From the Program Director's Desk
Missing Children, Changing Populations and Unrecognized Needs: *Why Governor Blagojevich's Child Welfare Task Force was so Important*

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"Social advance depends as much upon the process through which it is secured as upon the result itself."

Jane Addams (Social worker, founder of Chicago's Hull House, and first U.S. woman to receive the Nobel Peace Prize.)

Abstract

Bryan Samuels discusses his experience as head of the Governor's Task Force, which was charged with reviewing the policies of the Illinois Department of Children and Family Services and making recommendations on ways to improve the Department's operating systems, policies and programs. He presents the Task Force's findings, highlighting those that were the most unexpected: notably the markedly increased age of children entering substitute care, the dearth of services available to children and families who are not screened into the system, and the difficulty of incorporating measures of child well being into department databases. He presents for the reader the full range of the Task Force recommendations about how DCFS can address the problems of African-American over-representation, adoption disruption, missing and runaway youth, troubled youth needing independent living, mental health and substance abuse services for children and families, and needed changes in child protection investigations.

Introduction

Many expressed surprise when newly elected Governor Rod R. Blagojevich announced the formation of a Task Force to review the state's child welfare system. After all, the Department of Children and Family Services was a trend-setting, national award-winning agency with a reputation for achieving record adoptions of children in foster care. It was also the nation's largest child welfare agency to earn accreditation from the prestigious Council on Accreditation for Children and Family Services (COA). Both child abuse reports and substitute care numbers had declined sharply since Fiscal Year 1995, and the agency boasted a new, state-of-the art database designed to ease paperwork for frontline workers. However, a growing body of media stories catalogued a series of troubling incidents, including deaths of foster children and hundreds of missing wards, which revealed serious problems and hinted at larger systemic issues hiding beneath the surface. As Governor Blagojevich noted in his February 6, 2003 press conference announcing the Task Force,

> "In recent days and weeks, we've all seen headlines and stories that have upset and angered parents and people across our state, including me. (The Task Force will) anticipate, and we hope, prevent future recurrences of those kinds of tragic incidents."

Task Forces are rarely employed so early into a new administration, or asked to deliver results so quickly. The request for a final report within 60 days indicated the urgent need for a fresh, clear picture of the Department's strengths and weaknesses. This picture was urgent not only for a new Governor seeking to exercise greater fiscal responsibility, but also for all child welfare partners seeking to protect vulnerable children and families. As the Task Force would later discover, the picture drawn at the end was markedly different than that originally presented by the DCFS administration, and questions were raised as to whether the Department was focused on serving a population that had ceased to exist.

The purpose of this article is to describe the process and findings of the recent Task Force report, developed to 1) study the services of the Illinois Department of Children and Family Services, 2) identify and prioritize problems needing to be addressed by the agency, and 3) provide consultation to the new Governor for strategic planning for the future of child welfare services in the state. This article also aims to inform service providers in Illinois of our findings, and to

describe this process as a touchstone for those in other states and countries who seek to conduct comprehensive studies of services so as to improve strategic planning. Potentially, periodic systematic reviews of services and child welfare needs in a state can be one of the most constructive ways to help policy-makers and service providers improve services for this population. In addition, such reviews can be an important component of advocacy for the needs of these vulnerable children and families, who all too often lack sufficient means of articulating and redressing inadequacies in a state's policies. In subsequent articles, updates on progress with regard to efforts to remediate the central problems identified by the Task Force will be provided.

Task Force Work

I was honored when Governor Blagojevich invited me to lead a team of six experts to review the policies of the Department of Children and Family Services and to make recommendations about how the Department's operating systems, policies and programs might be improved. My co-workers included Dr. Daniel J. Cuneo, a widely-respected clinical psychologist and author with 24-years experience in public and private practice; Judith Walker Kendrick, who brought with her a distinguished career in leading government human service and family development programs; Deborah Daro, an Associate Professor and Research Fellow at the Chapin Hall Center for Children and a former President of the American Professional Society on the Abuse of Children; Sister Catherine M. Ryan, a legal specialist who has concentrated on child welfare and juvenile justice issues since 1975; Gil Walker, Director of Chicago Housing Authority's Resident Programs; and Illinois First Lady Patricia Blagojevich, a recognized strong advocate for women, children and seniors. During the following months of meetings, debates, and crafting our recommendations for the Governor, my appreciation steadily grew for the immense dedication and expertise this small team of individuals brought to the table. My own experience in developing outcome-based service systems, re-engineering case management systems, and social science research would also prove useful in the weeks ahead.

The mission of our Task Force was clear, but the process was inherently complex. Governor Blagojevich charged us with the responsibility to determine child welfare needs in Illinois; to assess how DCFS addresses those needs through its policies, methods and service delivery systems, and to assess the effectiveness of human and capital resource allocations. We were to highlight which DCFS practices and procedures were successful, which were in need of improvement, and we were to offer recommendations to improve the Department's ability to meet its mission through its structure, methods and practices. Finally, we were also asked to provide viable solutions to implement our recommendations.

From the beginning, our Task Force recognized the difficulty of managing DCFS and its transformation over the past decade. Ten years ago, Illinois faced numerous high profile child abuse deaths, many involving current or former DCFS clients. At the same time, a series of class action suits resulted in consent decrees that inspired unprecedented reforms. In response, and with the guidance of federal child welfare reform legislation, DCFS administrators gradually improved a variety of practice and outcome areas. Notable achievements included increased adoptions, reduced average lengths of stay, accreditation of the agency and its providers, and increased federal funding that boosted service levels for DCFS clients. Today, DCFS is among the largest, most sophisticated child welfare agencies in the nation, with thousands of employees and hundreds of contracts with private providers.

To develop an accurate picture of the Department's operations and its effectiveness, Task Force members interviewed and received written input from a wide range of stakeholders. Interviewees included DCFS administrators, private agency providers, foster parents, DCFS wards, the juvenile court and many others involved in assessing child well-being. We also scrutinized internal fiscal and case flow reports, case studies of specific youth, as well as the Department's annual reports and performance summaries. In addition, we reviewed recent policy and practice recommendations made by the Office of the Inspector General, the Public Guardian, and an assortment of DCFS advisory bodies.

Written commentary also proved especially useful. The Task Force and the Office of the Governor jointly identified a large number of individuals and organizations with expertise in the Illinois child welfare system. In early March, Deputy Governor Louanner Peters sent a letter inviting comments from child advocacy groups, judges, providers, researchers, local area networks (LAN) and parents of DCFS wards. The Task Force also accepted unsolicited feedback from additional people and organizations.

Because of the vast amount of information gathered, a decision was made early to divide the Task Force into two working groups. The **systems group** examined the Department's policy environment, particularly the underlying goals and objectives for child welfare held by key people. It also studied the legislation, regulations, and budget allocations relied upon to create programs and policies. Particular attention was paid to documenting the Department's program management and budgetary structure.

The **case review group** focused on how effectively policies, procedures and best practices were implemented in a sample of cases. Here, special attention was paid to the mix and pattern of services that might have led to poor outcomes, and then a determination was made as to whether corrective action was needed and had been taken, or whether further action was still needed to improve performance or accountability.

Using two groups with two different foci allowed the Task Force to compensate for the biases that would have occurred if one focus and methodology alone had governed the report design. This methodology – use of multiple focal variables and methodologies – is often referred to by social science researchers as triangulation, and is increasingly recognized as an important component of sound research and program evaluation.

While both groups worked independently, the entire Task Force met periodically to discuss findings. Frank, free exchanges of ideas and debates helped to ensure a full examination of issues from a wide range of viewpoints. Both local and national experts offered insights and recommendations, providing a broader view of the practice and policy trends in the Illinois system, particularly the Department's increasing emphasis on adoption, the development of performance-based contracting, and the structure of the agency's computerized management information system. Our final 60-page report to the Governor, including its recommendations, noted differences of opinion, as well as the common ground that was found. This degree of dialogue, debate, and forthrightness, I believe, would prove invaluable to the Governor in obtaining the most well-rounded understanding, based on how experts from different professional backgrounds viewed the same issue.

Findings

The Task Force found the Department's services to be significantly determined by statutes, consent decrees, funding policies, and other pressures that are unknown to most people outside the community of child welfare service providers. State and federal statutes establish authority, set mandates and provide funding. Consent decrees shape many operational expectations, and the U.S. Department of Health and Human Services' regulatory environment sets additional expectations and monitoring functions related to funding. The COA accreditation process also influences current DCFS operations. The fact that these pressures and constraints operate under the radar of the public at large is important because it means that the public (who are after all funding the services) for the most part sees only outcomes and cannot perceive the complexity of influences on the quality of services. This creates both a potential for explanatory models based on oversimplified versions of reality, such as scapegoating of individual DCFS workers or even the clients themselves. It also indicates the significant need for improved public education about child welfare services, it's clients, and the environment in which services are provided.

Perhaps the most decisive legislation passed in recent years was the 1997 Adoption and Safe Families Act (ASFA)[i], because it substantially changed the Department's priorities by giving greater weight to speedy permanency decisions for children. With more than 35,000 foster children moved into adoptive and subsidized homes since the passage of the act, Illinois has been touted as an example of ASFA's success. However, critics openly questioned if children who could eventually have been reunited with their families were instead adopted due to incentives built into the Act.

Statistical analysis provided some of the best indicators of the Department's trends and priorities. One important trend is a decline in child abuse reports and case openings. Since FY99, the hotline has annually responded to approximately 300,000 calls, about 20 percent of which produce a formal investigation for possible abuse or neglect. In FY01, slightly more than 100,000 investigations were initiated on behalf of 60,000 families. Of these investigations, there were 29,000 indicated allegations of abuse, neglect or imminent risk of harm to children. In cases where reported allegations are "indicated," this often means children have experienced more serious forms of maltreatment, and therefore may have greater needs for protective custody. Yet, only 21 percent of these children had cases opened, and it was unclear how many of the remaining 80 percent received any services. These numbers indicate repeatedly missed opportunities

to strengthen families of at-risk children – a reality not missed by frustrated professionals who reported suspected abuse and neglect, only to see no action taken by the Department responsible for intervention.

Between FY95 and FY00 there was a fifty percent reduction (down to four percent) in rates of intact care for children who were eventually taken into protective custody. A steep decline in substitute care was also noted, dropping from a peak of 51,000 children in FY97 to 26,000 in FY01 and 21,000 by the time of the Task Force report. Fewer children entering the system and more permanency placements contributed to this decline.

One of the most significant, yet little appreciated changes was a marked aging of the substitute care population. The percentage of children over age 17 increased from three percent in FY95 to eight percent in FY01. Yet despite the complex needs of this aging population, the Task Force found DCFS casework practice strategies largely unchanged and unprepared to meet the new demands posed by this older population.

Changing racial demographics were also noted. Year-end figures showed Hispanics continued to average around four percent of the substitute care population, while the Caucasian percentage dropped and the African-American percentage increased. In FY90, African-American children constituted 66 percent of the substitute care population. By FY95 their numbers had increased to 78 percent, before dropping to 72 percent in FY01.

Reflecting its reliance on federal guidelines, the Department has focused on outcomes related to protecting children either by empowering parents to care for them or by finding alternative permanent placements. In addition to evaluating outcomes related to permanency and child protection, our Task Force sought information on the quality of interventions. Many concerns were raised that did not easily translate into recommendations, but the Task Force felt they should be taken into account when shaping future DCFS policy and practice.

One important concern was the need to improve service access for "at risk" children, since the majority of child abuse reports do not result in a formal investigation or service provision. Service intake rates have declined, indicating that fewer children receive help. Task Force members felt that many families and children in unsubstantiated cases are in need of supportive and therapeutic services. Many interviewed also felt that regardless of whether the investigation results in an indicated report, that DCFS should be more active in preventing initial abuse by providing therapeutic and supportive services to families reported for child abuse, as well as to young adolescents living in high-risk situations.

It also became clear that an internal dispute was brewing over the role of protective services, as indicated by the title change from "Investigator" to Protective Services Worker, reflecting the philosophy that DCFS staff should be less intrusive and should emphasize services to the families. Critics insisted that the primary role of child protection staff should be investigation of risk, arguing that it is impossible to hire law enforcement personnel since DCFS does not accept law enforcement degrees as "related degrees" necessary for employment.

The Task Force also felt that the Department should commit to meaningful service assessments for all indicated cases involving young children. Rather than conducting traditional investigations in these cases, DCFS should place primary emphasis on whether and how children might be protected in the future.

In general, the Task Force found that too little attention had been paid to child well-being measurements. Interviewees suggested this was because caseworkers and managers focused on more easily measured outcomes (e.g., reducing a child's length of stay). This tunnel vision both harms service decisions and limits identification of new service needs. Workers also reported feeling overburdened by paperwork. A General Accounting Office (GAO) report noted that caseworkers in Illinois need to complete over 150 forms for every child on their caseload, with very few of those forms relating to quality-of-care or family-functioning issues. Contract agencies also complained that they were held more accountable for speedy permanent placements than for addressing a child's needs, producing short-term indicators of success while downplaying long-term success strategies for children.

The Task Force also found that many DCFS wards face repeated placements. According to a Chapin Hall study, approximately 1,000 wards have experienced 23 placements and some an excess of 50 placements. Wards also spoke of changing caseworkers as often as two to three times a year. While the Department had recently implementeda plan to conduct comprehensive assessments in cases where a child has experienced more than three placements in a year, the Task Force believed more should be

done to reduce turnover of placements and caseworkers.

The Department's inability to hire and develop qualified staff also led to critical shortages of direct service staff. For example, Southern Region investigators must sometimes travel more than 100 miles to reach a home. Also, while all supervisors and many direct service staff must hold MSW degrees, salary levels and working conditions are not competitive enough to attract a sufficient number of qualified applicants.

The Task Force also felt that supervisors should spend the majority of their time supervising workers, but many supervisors reported that bureaucratic work and court demands consumed most of their available time. Many supervisors and case managers also complained that unnecessary decision-making layers hindered timely decisions in securing needed services.

The Task Force noted that while progress has been made in building a more diversified workforce, many interviewees voiced concern that more people of color should be hired in policy decision-making positions, especially in downstate regions. There were also calls in favor of recruiting more African-American staff in the downstate regions, as well as addressing promotion disparities that favor Caucasians.

Recommendations

Much of the Task Force report is comprised of recommendations culled from countless hours of research and dialogue. Below is a summary highlighting the recommendations given to Governor Blagojevich.

Concerning overrepresentation of African American children:

1. Establish an integrated system to monitor overrepresentation of African American youth in the child welfare system and the Department's interventions.
2. Establish protocols and procedures to document differences in the clinical experiences of African Americans which affect the appropriateness of services received and their likelihood of successfully exiting the system.
3. Document and analyze how youth and families move through the system and can successfully exit. Using a strategy similar to the W. Haywood Burns Institute Model can help identify the best points for change.
4. Re-examine the incentive structure that favors adoption over reunification in performance contracting.
5. Examine the role of mandated reporting in hospital settings, where anecdotal evidence suggests that practices are partly responsible for African American children entering the child welfare system at an earlier age than Caucasian children.

Concerning Adoption:

1. Create a single system of practice-relevant, case documentation that can be used by both child welfare workers and evaluators of practice outcomes.
2. Expand the availability and range of services to families at risk of disruptions, especially in traditionally underserved geographic regions of the state.
3. Ensure full disclosure for adopting families by using MAC forms and training pre-placement workers on how to collect detailed information.
4. Consider reorganizing and extending existing supports exploring the use of a more integrated continuum of care model.
5. Follow-up workers should hold annual meetings with families receiving adoption assistance to determine if adoptive parents are having any difficulties and to ensure that the child's needs are being met.
6. Establish criteria for adoption assistance and level of care payment levels. A "gatekeeper" currently determines the level of care, but there is no rule governing how cost determinations are made.
7. Hire child welfare workers with expertise in post-placement services to replace retired workers in the post-permanency unit.

Concerning Missing and Runaway Youth:

1. Establish a single set of protocols and procedures for reviewing and monitoring all cases of missing children. DCFS should also provide technical support, conduct electronic and Internet searches, train case managers in effective protocols and procedures for locating runaways, and facilitate partnerships with local law enforcement.

2. Design a proactive intervention targeting the most likely group to run away - female wards between ages 14-16.
3. Train caseworkers to track missing youth, emphasizing the use of information available in case records.
4. Experiment with alternative placement options after runaways are located, instead of returning the youth to the original placement.

Concerning Independent Living And Troubled Youth:

1. Identify teenage wards at high-risk for committing violent acts, assessing the population for size, placement, and case status.
2. Implement a multi-systemic therapy (MST) approach and an intensive case management program for hospitalized wards with multiple yearly psychiatric hospitalizations, and for wards involved in both delinquency and adult courts.
3. Immediately cease placing youths under 18 years of age in unsupervised apartments, and require progressive step-down placements for wards over age 18 prior to independent living.
4. Develop a placement model similar to second stage housing established for homeless women and children.
5. Explore funding of evening intervention centers, similar to the current models utilized by the Juvenile Court in Chicago.

Concerning mental health services for DCFS wards:

1. Partner with the Illinois Children's Mental Health Task Force to organize a statewide mental health unit to evaluate mental health services for DCFS wards.
2. Screen all wards for mental health needs, and ensure that all wards requiring mental health services receive them -- especially in the underserved Southern Region.
3. Expand wraparound services to mentally ill wards, including linkages to other appropriate services, such as special education and substance abuse services.
4. Participate in a joint decision-making process with the courts and other child agencies to assure that no child is left behind and that services are integrated and coordinated.

Concerning services for substance abusing families:

1. Ensure that parents needing substance abuse treatment get the proper referrals, are successfully linked with a treatment program, and receive the necessary "wrap-around" services.
2. Enhance DCFS/OASA collaboration to divert children and adolescents from the DCFS system and to increase reunification rates.
3. Provide continuous training for direct service workers on substance abuse issues and signs to dispel misperceptions and the stigma attached to drug use and abuse.
4. When substance abuse is a contributing factor, every effort must be made at successful treatment outcomes to increase the likelihood of reunification.
5. Include substance abuse training as a component of training required for licensure of foster parents.
6. Identify youth in need of treatment services, make appropriate referrals to treatment, and then ensure ongoing communication with the caseworker and AOD provider during treatment and, in the case of residential treatment develop an aftercare plan upon discharge.

Concerning child protection investigations:

1. Fill vacancies in "front-line" child protective services.
2. Distribute caseloads to ensure that investigators have reasonable caseloads. Cases should not be assigned to investigators hours before they are completing their work week or are leaving for vacation.
3. Investigators should be given the support services they need to investigate and document their investigations. This may include support staff to enter case notes into the computer database, or to send out notifications required as part of an investigation.
4. Review recommendations by the Inspector General, Child Death Review Teams and the American Humane Association for possible implementation.
5. Review the paired team models used in investigations to determine if they are an appropriate model for every region, and if continued, the paired teams should be adequately staffed in order to implement the model.

Conclusion

Having the opportunity to serve on Governor Blagojevich's Child Welfare Task Force provided invaluable insights and lessons that I rely upon regularly as Director. The Task Force report offers a road map of needed changes. Equally important, the process leading to its development offered a rare chance to hear first-hand reports from all stakeholders (including wards, foster parents, caseworkers, managers and advocates) and an inside look at the debates leading to the Task Force's final recommendations. Few, if any, incoming DCFS Directors have had this kind of advantage before taking the reins of such a demanding job.

DCFS is making progress. A good example involves the plight of missing wards. In May 2003, approximately a month after the Task Force report was issued, our Department reported 413 children missing from their assigned placements, double the agency's reported number in February, which relied on recoded data that artificially lowered estimates. The more accurate accounting resulted from new guidelines for counting older missing youth. DCFS also issued new policies to find missing youth and convened the Illinois Missing Children's Task Force to find all missing children within 60 days and to review all issues related to youth absent from placement. One surprising outcome of the search was finding that missing child reports were not filed on more than 100 children. Another surprise came when nearly 70 of those children were quickly located during the simple process of collecting information needed to file a report. When staff follow existing rules to file missing child reports, many children can be found much earlier. In November 2003, per the Task Force's recommendations, a special missing children's unit with a 24-hour hotline was created to coordinate search efforts with law enforcement.

More vacancies are also being filled, though much more slowly than I wished. Divisions have been reorganized to provide a more integrated, comprehensive and collaborative approach to delivering quality services. More attention is also being focused on training, quality control and services involving reunification, mental health, permanency and child protection issues. Meanwhile, initial and subsequent child abuse reports are still declining, as well as the number of children remaining in foster care.

As mentioned earlier, the opportunity to serve as a Task Force member has given me unprecedented insights into the issues I face daily. Predictably, there is also a special feeling of investment in the recommendations I had a hand in creating. Tough challenges remain in their implementation, and funding will play an important part in choosing how the Task Force recommendations presented to the Governor are prioritized. Time is also a factor, with some recommendations involving difficult systemic problems faced by child welfare agencies nationwide. However, unlike some government Task Force reports written in the past, this report is assured to play an important role in shaping Illinois child welfare service delivery for years to come.

[i]The Adoption and Safe Families Act of 1997 (Public Law 105-89), Titles IV-B and IV-E, Section 403(b), and Section 1130(a) of the Social Security Act.

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