of the class were overwhelmingly positive. Most caregivers from both focus groups A and B first learned about NPP from their caseworkers or casework agencies, with some receiving letters or phone calls.

In Group A, most participants expressed initial reluctance to being referred to NPP-CV, and one expressed initial surprise; one caregiver remarked that initially she wondered: "Why do they have me here? I've already raised children." Another caregiver in Group B echoed those sentiments: "I've had him [the foster child for whom she was referred for NPP-CV] since he was 8 months I'm not sure why I have to take this class."

In Group B, some caregivers expressed initial interest in the group as a chance to meet with other caregivers and spend time with adults. Others in Group B expressed initial confusion about the trauma focus of the group that had been described to them, suggesting no obvious traumas that had been experienced by their children.

All of the caregivers in both groups were in agreement that the program helped them in multiple ways, with caregivers stating they would take NPP-CV again if it was possible. Group A caregivers remarked that NPP-CV allowed them to learn about how to "restructure" the way they parented in a safe environment in which they did not feel ashamed about what they did not know and were able to be open. One caregiver in Group A stated that her family's situation "calmed" once she began NPP-CV because she began to understand what was happening and what had happened to the children for whom she was caring (i.e., trauma experiences), and learned how to manage her foster child's behaviors: "The program helped. It was like therapy." A Spanish-speaking caregiver described NPP-CV as a tool to help her learn what she needed in caring for her children: "We have all the ingredients; we just don't know how to put them together to create the recipe. [NPP-CV] provided us with directions to complete the recipe." Overall, caregivers felt that NPP-CV was a "great experience."

II. There was much that the caregivers liked about NPP-CV, specifically the support from other caregivers in the class and the facilitators. Caregivers had family and social relations that supported them throughout NPP-CV. Caregivers shared they felt safe enough in the NPP-CV classes to open up to share experiences, provide understanding, and learn something different. The caregivers and their classmates acted as a support system. The way the caregivers interacted with each other within the focus groups themselves demonstrated that the caregivers had internalized the skills and knowledge that were taught in NPP-CV, including the effects of trauma, being empathetic, and engaging in self-care. For example, though meeting for the first time in the study, the Group B caregivers were very open with one another and discussed enjoying the time in the focus group to connect with other caregivers; when problems with a child or with the foster care system arose in the focus group conversations, caregivers offered support, suggestions, and contact information to help one another. One caregiver shared, "this is what you get in the groups, the sharing of the experience". In Group A, a discussion rose up organically when a caregiver mentioned she was struggling about whether or not to tell one of

her children that he is adopted; the other caregivers offered advice, and suggested they exchange phone numbers to talk more after the focus group.

Nothing but praise was given for the NPP-CV class facilitators. Caregivers mentioned the instructors to be "relatable" and "uplifting," which differed to one participant's experience in other classes where instructors felt "far away and unreachable." In Group A, caregivers liked the tag-teaming style of two NPP-CV facilitators leading the class. Caregivers stated that the NPP-CV facilitators "did not hide anything" and "gave examples explaining things in a way that were understood." When child care issues arose, participants spoke to the flexibility from the NPP facilitators to bring the child with them so they would not miss class. In Group A, the Spanish-speaking caregiver had a unique experience in which she was the only person in her class, and she enjoyed the individual attention she received from her sole facilitator.

Interestingly, though the monetary incentive implemented by IB3 for those who complete NPP-CV was not mentioned during any of the focus groups, one caregiver in Group B appreciated how many credit hours NPP-CV counted toward their licensing.

Participants enjoyed being "brought back to childhood" by engaging in activities like the "hokey pokey," a dance. It is possible that the parents' experience of having fun and being able to be kids in the context of the NPP-CV allowed them, through a parallel process, to give their children an experience of being kids. Additionally, there was appreciation in having a diverse age range of caregivers taking NPP; one caregiver mentioned having an older caregiver taking the class along with her, which provided her with an understanding of her own mother's experiences.

Focus group questions related to support asked caregivers if: they ever needed help from their family or friends to attend NPP; what resources they were able to use; and in Group B, they were asked what help they wished they had. Caregivers documented the support they received from their family members and how it was crucial to allowing them to attend class; family supports were credited with babysitting, helping make dinners, and even learning along with them throughout the program. In Group A, one of the caregivers mentioned her support system attended NPP-CV with her. None of participants in these groups mentioned receiving support from caseworkers, other agency staff, or other childcare supports.

III. Parents did not have anything bad to say about NPP-CV and how it was delivered; scheduling the class was the most prominent challenge. Remarkably, participants noted very few things they did not like about NPP-CV. All caregivers in Group B agreed that limited class options made it difficult to sort out their schedules; one caregiver noted this: "Initially I did not like I had to go and juggle my schedule, [but once you were there] it went fast." When issues with their childcare arose, caregivers described the flexibility of facilitators in allowing them to bring their children with them to the group. In Group A, most agreed that the video used in the class was outdated and could be replaced.

IV. Most caregivers demonstrated awareness of trauma and its impact. In Group A, participants discussed the trauma their foster children experienced and how it affected them without using the words for trauma: "When kids have been hurt and are just blank, one day they might start showing emotions and give you hugs. As caregivers we just melt and continue to help fill in those emotional gaps and other gaps we may not even know are there. It's a lot of work." When Group B was initially asked about trauma, the group brushed off the concept and required further probing. Throughout the rest of the conversation after the question about trauma was posed, participants kept referring back to trauma and demonstrated an understanding of this concept. One caregiver was discussing her infant's sleeping issues and another stated "well that's trauma right there…being is three homes already [referring to a 5.5 month old baby]." Another caregiver wanted to learn about trauma "because my kid was being taken to visits in jail. Y'all taking him to visit her [his mother] in jail, how is that gonna affect him. He has been in the system so long, I'm kinda seeing some things." Given the focus on trauma in NPP-CV, it is likely that these examples reflect an increased understanding of trauma and its harmful effects. Furthermore, the "real-life" descriptions of trauma and loss that children experience reflect a more genuine interest and understanding than if caregivers were simply using trauma terminology without connecting the words to their experiences with children.

V. Caregivers were able to discuss how their parenting changed because of NPP-CV. The five constructs of the AAPI focus on understanding the skills and abilities of children, parental empathy, disciplining children, appropriate parental expectations of children, and empowering children. In Group A, time within the focus group ran out before the group was asked specifically about each of these topics. In Group B, questions were posed about what caregivers learned within each of these constructs and how that learning affected their parenting. However, because the content of the constructs overlap, the findings are presented generally here.

Caregivers from the focus groups described learning new information about what was happening to their children, how to respond, and how to make sure they were taking care of themselves in the process. Group B participants spoke to learning about developmental expectations for their child at a certain age: "For our family it tailored [us] to not be *that* parent [referring to her own upbringing] and manage [our] expectations of a child. He [the child] can hold a conversation, but he is still a child." Caregivers discussed having to treat each child different as they have their own skills and needs. One mother said: "Sometimes I wonder why they are acting like that. I want to have expectations and I shouldn't. I check myself, [it's] and ongoing process." All participants discussed how the child's needs changes, and they actively work to change with them. One caregiver stated that "kids actually learn the way you teach them, if you teach them correctly. The biggest time for a child to learn is birth to 3. The important learning stages, these constructs are really valuable during these years… kids don't forget, is it about unlearning [referring to things from previous homes that child had been placed in]." This particular caregiver demonstrated an understanding of the critical development period within a child's first three years of life.

The idea that "kids should be kids" came up multiple times in both groups, indicating an understanding of parentification. In Group B, a caregiver stated that NPP-CV involved "learning you are putting your heart where they [children] are, teach them to be social, and you want to raise them to be respectful. You also want them to be free and be children. I'm 50 years old and I have been taught something new that I can instill in him, something he can learn. I've learned the difference." Caregivers in both groups discussed having to educate family members on what they had learned—for example, the difference of spoiling a child or over correcting a child versus showing them appropriate levels of attention.

Several participants stated the area of discipline was a challenge in participating in the class and acknowledged it as an area of growth. Caregivers in Group B expressed the class helped them learn improved ways to discipline their child that did not including hitting or spanking. This was discussed as a difficult pattern to break, as many had known that form of discipline from their own upbringing. One participant stated: "Discipline is a big thing in the black community, especially in the 60s and 70s, that era is so different than the discipline we have to give out, we have to relearn." Caregivers indicated a change in attitude concerning discipline after NPP-CV; one caregiver in Group A commented that she "enjoyed seeing older caregivers [in the class] learn new discipline techniques instead of using threats like, 'I'll knock you into the next day.'" Group A also discussed specific discipline techniques they learned in NPP-CV, including giving children time outs, taking things away from them (such as turning the TV off, or sending the child to bed earlier), and giving children less attention when they are throwing a tantrum.

Self-esteem was recognized as important concept to learn as the children "get down regularly by being in the system". The participants verbalized building self-esteem by giving children appropriate tasks to build confidence and praising accomplishments. The importance of empowering children was suggested by a caregiver in Group A: "Kids also have a lot of energy and you [the caregiver] need to show them patience, love, & compassion. Empower your child."

Caregivers appreciated learning the concept of self-care, with many actively using this practice today. Caregivers described self-care techniques they learned from NPP-CV and which they still find themselves using, such as taking "me time" (one caregiver remarked taking her me-time in the garage, and another in the bathroom even if it is just for five minutes), deep breathing, and praying.

VI. Caregivers recommended expanding NPP-CV to more audiences, and providing more times and locations the class can be taken and refreshers on the NPP-CV concepts taught. Interestingly, caregivers brought up the following recommendations for NPP-CV even when the facilitators in both groups did not pose a question directly on the caregivers' thoughts for recommendations. Caregivers in Group A suggested that NPP-CV be offered to: new parents, even those not involved with DCFS; to youth in group homes; and to youth in alternative high schools, where one of the participants has worked with teenage parents. Parks and libraries were identified as potential venues for the class. Caregivers in Group B suggested the class be mandatory for all foster parents (and biological parents), as they all learned a lot from participating in the class. One of the caregivers said: "Honestly, this is a good class to help foster

parents. I think this needs to be across the state." Caregivers' multiple recommendations for expanding NPP-CV can be viewed as illustrating their enjoyment of and strong belief in the benefits of the program.

Caregivers in Group B recommended that NPP-CV offer more class time and day options. Some were surprised to learn that other caregivers were able to take the class on a weekend, while weekend group members were surprised to hear that evening classes were offered to others. They also were surprised to hear of the available locations and stated that they wish their class had been at the other location.

Group B caregivers recommended offering a half day refresher course for participants to be reminded of concepts and to be able to address new development concerns that they may have, as well as to be reunited with fellow caregivers from their class.

Limitations

It is not possible to generalize the findings to the experiences of all caregivers caring for foster children in IB3, given that the sample size for this study was small (N=5 in Group A and N=4 in Group B). The self-selected participants were likely more interested and committed to improving their parenting than most caregivers. This study does not capture the experiences of those caregivers who were referred to NPP-CV but did not start or those who started NPP-CV but did not complete the program. Nonetheless, the findings presented here illustrate the importance of NPP-CV to a sample of caregivers in terms of learning new parenting skills and knowledge, accessing resources and supports, and practicing self-care as they continue to parent.

Appendix E: Implementation at-a-glance

IB3 utilized the two tables below to reflect on some of the key implementation challenges that arose throughout the 5 years of the waiver (beginning July 1, 2013 through June 30, 2018), and the strategies utilized to address those challenges. Past semiannual reports were reviewed and conversations with program staff and researchers were held to document those challenges and the ways they were addressed. IB3 hopes that this information can provide implementation guidance for future child welfare programs.

Table 1: IB3 key implementation activities: IB3 program eligibility and assessments, CPP, NPP, and implementation support

	IB3 Program, Program Eligibility, and Assessments	**Child Parent Psychotherapy (CPP)**	Nurturing Parenting Program (NPP)	Implementation Support
FY14 Q1—Q2 July 1, 2013—December 31, 2013	Process for coding/identifying intervention and comparison waiver cases implemented: rotational assignment Manual master log created to track case assignment Enhanced screenings conducted on all new cases fitting eligibility criteria Risk determinations completed on 128 cases as of 12/17/13 Extensive work conducted on risk determination algorithm IB3 assessment manual written Weekly technical assistance and consultation meetings held by IB3 staff with Integrated Assessment staff to support implementation of the Waiver's enhanced assessments "Refresher training" held to review and discuss administration issues with the use of the instruments	CPP fidelity monitoring tool developed IB3 enhanced screening tools adopted by CPP providers		Ad hoc meetings held to support implementation efforts
FY14 Q3—Q4 January 1, 2014—June 30, 2014	309 risk determinations completed Increased consistency in decision-making for process of risk determinations IA managers and EC supervisors meet	Waitlist created due to limited CPP provider capacity Due to waitlist, intervention cases are now identified as sequential, these cases are offered NPP services	121 children, 162 birth parents identified for NPP 47 NPP-PV referrals made 34 NPP-CV referrals made Barriers identified for both birth and	Ad hoc meetings held to support implementation efforts

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	weekly, cases are discussed and issues resolved IB3 assessment manual continues to receive updates which reflect lessons learned through implementation		foster parents, strategies developed to address these barriers All 4 NPP-PV providers convened at least one group	
FY15 Q1—Q2 July 1, 2014—December 31, 2014	298 new cases opened during FY, bringing overall waiver enrollment to 801 children High percentage of families deemed high risk Evaluators identify that 20% of waiver families are former wards, exceeding the proportion in the general population of parents Advanced level of risk and service determinations process continues Data tracking of enhanced assessments and risk determinations continues to be manually tracked IB3 assessment manual continues to receive updates	Waitlist continues, families being referred to NPP group intervention; 49 high risk cases in need of CPP services are currently receiving NPP services All CPP providers continue using Medicaid utilization	Significant increase in cases being recommended for NPP; first wait-list occurs for NPP-PV due to a group size exceeding the recommendations of the NPP model; strategies are implemented to avoid waitlists for NPP Two NPP-CV groups convened IB3 program working to support referrals at the case and agency level through working with agency managers Service participation barriers and engagement continue to be identified for both birth and foster parents, strategies developed to address these barriers New groups are added to remaining two NPP-PV providers Challenges specific to engaging foster parents due to systematic issues is identified; outreach conducted to foster parents and education of agencies provided in order to increase foster parent engagement in NPP-CV	Ad hoc meetings held to support implementation efforts; a new meeting was held with supervisors of intervention agencies, these meeting types are slated to continue through next fiscal year
FY15 Q3—Q4 January 1, 2015—June 30, 2015	Overall balance between comparison and intervention groups remains on target (49 and 51%) Assessment procedures continue to be stable The trend of cases being identified as high risk continues	Waitlist continues to increase; 56 children identified on waitlist, given the length of this treatment this is identified as a crisis in the implementation efforts of CPP IB3 staff monitor cases on wait-list in order to move them to the intervention immediately when slots become	NPP-PV groups conducted tripled in FY 15, enrollment increased by 17% Noted that several cases where 2nd or 3rd referrals were required for NPP-PV resulted in successful enrollment NPP-PV capacity grows by training new providers	Enhanced use of a ground game is created to work more closely with field staff, new staff are hired to support this effort Ad hoc meetings held to support implementation efforts

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	IB3 program staff and evaluators partner to assess risk determination algorithm; algorithm is revised to distinguish high risk from high need cases Enhanced assessments and risk determinations continue to be manually tracked IB3 Waiver case reviews highlight the significant issue and barriers that exist in order to accomplish reunifications in less than one year	available IB3 program working diligently to increase existing capacity IB3 team re-considers training standards for CPP clinicians; model approved by developers and clinicians are allowed to carry cases while still in training rather than being required to have completed the full training prior to carrying CPP cases Staff turnover has dramatically increased; with the loss of 4-6 CPP therapists, including 2 master trainer/therapists. Creating a serious impact on capacity, already at a critical point Courts becoming frustrated with the inability to accommodate new CPP referrals	NPP-CV engagement challenges continue; only 14/141 foster parents completed NPP-CV in FY15 New tool created to support NPP-PV referrals; used to support caseworkers and to capture barriers that impede enrollment Spanish language class capacity addressed, NPP facilitator utilized to enhance engagement of Spanish speaking referrals Efforts increased to engage referrals living outside geography of NPP providers NPP-CV curriculum modification and session requirements identified for consideration NPP-CV classes are slated to expand to 6 for FY16	
FY16 Q1—Q2 July 1, 2015—December 31, 2015	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Continuation of a small number of cases originally assigned to Intervention agencies transferred to specialized foster care programs and still counted as a part of the waiver The use of the previously modified risk determination algorithm, which divided high and moderate each into two subcategories and differentiates between children in immediate need of CPP vs. those who could have caregivers referred for NPP first and be considered for CPP at a later date, has continued	Risk determinations continue to identify more high risk children than available CPP slots can support; wait-list stands at 85 and IB3 working with the participating provider agencies to address enrollment Turnover of 55% of the highly trained CPP clinicians across the provider agencies, but staff largely replaced Despite the availability of Learning Collaboratives, onboarding of the new CPP staff slowed the flow of cases dramatically during this reporting period IB3/CPP staff worked on modification of existing outreach notifications to the case agencies to enhance communication with casework staff to	Birth parents are first referred for NPP-PV for psycho-education and skill development on attachment, infant/ toddler brain development, developmental expectations to support later engagement in CPP interventions. Caregivers of children who are in immediate need of CPP are referred to NPP-CV, so as to offer support while the child is on the wait list NPP-CV team have begun orientation sessions involving program alumni as well as home outreach to families with high risk IB3 children Immediate notification to caseworkers of case openings and the identification of NPP-PV groups by agency staff has created a much more seamless flow of	DCFS is currently planning to meet with the developers of CPP along with other national model experts. Irving B. Harris have reached out to discuss CPP implementation challenges "Ground Game" implementation support continues to engage the intervention agency administration to discuss the purpose of IB3 implementation support and to identify strategies for gaining entry/ access to casework and supervisory staff; Ground Game's new Intervention manager has visited and formed relationships with a number of targeted Intervention agencies Partnership between IB3 and our field coaching program, known as STEP [STEP-Supervisory Training to

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	Continued staff turnover has necessitated ongoing hiring and training of new IA and Early Childhood screeners The screening tools that continue to be used for IB3 cases are: The Ages and Stages Questionnaire-3 (ASQ-3); the Denver Developmental Screening Test (Denver II); the Child and Adolescent Needs and Strengths (CANS); the Devereux Early Childhood Assessment (DECA); the Infant Toddler Symptom Checklist (ITSC); and the Parenting Stress Index-Short Form (PSI-SF) A project was designed and conducted to systematically interview licensing staff in order to determine how foster parent information is used by the agencies and to educate staff on importance of parental/caregiver participation in IB3 services	determine if birth parents are currently available to participate in CPP services	referrals to provider agencies Outreach through letters, emails and phone calls are made both to newly recommended families and entire pool of foster parents recommended for NPP over the life of the waiver. Licensing staff were also educated to encourage participation of foster parents The pre-class home visits show initial promise in getting more foster parents to agree to attend the classes Another addition to the NPP-CV instruction was one-on-one conferences with the foster parents completing NPP-CV to review and interpret their AAPI pre and post-test scores in order to provide caregivers with greater understanding and insight into their parenting styles, parenting beliefs and nurturing abilities Agency staff now made aware of high risk NPP-PV and CV referrals has resulted in a dramatic increase in NPP home coaching sessions For NPP-PV & CV, IB3 has been covering costs of providing food for participants and other incentives including a stipend, which participants receive at end of group participation, since the start of the waiver NPP-CV curriculum modified for additional emphasis on constructs and foster parent training content Calendars of training are now available to agency staff for the upcoming dates of CV training sessions Foster parents incentivized for completing NPP-CV. Alumni of the program are also given the chance to	Enhance Practice] continued to move forward Ad hoc meetings held to support implementation efforts

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
			attend follow-up sessions planned to concur with the orientation sessions	
FY16 Q3—Q4 January 1, 2016—June 30, 2016	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Continuation of a small number of cases originally assigned to Intervention agencies transferred to specialized foster care programs and still counted as a part of the waiver After years of Early Childhood supervisors individually reviewing each initial assessment to assure the risk determination followed the algorithm, it was determined that this review was no longer necessary. Supervisors do continue to offer consultation on an individual	NPP-CV program increased utilization by 42%	NPP-CV engagement continues to be a challenge. Extensive outreach by NPP-CV facilitators and field support team has resulted in greater awareness and an increase in participants NPP-CV continues to provide home coaching. One-on- one conferences with to review and interpret their AAPI pre and post-test scores have also been continued In order to engage foster parents who don't see the need for NPP-CV training, IB3 continues to provide: information through orientation sessions; home visits as an extension of orientation; outreach by staff to caregivers via phones and letters; incentives for attending and completing groups; exploring of options for transportation and child care barriers to engagement; outreach to licensing staff at agency; and sharing calendars of NPP-CV trainings to agency	Implementation Support Team (IST) met their goals for the year for agency engagement (monthly support to 8 of 9 intervention agencies, including meetings with several supervisors/caseworkers more than once). IST involves direct interaction with agency administrators, supervisors and caseworkers of the IB3 intervention agencies. A glossary tool guide was developed to provide understanding of field support activities in the IB3 implementation support approach for intervention agencies. IST framework was developed focusing on: monitoring of client status; CQI; IB3 practice; and permanency Staff training on IB3 interventions ongoing
FY17 Q1—Q2 July 1, 2016—December 31, 2016	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Continuation of a small number of cases originally assigned to Intervention agencies transferred to specialized foster care programs and still counted as a part of the waiver Integrated Assessment Screeners and Erikson Early Childhood Screeners continued to perform enhanced assessment		NPP program has experienced capacity challenges during this period and IB3 has responded by training new and providing monthly support to the agency. Patrushka Thigpen is the "NPP Provider coach" who will provide implementation support 37% of parents recommended for NPP-CV are no longer available due to substantial mental health/substance abuse issues or due to goal changes and unknown status Extensive outreach by NPP-CV facilitators and IST has resulted in greater awareness of the program and	Two new IST staff were hired and assigned to intervention agencies. Model developed which involves having onsite field support at agencies on a monthly basis. The team established "office time" at some of the assigned foster care agencies to enhance their presence, availability and overall utilization New implementation staff has allowed separation of administrative and provider functions from PRIDE staff who conducts the groups for foster caregivers. PRIDE staff will now focus exclusively on conducting groups and home coaching, and IB3 staff will

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	Screeners perform subsequent enhanced assessments and risk determinations at 6 month intervals on all IB3 children, including Comparison and Intervention groups. These rescreens are reviewed by Erikson Early Childhood Supervisory staff, who work with IB3 Implementation support to make referrals that emerge from needs identified through these assessments		an increase in the number of participants A substantial portion of NPP caregivers are relative caregivers whose social and family situations are challenging and interfere with their participation NPP-CV continues to provide home coaching. One-on- one conferences with to review and interpret their AAPI pre and post-test scores have also been continued In order to engage foster parents who don't see the need for NPP-CV training, IB3 continues to provide: home visits as an extension of orientation; outreach by staff to caregiver, and this time the same staff person made all calls to foster parents, creating a relationship; incentives for attending and completing groups; exploring of options for transportation and child care barriers to engagement (services are available to foster parents for funding for "enhanced day care," through Illinois Action for Children); outreach to licensing staff at agency; and sharing calendars of NPP-CV trainings to agency. Orientation sessions were discontinued.	conduct initial outreach to foster care agencies, complete all data entry, and track outcomes Field support team has recognized need for ongoing staff training on IB3 interventions beyond tools provided to support casework staff to explain the services to birth parents and foster parents more effectively, so they are responding by providing case management and agency staff meetings. A framework was developed to support the process of implementation and the primary area of focus with supervisors and caseworkers has been permanency. Team continues to utilize the point-in-time snapshot or "dashboard" to review and monitor client status in IB3 interventions NPP Provider coach continues implementation support to facilitators/clinical managers at provider agencies, with coaching occurring 1-2 times a month focusing on building capacity in the areas of knowledge of IB3 processes and required documentation activities IST plans to introduce modules, with the first one targeting testifying in court on the progress of evidence-based interventions
FY17 Q3—Q4 January 1, 2017—June 30, 2017	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Continuation of a small number of cases originally assigned to Intervention agencies transferred to specialized foster care programs and still counted as a part of the waiver	The shortage of CPP therapists and transition in agencies continues to be a leading factor in maintaining full contractual capacity There has been more CPP participation of biological parents, primarily due to a smooth transition and communication between the NPP-PV Coordinator and CPP Coordinator of parents who have completed the NPP-PV program;	To address the NPP-PV population decrease, targeted outreach to the referring agencies continues to be the priority; barriers include substance abuse, mental health problems, and domestic violence Our newest NPP-PV provider did begin service during this period and will be a primary provider of Spanish classes	The Implementation Support Team (IST) continues to highlight "the foster parent challenge" with data and case reviews, particularly in permanency updates where the foster parent may be the permanency goal The IST has specifically impacted intervention agency staff in two major areas, knowledge and practice; the team utilized psychoeducation, facilitated

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	Dr. Kimberly Mann became the Deputy Director of the DCFS Office of Child Well-Being which houses the waiver; she previously served as the Program Director for the waiver since its inception. Sherri L. Moore, LCSW assumed the role of Program Director; she previously held the position of Senior Manager for the waiver. Jason Sage was promoted from his position as IST Specialist to Intervention Manager. His role was assumed by a new incumbent, Felicia Nolan Robinson. We close the year fully staffed. Support for all staff that have transitioned or have joined the team continues Assessment innovations during this year were expanded state-wide The IB3 program has focused on assuring that children receive subsequent assessments at 6-month intervals. While these are scheduled for all children, it has been difficult to assure that children attend appointments. The program has screeners and supervisors visiting every agency managing the cases of children in care NPP model expansion will deliver the model primarily as a group modality. In certain areas of Illinois that do not lend geographically to the conducting of groups, sessions may be implemented as individual, home-based sessions with parents	families that have completed NPP-PV and are eligible for CPP are open to ongoing support through CPP The number of CPP slots was expanded, with existing contracts allotting more slots, and a new contract structure (actual costs vs. fee-for-service) being developed. As stated above, in this past fiscal year, that has enabled 100 children and their appropriate parent /caregiver(s) to be referred for the service	There is substantial progress in the NPP intervention for foster parents (NPP-CV).	discussions on case status reviews, participated in clinical staffing, participated in agency all staff meetings, and provided field coaching IST Specialist has been assigned to Outlier agencies to provide ongoing field coaching to supervisors and their teams.
FY18 Q1—Q2 July 1, 2017—December 31, 2017	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Continuation of a small number of cases originally assigned to Intervention	The highest number of clients referred to Child Parent Psychotherapy in the life of the waiver during a single reporting period occurred It has been difficult to obtain full assessment results from the CPP	To address continued low referral and enrollment in NPP-PV, the following strategies were utilized: continued visits by IST at agencies; recommending agencies create process to review parents to identify those ready to enroll; IB3 field staff made available to answer	The Implementation Support Team (IST) has increasingly become more engaged beyond their critical monitoring functions to enhanced provision of psychoeducation and clinical consultations to build the awareness of the field in the unique

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
	agencies transferred to specialized foster care programs and still counted as a part of the waiver Erikson Early Childhood Project have hired and trained two additional screeners; now each individual screener has 100-150 children to screen vs. 250-500 children; more manageable caseloads have allowed screeners to visit agencies and create reports to each agency on all the young children whose cases they manage, provide information on their last assessment, and attendance. As a result, agencies have increased their efforts to assure those young children in need of follow-up assessments get appointments scheduled as soon as feasible	agencies, which resulted in clarification of reporting requirements, plans for additional training for newer clinicians, and refresher training for those who requested it The shortage of therapists and transition in agencies continue to be leading factors in maintaining census at contractual capacity Continued transition and communication between the NPP-PV Coordinator and CPP Coordinator of parents who have completed the NPP-PV program have increased participation of biological families in CPP	referral questions; caseworkers encouraged to invite NPP facilitators to Child and Family Team Meetings (CFTMs); and provide timely feedback to caseworkers when clients do not enroll Families unable to be engaged in child welfare interventions have a status of "whereabouts unknown" or "difficulty engaging" and ultimately require a goal change Program staff met with daycare resource personnel at the Illinois Action for Children to enhance the process for increased utilization of this resource	developmental needs of young children; the IST consistently provides monthly on-site coaching to IB3 intervention agency staff, and utilized distance coaching or phone coaching and electronic technology to support coaching in real time with caseworkers and supervisors. IST visits, specifically with licensing representatives and their supervisors, focus on increasing staff's awareness of the foster parents recommended for NPP-CV, strategize their engagement, and support provision of education and engagement of foster parents IST has received increased invitations to Child and Family Team Meetings (CFTMs); coaching prior to the CFTM focused on supporting caseworkers and supervisors to reflect on the assessment of the needs and well-being of the child and family
FY18 Q3—Q4 January 1, 2018—June 30, 2018	No changes to DCFS Case Assignment Unit (CAPU), continuing in an equally balanced assignment between intervention and comparison agencies Site visits conducted and feedback is given to case managers and supervisors about which children have been assessed on schedule and which are outstanding. Families who miss more than two appointments are flagged for their case management teams and receive more follow up. In FY18, attendance rose, with 58 % of appointments resulting in successful completion of follow up assessments	Shortage of therapists and transition in agencies continue to be leading factors in maintaining census at contractual capacity	Continued utilization of enrollment letters to inform caseworkers of their referred clients' enrollment status in NPP-PV which has had a positive impact in that the parents who did not successfully enroll were immediately re-referred for engagement and/or their readiness status was immediately communicated to the program Implementation support specialist assigned to NPP-CV executed the practice of engaging the caregiver via phone, postal, and email communication to educate on the recommendations for the intervention as well as the intervention itself; to engage those caregivers identified as "Difficulty Engaging", NPP-CV facilitators began conducting home	Implementation Support Team (IST) continues to utilize on-site monthly field coaching to support caseworkers and supervisors with implementing the interventions The IB3 manager would check in monthly with each provider agency to determine if any new IST consultations were needed as well as ensure follow up to previous consults Ongoing educational support focusing on early exposure, and the components of the IB3 program to new staff were conducted at each intervention agency due to the large number of turnover in the last 6 months IST continued intentional focus on permanence planning. Case status

	IB3 Program, Program Eligibility, and Assessments	Child Parent Psychotherapy (CPP)	Nurturing Parenting Program (NPP)	Implementation Support
			visits to educate caregivers Program staff continues to collaborate with the Illinois Action for Children to ensure that childcare is addressed despite underutilization of the resource	reviews have been successful in helping supervisors assess the Viability of and Readiness for Reunification (VRR) and other permanence goals IST was not able to finalize the court testimony coaching module during this reporting period, but remains committed to developing in the next quarter

Table 2: IB3 key implementation activities: Data systems, continuous quality improvement, waiver contracts, and program communication & training

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
FY14 Q1—Q2 July 1, 2013—December 31, 2013	Development of the functional design of the IB3 data information system Back-up database developed in REDCap; interim plan until full production of the IB3 information system takes place	CQI team meetings occur on the 1st and 3rd Thursday of each month; consisting of referral status reports, and extensive follow-up activities on implementation of the interventions Meeting held with representatives from licensing, Agency Performance Teams/Regional Monitoring, and foster care to discuss the engagement of foster parents in intervention services Semi-annual intervention agency meetings held to provide program updates, performance data, and ongoing engagement and implementation support for the program Executive Leadership Team: meets weekly to review waiver progress, develop plans, and monitor	Intervention and evaluation contracts executed Plans made to extend the evaluation contract over the life of the waiver Revised evaluation plan developed for submission to the Children's Bureau Provider contracts positioned for conversion to Medicaid and fee-for-service funding expected to begin in early CY 2014	Final introductory session of IB3 orientation training (3 hours) for direct service staff held in July, 2013 2-hour training presented in August, 2013 to Guardian Ad Litem's (GALs) of the Cook County Juvenile Court, attorneys from the Public Defender's Office also attended Refresher training on assessment tools held in November, 2013 for all Integrated Assessment staff and Early Childhood Development staff 3 brochures created specific to interventions Webinar training conducted IB3 Advisory Committee: meets quarterly, provides information, support

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
		implementation efforts NPP Providers Work Group: intermittent meetings help with management level representatives CPP Providers Work Group: two meetings convened with providers of CPP services		and guidance to the Waiver IB3 IV-E Leadership Group: meets weekly to review all aspects of the Waiver
FY14 Q3—Q4 January 1, 2014—June 30, 2014	Development of the functional design of the IB3 data information system still in progress Data entered in to REDCap system, preliminary analysis of the data conducted by evaluators Manual reports utilized in the interim of a fully functional IB3 database, reports generated weekly, bi-weekly, monthly and quarterly Intervention agencies receive monthly reports: including new referrals, total number of children, and information about engagement with birth and foster parents. If children are on a waitlist, that is also noted. (Monthly Master Logs, Monthly Referral Status Reports) UNC and DCFS partner with Chapin Hall to provide additional implementation and data support to IB3; supplementing data reporting and analysis is planned	CQI team meetings occur on the 1st and 3rd Thursday of each month; consisting of referral status reports, and extensive follow-up activities on implementation of the interventions Semi-annual intervention agency meetings ongoing NPP Providers Work Group: intermittent meetings ongoing CPP Providers Work Group: two meetings convened with providers of CPP services	CPP contracts converted to Medicaid, to be effective July 1, 2014 CPP tangency capacity expanded in contracts NPP-PV provider contract lost, looking to replace during FY15. Loss of this contract impacts capacity to offer Spanish-speaking capacity in NPP-PV	Online self-directed webinar training made available: 3-hour "IB3 Training for Direct Service Staff" Monthly reports are provided to intervention agencies identifying staff who have completed the online IB3 webinar training CPP provider agency training on Medicaid billing conducted CPP provider training on assessment tools held Pamphlet created to provider overall information about the waiver for staff use NPP, draft calendar of training dates for FY15 shared with intervention agencies: intention to enhance agency awareness of NPP providers, class start dates, and locations IB3 Advisory Committee continues to meet quarterly Executive Leadership Team: meets weekly to review waiver progress, develop plans, and monitor implementation efforts IB3 IV-E Leadership Group continues to meet weekly

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
FY15 Q1—Q2 July 1, 2014—December 31, 2014	IB3 database at 95% completion Efforts begin to enter data in to the IB3 database First data transfer between DCFS and evaluators completed Intervention outcomes (limited) are now available Efforts continue to increase the technical capacity between DCFS' OITS and Chapin Hall Adult-Adolescent Parenting Inventory (AAPI) scores are now available through NPP (PV/CV) Intervention agencies receive monthly reports: including new referrals, total number of children, and information about engagement with birth and foster parents. If children are on a waitlist, that is also noted. (Monthly Master Logs, Monthly Referral Status Reports)	CQI team meetings occur on the 1st and 3rd Thursday of each month; consisting of referral status reports, and extensive follow-up activities on implementation of the interventions Semi-annual intervention agency meetings held to provide program updates, performance data, and ongoing engagement and implementation support for the program NPP Providers Work Group: intermittent meetings continue CPP Providers Work Group: meetings continue	Contracts are increased and additional staff training with remaining NPP-PV providers, adjusting for the loss of one NPP provider IB3 program discontinues contract with another NPP-PV provider, Spanish speaking capacity is maintained via remaining providers FY 16 contract planning begins	Noticeable increase in awareness of the IB3 program and intervention services Pamphlets developed for the IB3 Waiver are produced in Spanish and made available to all intervention agencies and service providers IB3 program plans to hire two new staff, devoting more resources to program communication and implementation support First IB3 summit convened, more than 100 individuals participate IB3 staff plan for in-person trainings to occur in the next fiscal year; targeted at new hires of intervention agencies Agencies are provided with reminders of online training availability with continued reports of staff attendance A manual is created to accompany the online webinar training to be used by staff interested in learning more about the IB3 Waiver Manual created detailing operational procedures NPP-PV providers send 9 additional staff for NPP training with Dr. Bavolek, strengthening provider capacity in NPP-PV The need for court outreach is identified and initiated Work begins on the IB3 video project that is intended to produce a short video explaining the IB3 program and the intervention services IB3 Advisory Committee continues to

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
				meet quarterly Executive Leadership Team continues to meet weekly IB3 IV-E Leadership Group continues to meet weekly
FY15 Q3—Q4 January 1, 2015—June 30, 2015	IB3 database is complete; reporting functions are still in process The majority of current caseload and backlog have been entered in to the IB3 database Chapin Hall extracts data from IB3 database; evaluators begin to analyze service participation data and outcomes AAPI scores are analyzed; significant changes in parenting beliefs for NPP participants is noted Chapin Hall, IB3 program staff, and OITS staff work together to resolve data entry and or database issues identified Data analysis on reunification outcomes show that the rate is still extremely low for both intervention and comparison cases Data sub-committee created in January, 2015 meets monthly; consists of IB3 administrators, the entire evaluation team, and members of the CQI team. Reviews data extracted from IB3 database to Chapin Hall, identifies and plans for any data related concerns Intervention agencies receive monthly reports: including new referrals, total number of children, and information about engagement with birth and foster parents. If children are on a waitlist, that is also noted. (Monthly Master Logs,	Agency level data is analyzed by the IB3 program and intervention agencies are provided data related to the activity/participation level of their identified cases NPP-CV engagement issues prompted further efforts in strategies towards client engagement and the effects of 'business as usual' in child welfare in particular with regards to foster parent engagement; visits to agencies, invitations to IB3 trainings, and the distribution list of monthly reports expanded to include licensing supervisors and their staff AAPI data is shared with court personnel, the hope is to continue efforts in improved communications with the court system Lists are provided to Chief Deputy General Counsel of DCFS Legal per identified court room, providing information to judges as to which cases are IB3 cases Efforts are planned to improve communication between providers and caseworkers so they are better informed on parents' progress in order to communicate this to the courts in a meaningful way CQI team meetings occur quarterly; consisting of referral status reports, and extensive follow-up activities on	It is identified by IB3 program staff that CPP agencies refuse to accept new cases, not making full use of available slots. This appears to be at least partially due to the fee-for-service structure IB3 administration pursued several agencies for expansion of CPP capacity CPP contracts with individual therapists explored NPP fee structure is identified as inadequate; plans are made to modify this structure in the next reporting period	A 3-hour in-person training occurred in June, 2015 and was attended by 43 casework, licensing, and supervisory staff In April, 2015 IB3 administration met with judges to provide information about trauma based interventions and young children. At least two judges at this training expressed beliefs that permanency is not necessarily a positive goal, and long term foster care was preferable for many families In March, 2015 a training was provided for Juvenile Court Lawyers, attorneys from the DCFS Legal Department, GALs, State's Attorneys, and Public Defenders all attended the training Planning for the 2nd Annual IB3 Summit is underway, NPP will be the featured service and Dr. Bavolek is slated to be the featured presenter The IB3 Video Project is completed and is well received Class calendars are created for NPP-CV and distributed to caseworkers and licensing IB3 Advisory Committee continues to meet quarterly Executive Leadership Team continues to meet weekly

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
	Monthly Referral Status Reports)	implementation of the interventions Semi-annual intervention agency meetings held to provide program updates, performance data, and ongoing engagement and implementation support for the program NPP Providers Work Group intermittent meetings continue CPP Providers Work Group meetings continue		IB3 IV-E Leadership Group continues to meet weekly
FY16 Q1—Q2 July 1, 2015—December 31, 2015	IB3 database which has provided successful data feeds to evaluators at Chapin Hall. Ongoing modifications in the database account for differences between program data and evaluation data. Evaluation team helped program staff clean and review data which ultimately enhanced CQI Work with the database developers to enhance functionality of reporting has also been a challenge Evaluators spent time with DCFS on linking various administrative data sources to the IB3 database in order to assess the integrity of rotational assignment and to track referrals to NPP and CPP Data sub-committee continues to meet monthly	Early Childhood supervisors review all individual risk determinations to assure the correct tools were utilized, individual scores are examined, and that the risk determination adheres to the algorithm Since the onset of the Waiver, early childhood supervisors have provided 247 individual consultations with IA staff to support assessment determinations. IA continues meet with IB3 staff on an as-needed basis, reduced from weekly meetings Customized lists of IB3 cases continue to be sent to the Juvenile Court, making it possible to identify IB3 cases on the calendars of each judge, along with other lists to DCFS support units which utilize this information to support the waiver when they interact with Intervention agencies One primary challenge for CQI has been the conversion from manual reports created by IB3 staff to automated reports generated by the IB3 database. The hope is to provide agencies with a single report known as the "master log" however the number of data fields in this report made it	Across the 5 CPP provider agencies, total FY15 allocation yield was only 29%, covering only 42-48% of their costs. Discussions are underway to modify the contract structure NPP providers were being paid at a bachelor level rate in despite intervention requiring and utilizing master level staff. NPP contracts was reviewed and an approved decision memo now reflects master level clinicians IB3 will be pursuing budget allocations for implementation support staff. To date, support staff have been "borrowed" from our Pride (foster parent training) staff and from training staff on other university contracts	IB3 completed training-of-trainers for NPP with one of the national staff from Family Development Resources. All participants have been approved to conduct training of own agency staff. IB3 hosted 2nd annual summit for provider and intervention agencies. Dr. Stephen Bavolek, the developer of NPP was the featured speaker. The summit was positively received for information/content and speaker quality, though there was low participation from agency caseworker staff. Dr. Bavolek was able to spend all day with NPP providers and met with the IB3 evaluation team Ongoing staff turnover has continued to necessitate ongoing hiring and training of new IA and Early Childhood Screeners; childhood supervisor offers day and a half training in the enhanced screening tools Online, self-directed training on the IB3 Waiver continues to be available for new foster care staff; the IB3 administrative team offered another session of in-person training on the waiver

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
		completely unreadable and unusable. Feedback on content and structure received by agencies Agency level data continue to be analyzed by the IB3 program and intervention agencies are provided data. Meetings have included a greater emphasis on data. Provider agencies routinely receive information on client engagement and when appropriate on costs associated with the interventions. A recent review by our Medicaid team helped the CPP providers to examine utilization of CPP by case activities CQI team meetings continue occur bimonthly, members expanded to include agency outreach and engagement; team focused on engagement data, referral procedures and reports to agencies. Monthly reports of referrals sent to each waiver agency are being replaced with more up to date reports generated from the IB3 database Semi-annual intervention agency meetings continue to be held. The administrators, program managers, supervisors and direct service staff attend these meetings from agencies involved with IB3 families. Participants receive updates on all areas of the waiver, including data on agency participation in the waiver, referral procedures for intervention services, and status of IB3 cases. Issues such as engagement, retention and barriers to service participation are discussed NPP Providers Work Group continue to be held quarterly CPP Providers Work Group continue to		IB3 Advisory Committee continues to meet quarterly Executive Leadership Team continues to meet biweekly IB3 IV-E Leadership Group continues to meet weekly to review all aspects of the Waiver

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
		be held bimonthly		
FY16 Q3—Q4 January 1, 2016—June 30, 2016	Risk determinations as assigned by IA and EC screeners are entered into the database as written by the screeners IB3 staff continues to identify and resolve minor errors in the IB3 database Monthly meetings with IB3 Intervention agencies utilize a "dashboard" to review and monitor client status in IB3 interventions Information gathered in focus groups and interviews intends to evaluate program implementation and function of communication within IB3 intervention agencies, identifying barriers and strengths in the implementation, and evaluating data related to IB3 service participation, retention, and completion Data sub-committee continues to meet monthly	Staff have participated in excel training with several evaluators in order to develop their technical skills in manipulating information using pivot tables and to validate data and identify emerging threats to data integrity Monthly program summaries which are shared with the evaluation team at monthly evaluation meetings. Data has been used to support foster care agencies, provide feedback to intervention agencies and to identify questions/issues to work through with the evaluation team Semi-annual intervention agency meetings continue to be held CQI team meetings continue occur bimonthly NPP Providers Work Group continue to be held quarterly CPP Providers Work Group continue to be held bimonthly	CPP contracts for FY '17 will utilize an actual cost model and providers will continue to bill Medicaid. These changes went into effect during the final quarter of FY '16 for the months of May and June. CPP capacity for 2017 will increase by 66% CPP agencies will be allotted 7.5 FTEs and Spanish language capacity increased dramatically as CASA Central hired a new CPP clinician and is finalizing a second Enhanced fee structure for NPP allowed capacity to be maintained and enhanced bi-lingual capacity Implementation support specialists will increase by 2-FTEs and the Quality Improvement Technician will add 1-FTE on the UIUC contracts, enhancing capacity for implementation support, NPP referrals, and data entry. To support the substantial increases in the IB3 population, there are 2-FTE screening positions and one clerical support position on the Erikson contract to support screening and assessment	Presentations on the IB3 waiver have been provided as requested by Intervention agencies and various support units with DCFS IB3 video revisions completed Recent webinar conducted for the National Child Welfare Workforce Institute by Drs. Tate and Mann to about 300 attendees on the application of implementation science to the IB3 demonstration. It was well received IB3 Advisory Committee continues to meet quarterly Executive Leadership Team continues to meet biweekly IB3 IV-E Leadership Group continues to meet weekly to review all aspects of the Waiver
FY17 Q1—Q2 July 1, 2016—December 31, 2016	Client dashboards are routinely prepared along with current outcome data to enhance understanding and problem analysis IB3 collaborative case review conducted to understand barriers to permanency once parents completed NPP; it resulted in an algorithm that may support case conceptualization, ultimately support case planning	Erikson Early Childhood Supervisory staff provides the screeners ongoing and as needed feedback about their work in the IB3 Waiver which assists in the screeners' continual learning and better understanding on how to determine risk and specific interventions to recommend IB3 conducted CQI meetings with all CPP providers with support of CPP consultant Lili Gray, national trainer for the CPP model, offering the		The 3rd Annual IB3 Summit was presented to 122 DCFS and private agency staff with a focus on engagement and permanency challenges. It included panel of birth parents that had completed NPP. Participant evaluation responses were extremely positive Dr. Mann and two members of the evaluation team, Drs. Rolock and Syrjanen, presented at the 20th National Conference on Child Abuse and Neglect

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
	The Chapin Hall research team surveyed caseworkers, supervisors, and program managers from the IB3 intervention agencies to help IB3 leadership understand, from the perspective of the IB3 workforce, how implementation of IB3 is going Data sub-committee continues to meet monthly	development of an individualized support plan Monthly CQI reports and program data continued to be produced, used by field support staff to report outcomes on a regular basis. The CPP Consultant for IB3 had her first day with the goal of assessing the CPP capacity of each provider agency and establishing collaborative plans for outcome enhancement Intervention agency meetings increased from semi-annual to quarterly CQI team meetings continue occur bimonthly NPP Providers Work Group increased their meetings from quarterly to every other month CPP Providers Work Group continue to be held bimonthly		(NCCAN) Three members of the IB3 presented at the ZERO TO THREE's Annual Conference IB3 Advisory Committee continues to meet quarterly Executive Leadership Team continues to meet biweekly IB3 IV-E Leadership Group continues to meet weekly to review all aspects of the Waiver
FY17 Q3—Q4 January 1, 2017—June 30, 2017	University of North Carolina subcontracted with the University of Illinois at Chicago Survey Research Laboratory (SRL) to conduct a child well-being survey with approximately 270 caseworkers and 800 caregivers of approximately 1,000 children who were enrolled in the demonstration during fiscal years 2013-14 and 2014-15. Obtaining up-to-date contact information for will continue to be a challenge, but SRL has taken steps to maintain current information DCFS is using MindShare data to support analysis of outcomes related to permanency and well-being Dr. Testa from UNC is working with IB3 staff and the DCFS Director's	The Erikson DCFS Early Childhood Project continues to offer support to Integrated Assessment on an as-needed, by request basis Follow up assessments are each reviewed individually by Erikson Supervisors for the QA process, and then entered into the IB3 database IB3 conducted annual monitoring meetings with all the CPP providers with the support of the CPP Consultant, Lili Gray. Lili Gray has also met with each provider on a consistent basis to offer support around cases and CPP implementation On-site Implementation Support Team (IST) provided real time updates on the	Minor capacity changes will be made to expand CPP capacity in 2 agencies (CASA Central and Family Focus of Englewood) in order to accommodate IB3 children that are also identified to participate in the state's new Safe Baby Court Team program	The program began the use of case staffings with the Erikson Early Childhood staff to identify common issues, develop capacity, and better coordinate our responses. One such meeting was held this reporting periodv IB3 Advisory Committee continues to meet quarterly Executive Leadership Team continues to meet biweekly IB3 IV-E Leadership Group now meets bimonthly

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
	office to encourage agencies that have not completed the agency follow-up survey known as the LADQ to participate as soon as possible Delays in the execution of the contract for the evaluation led to delays in implementing the evaluation With the assistance of Chapin Hall and UMW, the UNC research team has assembled a comprehensive administrative database integrating clinical assessments, parental service participation, AAPI scores, placement history, and permanency outcomes for the 1,606 children ever assigned to the demonstration through December 30, 2016 Data sub-committee continues to meet monthly	parents' readiness for services; parents ready to engage are discussed and strategies on how to engage them are developed. CPP Coordinator is made aware of the case status in real time and is able to make the necessary referrals based on readiness for the families IB3 collaborated with the Juvenile Protective Association (JPA) to implement a case status review pilot, the findings of which resulted in the IST Specialist utilizing an enhanced monthly IB3 report with additional fields: case status update/change; service outcomes; goal/permanency and the viability of readiness and reunification (VRR) rating. During the next reporting period, IST will integrate the use of the viability of readiness and reunification tool into the coaching process with supervisors to help with categorizing where a family is in achieving permanence and identifying specific case activities that must occur to move toward the identified goal The first phase of CPP CQI meetings have taken place IST continues to obtain valuable case data through the review of monthly reports and facilitation of monthly case status reviews with supervisors and caseworkers. The CQI team has informed trauma, rescreens, and child and family team meeting practices in the past 6 months Quarterly intervention agency meetings continue CQI team meetings continue occur bimonthly NPP Providers Work Group continue to		

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
		meet every other month CPP Providers Work Group changed from meeting every two months to meeting quarterly with IB3 staff to receive waiver updates and discuss clinical issues around service delivery		
FY18 Q1—Q2 July 1, 2017—December 31, 2017	To-date caseworker interviews are completed and caregiver interviews are underway. SRL reports 80% of caseworkers identified have completed interviews across 32 agencies; caregiver data collection ongoing High rate of caseworker turnover presented special challenges to collecting reliable data about IB3 services and parental experiences while children were in care Follow up assessments are each reviewed individually by the Erikson DCFS Early Childhood Supervisors for the QA process, and then entered into the IB3 database. There is always a lag between the screening being completed, and entry into the database Team members ensure data was valid within the IB3 database, which is used to generate monthly reports to each agency that works with a child in the intervention group Evaluation team focused on two additional primary data collection efforts, Child Well-Being Surveys, and a second iteration of the Local Agency Director Questionnaire (94% response rate) Data sub-committee continues to meet monthly	Erikson DCFS Early Childhood Project continues to offer support to Integrated Assessment on an as-needed, by request on screening tools and the effective use of the risk determination algorithm IB3 conducted annual monitoring meetings with all the CPP providers with support of CPP Consultant. The consultant continues to meet with each provider on a consistent basis to offer consultation on cases and CPP fidelity Implementation Support Team conducts regular monthly case status reviews for children in the IB3 program; during field coaching, IST provides caseworkers and supervisors monthly data reports, facilitates clinical discussions, and implements strategies to help agency staff identify families' readiness for the IB3 interventions. The IST has integrated the Viability of and Readiness for Reunification (VRR) tool in the coaching process during this reporting period, which promotes discussions on the progress a family has made toward the identified permanence goal and on the decision making and case activities needed to maintain the current permanency goal Quarterly intervention agency meetings continue CQI team meetings changed from meeting bimonthly to monthly	Ongoing monitoring of contracts remains a priority for the program. A billing error was identified in one CPP provider that required corrective action. We are also implementing a corrective action plan with an NPP provider after a year of providing supports to the agency. Late client reporting and billing are the central concerns	IB3 has been able to coordinate and facilitate staffings to include intervention providers, caseworkers, supervisors, biological parents, and foster parents focused on engagement The 4th Annual IB3 Summit convened 11/2/2017. Charles H. Zeanah, M.D. was the featured presenter. Summit had a panel of foster parents sharing their experiences with the NPP-CV IB3 Advisory Committee continues to meet quarterly Executive Leadership Team meets monthly IB3 IV-E Leadership Group meets monthly

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
		NPP Providers Work Group continue to meet every other month CPP Providers Work Group continue meeting quarterly		
FY18 Q3—Q4 January 1, 2018—June 30, 2018	While descriptive analyses have been conducted on CPP referrals, attendance, completion, and family and caregiver characteristics, detailed analyses remain to be conducted in order to better understand the relationship between CPP referrals, attendance, completion and permanency outcomes Data employees' resignation means that presently there are at least 90 assessments to be entered into the IB3 database During the current reporting period, the Survey Research Laboratory (SRL) at the University of Illinois at Chicago completed primary data collection with caseworkers and caregivers from a sample frame of 1,029 children assigned to the demonstration prior to July 1, 2016 With the assistance of Chapin Hall (CH), the University of Wisconsin-Milwaukee (UMW), and the Juvenile Protective Association (JPA), the University of North Carolina, Chapel Hill (UNC) research team has assembled a comprehensive administrative database that integrates the clinical assessments, parental service participation, placement history, and permanency outcomes for the 1,887 children ever assigned to the demonstration who were eligible for IB3 screening through June 30, 2017	Process in place for CPP therapist to contact the CPP coordinator on challenging cases and a family team meeting is then scheduled with the agency to discuss and problem solve, helping with the engagement of families in services and a better understanding of the case status Quarterly intervention agency meetings continue CQI team meetings continue monthly NPP Providers Work Group continue to meet every other month CPP Providers Work Group continue meeting quarterly		Implementation Support Team (IST) facilitated two Outlier Agency Engagement workshops Chandra Ippen Ghosh, one of the developers of Child Parent Psychotherapy, was at the Erikson and many of the CPP clinicians attended IB3 Advisory Committee continues to meet quarterly Executive Leadership Team meets monthly IB3 IV-E Leadership Group meets monthly

	Data Systems	Continuous Quality Improvement (CQI)	Waiver Contracts	Program Communication and Training
	Data sub-committee continues to meet monthly			