Findings from Phase II of the Evaluation of LifeSet in Illinois

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Disclaimer

The points of view, analyses, interpretations, and opinions expressed here are solely those of the authors and do not necessarily reflect the position of Illinois DCFS or Youth Villages.

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ABSTRACT

LifeSet is an intensive case management program that prepares young people in foster care for the transition to adulthood. This report presents findings from Phase II of Chapin Hall's evaluation of LifeSet in Illinois. Phase II evaluation activities included focus groups with LifeSet specialists; interviews with LifeSet supervisors, licensed program experts, and young people who participated in LifeSet; and an analysis of both DCFS administrative data and GuideTree program data from Youth Villages. Although LifeSet specialists and supervisors report ongoing implementation challenges, they support the relaxation of transitional living program (TLP) and independent living program (ILO) eligibility criteria for young people who enroll in the program. They also support the focus on youth-driven goals. Young people report positive experiences with the program and with their specialists. Our impact analysis found two statistically significant differences in the occurrence of nonplacement events between young people who participated in LifeSet and a matched comparison group of young people in traditional TLP and ILO placements.

INTRODUCTION

In 1999, Youth Villages established LifeSet, a youth-centered and service-focused model, to help youth in Tennessee who were formerly in the child welfare or juvenile justice system make a successful transition to adulthood. LifeSet specialists meet weekly with youth to provide individualized, intensive services as youth work towards self-defined goals in areas such as housing, employment, education, and money management. They also help youth build and maintain healthy relationships with family, as appropriate.[1]

MDRC evaluated the model using a randomized controlled trial. Their sample included approximately 1,300 18- to 24-year-olds in Tennessee who had exited foster care or the juvenile justice system and were randomized to either LifeSet or a control group between October 2010 and October 2012.[2] One year post-enrollment, LifeSet had increased employment and earnings, reduced housing instability and economic hardships, and improved some outcomes related to health and safety (Valentine et al., 2015). However, MDRC found no significant impacts on outcomes in the areas of education, social support, and criminal involvement. At 2 years post-enrollment, LifeSet had not increased total average earnings, although it did increase the percentage of young people earning $2,500 or more. No impacts related to education or criminal involvement were observed, and the other outcomes were not measured (Skemer & Valentine, 2016).

Over the past two decades, LifeSet has expanded its geographic reach. It is currently being implemented in 18 states and Washington, DC by Youth Villages, a public agency, or nonprofit partners. Depending on the jurisdiction, LifeSet participants include young people who are or were in foster care as well as young people without a foster care history who are struggling with the transition to adulthood.

Implementation of LifeSet in Illinois

In 2018, the Illinois Department of Children and Family Services (DCFS) was one of four jurisdictions awarded funding by Youth Villages to implement LifeSet. DCFS has traditionally contracted with private sector service providers to help prepare transition-age youth in foster care for independence through transitional living programs (TLPs) and independent living programs (ILOs). It has integrated LifeSet into its existing service array by contracting with TLP and ILO providers to implement the model. Youth Villages supports those providers with ongoing training, technical assistance, and tools.

As of March 2023, two providers in Cook County (UCAN and Lawrence Hall) and one in the Southern region of Illinois (Hoyleton) have implemented LifeSet.[3] Implementation began on or

[1] https://youthvillages.org/services/lifeset/

[2] At the time of the MDRC evaluation, LifeSet was called the Youth Villages Transitional Living Program.

[3] Additional information about the three LifeSet providers can be found in Appendix A.

after November 1, 2019. Both Hoyleton and Lawrence Hall achieved fidelity at their 6-month program model review; UCAN achieved fidelity at their 12-month program model review.

Illinois implements LifeSet differently than other jurisdictions do. One difference is that Illinois LifeSet providers are also placement agencies, meaning that they are responsible for providing young people in LifeSet with placements in supervised (TLP) or community-based (ILO) housing. In other jurisdictions, LifeSet providers are not responsible for placement.

Another difference is that LifeSet specialists in Illinois are also legal caseworkers.[4] In other jurisdictions, young people have both a legal caseworker and a LifeSet specialist. One consequence of this dual role is that young people who exit LifeSet before their 21st birthday remain on their specialists' caseloads until they age out of care. This does not happen in jurisdictions where the LifeSet specialist is not a legal caseworker.

LifeSet Referrals and Eligibility

LifeSet eligibility criteria were established by DCFS in consultation with the LifeSet program developers. Youth must be between the ages of 17.5 and 20 years old but are not required to meet all of the traditional TLP or ILO eligibility criteria.[5] For example, LifeSet youth can live independently in the community even if they have not completed high school.

The DCFS central matching team manages the referral process. If a youth is being referred for a TLP or ILO placement by their caseworker, the team assesses whether a LifeSet referral is appropriate.[6] If so, the youth is matched to a LifeSet provider. A LifeSet supervisor or specialist reviews the referral and conducts a preenrollment assessment with the youth to determine if LifeSet is a "good fit."[7] Youth who meet at least two of nine exclusionary criteria are generally ineligible for LifeSet unless protective factors that would mitigate concerns raised by the exclusionary criteria are also present. If LifeSet is determined to be a "good fit," the specialist works with the youth to determine whether supervised or community-based housing is best.

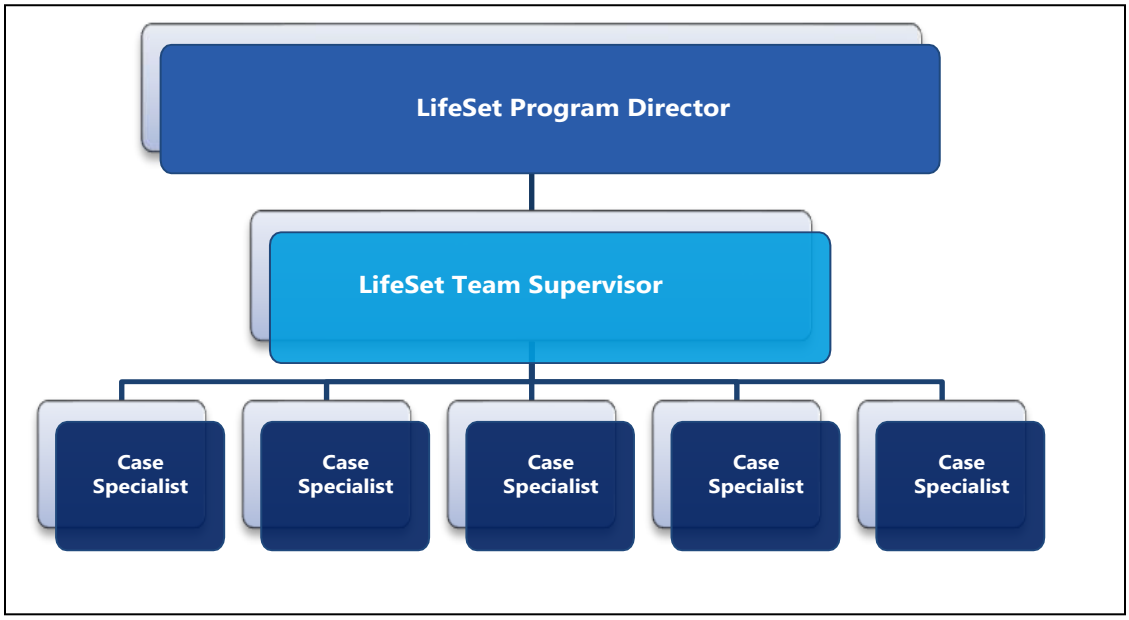
LifeSet Teams

The three agencies implementing LifeSet in Illinois have a total of five LifeSet teams. Hoyleton has one team; UCAN and Lawrence Hall each have two. Each team is composed of five specialists who report to one supervisor and each specialist is expected to carry a caseload of six to eight young people (see Figure 1).[8,9] This is lower than the typical caseload of 10 youth per caseworker for young people in extended foster care because the services provided to young

[4] LifeSet specialists also serve this dual role in Louisiana.
[5] More information about traditional TLP and ILO eligibility criteria can be found in Appendix B.
[6] More information about the matching and referral process can be found in Appendix C.
[7] More information about the exclusionary criteria can be found in Appendix D.
[8] DCFS, Bureau of Operations. FY 2021 LifeSet Pilot Program: Program Plan.
[9] Originally, each LifeSet team was expected to have a census of 30 LifeSet youth. Moving forward, each team will be expected to have a census of 30 youth, some of whom may not be enrolled in LifeSet.

people in LifeSet are more intensive and specialists also serve as young people's legal caseworker.[10] For example, specialists are expected to meet with young people at least once a week (rather than once a month). Caseloads typically include a mix of young people who are currently enrolled in LifeSet and young people who were formerly enrolled in LifeSet but are now in traditional extended foster care (EFC). Because specialists are also legal caseworkers, young people remain on their caseload after they have exited LifeSet.[11]

Figure 1. LifeSet Team



Youth Villages employs a licensed program expert (LPE) to work with each of the LifeSet teams. The LPE provides clinical consultation to ensure fidelity to the LifeSet Program Model and Treatment Design. The LPE conducts ongoing clinical training and delivers clinical support through weekly red-flag meetings, clinical consultation, and development of the team supervisor.[12]

Monthly Service Plans

Each young person enrolled in LifeSet has a service plan that is updated every month. The service plan reflects the problems or "referral issues" the young person wants to address, the goals or "treatment objectives" the young person wants to achieve, and the interventions or action steps the young person will take to achieve those treatment objectives. Specialists work with young people to identify the "drivers" or factors contributing to the referral issues, the reasons those drivers exist, and the interventions needed to address them.

[10] DCFS, Bureau of Operations. *FY 2021 Independent Living Opportunity/Transitional Living Program Plan.*
[11] DCFS, Bureau of Operations. *FY 2021 LifeSet Pilot Program: Program Plan*.
[12] Youth Villages. (2023). LifeSet Program Manual.

GuideTree

A key component of the model is GuideTree. GuideTree is the online toolbox that specialists can turn to for support with case conceptualization, service planning, and intervention development. It is also the portal into which LifeSet providers enter data on individual youth as well as other program and performance data.

Evaluating LifeSet

DCFS contracted with Chapin Hall at the University of Chicago to evaluate LifeSet in Illinois. The evaluation team has convened regular meetings with Youth Villages and DCFS to discuss LifeSet's implementation. These discussions have enhanced our understanding of the model and helped shape the design of the evaluation. During Phase I, we conducted a formative evaluation that addressed two questions:[13]

- How do supervisors and agency administrators perceive LifeSet and LifeSet youth?
- How are the characteristics of LifeSet youth similar to or different from the characteristics of youth in non-LifeSet TLP or ILO placements?

During Phase II, we continued the formative evaluation that began during Phase I and conducted an impact evaluation that assessed the effect of LifeSet on young people's outcomes. Phase II addressed the following research questions:

- What do specialists and supervisors think about LifeSet and what implementation challenges have they experienced?
- How do young people experience LifeSet?
- What is the effect of LifeSet on the outcomes of young people in care?

[13] See Gitlow, Kugley, Shapiro, Kakuyama-Villaber, Jacobsen, Chor, & Dworsky (2022) for the Phase I findings.

METHODS

Phase II of the evaluation continued the formative evaluation that began during Phase I and added an impact evaluation, described in more detail below.

Formative Evaluation

We conducted semi-structured interviews and focus groups with supervisors, case specialists, licensed program experts (LPEs), and young people about their experiences with LifeSet.[14] The interviews and focus groups were conducted over Zoom or by phone between June and November 2022.

Supervisor Interviews

We interviewed the five supervisors we initially interviewed during Phase I of the evaluation. The supervisor interviews lasted about an hour ,on average, but ranged between 36 and 77 minutes.

Case Specialist Focus Groups

We held one focus group with specialists from each of the five LifeSet teams. Fifteen specialists participated in the focus groups. We also interviewed one specialist who could not participate in the team's focus group.[15] The focus groups lasted about 75 minutes, on average, but ranged between 52 and 82 minutes.

LPE Interviews

We interviewed both LPEs. The average length of those interviews was 108 minutes.

Youth Interviews

Case specialists recruited young people on their caseloads to participate in an interview. Young people were eligible if they were at least 18 years old and had been enrolled in LifeSet for at least 60 days. Nineteen young people expressed an interest in being interviewed by sharing their contact information with the evaluation team. Thirteen of those young people completed an interview. The interviews lasted 41 minutes, on average, but ranged between 22 and 81 minutes. Each young person who participated in an interview received a $25 gift card.

All but one of the interviews and all but two of the focus groups were recorded and the recordings were transcribed verbatim. When interviews or focus groups were not recorded, we took detailed notes.[16]

Data Analysis

Two members of the evaluation team reviewed the notes and transcriptions for accuracy and completeness, de-identified the materials, and uploaded them into Atlas.ti (v8), a qualitative

[14] Interview and focus group guides can be found in Appendices F through I.
[15] Hoyleton has one LifeSet team; UCAN and Lawrence Hall each have two LifeSet teams.
[16] One young person's interview was not recorded due to the poor quality of the phone connection. Two focus groups were not recorded because at least one participant did not consent to the recording.

software package, for thematic analysis (Braun & Clarke, 2006) using open and descriptive coding (Saldaña, 2015). They developed initial codebooks for each respondent group (supervisors, specialists, LPEs, and young people) based largely on the interview and focus group guides. Then they met regularly to discuss their coding, create additional codes as needed, and resolve discrepancies. Once the coding was complete, they exported the coded notes and transcripts into Excel to identify themes.

GuideTree Data

To learn more about the characteristics of the young people who enrolled in LifeSet and the flow of young people into and out of the program, we analyzed the data Youth Villages collects and maintains in its GuideTree database from the inception of the program in Illinois through March 31, 2023.

Impact Evaluation

We assessed the impact of LifeSet on youth outcomes using a quasi-experimental design and an Intent-to-Treat (ITT) approach.

Intervention Group

The intervention group, which we identified using GuideTree data, includes 315 young people who were enrolled in LifeSet between December 1, 2019 and October 31, 2022.[17] Of these young people, 195 were placed in a LifeSet TLP and 120 were placed in a LifeSet ILO.[18] We refer to these LifeSet TLPs and ILOs as the young people's index placements and treat the date on which they were enrolled in LifeSet according to GuideTree data as the start of their index placement.[19]

Comparison Group

We constructed our comparison group using a two-step process. First, we identified 483 young people who were placed in a non-LifeSet TLP or ILO between July 1, 2019 and October 31, 2022.[20] We refer to this qualifying TLP or ILO placement as the index placement. We excluded young people from the comparison group if their index placement was a TLP that serves populations with special needs (such as populations with developmental disabilities) or a non-LifeSet TLP operated by one of three LifeSet providers.[21]

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[17] We use October 31, 2022 as the cutoff date because we had DCFS administrative data through April 30, 2023 and we wanted to have DCFS administrative data for at least 6 months post-enrollment.

[18] Although we used the GuideTree data to identify our intervention group, we had a list of LifeSet TLP and ILO contract IDs. Four of 315 young people who were enrolled in LifeSet, according to the GuideTree data, were not in a LifeSet TLP or ILO, according to the DCFS administrative data.

[19] The TLP or ILO placement date according to the DCFS administrative data and the LifeSet enrollment date according to the GuideTree data were not always aligned. This was often due to the fact that young people who were in a TLP or ILO placement supervised by one of the three LifeSet implementing agencies on July 1, 2019 were "rolled over" into a LifeSet contract. It took time for Youth Villages to assess whether these youth were eligible for LifeSet and enroll them in the program if they were eligible.

[20] We identified the non-LifeSet TLPs and ILOs using a list of contract IDs.

[21] We identified these "special needs" TLPs using a list of contract IDs.

Second, we used propensity score matching (Rosenbaum & Rubin, 1983) to "control" for observable differences between the intervention and comparison groups before the index placement. We calculated propensity scores by estimating a logistic regression model that included eight variables. These eight variables, which were selected based on the findings from Phase I of our evaluation and LifeSet's exclusionary criteria, included:[22]

- Age
- Gender
- Race
- Number of years in care
- Number of days in detention prior to index placement per years in care
- Number of days in a psychiatric hospital prior to index placement per years in care
- Number of days absent from placement without authorization prior to index placement per years in care[23]
- Placement in congregate care immediately prior to index placement[24]

We used a 1:1 nearest neighbor method without replacement. After matching, we ended up with a sample that included 315 young people in the intervention group and 315 young people in the comparison group. A power analysis indicated that this sample is large enough to detect a small effect size (.2) with power > .8 and an alpha of .05 for a two-tailed t-test of the difference between matched pairs and between independent samples.

Balance Test

We conducted a balance test to determine whether propensity score matching produced intervention and comparison groups that were equivalent on observable measures. Our observable measures included all the matching variables, several measures related to young people's foster care placement histories prior to their index placement (such as most recent placement in congregate care, number of days in care, ever absent from placement without authorization, ever in a psychiatric hospital, and ever in detention), and all the Child and Adolescent Needs and Strengths (CANS) items except for the items in the domain pertaining to children 5 years old and younger. The CANS is a 139-item trauma-informed assessment tool used to support decision making around level of care and service planning and to monitor service outcomes (Lyons, 2009). In Illinois, caseworkers are supposed to administer the CANS at least once every 6 months. Each CANS item is rated on a 4-point scale ranging from 0 to 3 to

[22] See Appendix D for a list of the exclusionary criteria.
[23] Unauthorized absences from placement include the following living arrangements: runaway (RNY), whereabouts unknown (WCC, WUK, or UNK), and unauthorized placement (UAP, UAH).
[24] Congregate care includes group home, qualified residential treatment center, or a public or private institution.

indicate the level of need or strength. Higher scores indicate a greater need for action to address a need or build a strength. For the balance test, we used the last CANS completed within 180 days before each young person's index placement.[25] The balance test indicated that the two groups were equivalent on all but two observable characteristics prior to the index placement.[26]

Outcome Measures

We used DCFS administrative data to measure outcomes related to nonplacement events, outcomes related to placements, and outcomes related to the transition to adulthood. We describe each type of outcome below.

Nonplacement Outcomes

We measure three types of nonplacement events that interrupt out-of-home care placements: unauthorized absences from placement,[27] psychiatric hospitalizations,[28] and detentions or incarcerations.[29] For each type of nonplacement event, we calculated the number of events per 100 days in care by dividing the number of times young people experienced the event by the number of days in care between the start of their index placement and either the date they exited care or April 30, 2023, if they had not exited by that date, and multiplying by 100.[30]

Placement Outcomes

We distinguish between two types of placements—supervised (TLP) and community (ILO)—and divide the number of days young people were in an ILO placement by the number of days in a TLP or ILO placement between the start of their index placement and either the date they exited care or April 30, 2023, if they had not exited by that date. To gain additional insight, we report binary outcomes related to living in the community, including how many people ever moved from one placement type to the other, and how many ended care in an ILO.

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[25] Caseworkers are supposed to complete a CANS assessment at least once every 6 months for every young person in care. However, no CANS was completed for 95 young people in the intervention group and 104 young people in the comparison group within 180 days before their index placement.

[26] The two characteristics that distinguished the two groups were DCFS region and the CANS item related to job functioning (#94). The two groups are not equivalent on region because two of the LifeSet implementing agencies are in Cook County and one is in the Southern region. The comparison group includes young people in all four DCFS regions (Cook, Southern, Central, and Northern). See Appendix E for the balance test results.

[27] Unauthorized absences from placement include the following living arrangements: runaway (RNY), whereabouts unknown (WCC, WUK, or UNK), and unauthorized placement (UAP, UAH).

[28] Psychiatric hospitalizations include one of two living arrangements: psychiatric hospitalization (HFP) or hospitalization (HHF) if the reasons for placement was either behavior management problem (BMP) or mental health problem (MHP).

[29] Detention includes two living arrangement type codes, Institution - Committed to the Department of Correction (IDC) and Detention Facility/Jail (DET).

[30] April 30, 2023 is the last date for which we had DCFS administrative data.

Transition to Adulthood Outcomes

Our outcome measures include four items from the Transition to Adulthood CANS domain: independent life skills (#87), transportation (#88), educational attainment (#92), and victimization (#93). These are the only four items in that domain that apply to all youth age 14.5 and older.[31] For each young person in the intervention and comparison groups, we used the last CANS completed at least 60 days after their index placement. Among LifeSet participants, 437 days elapsed on average between the index placement and the outcome CANS assessment, ranging from 69 to 1,048 days. Among the comparison group, 424 days elapsed on average, ranging from 63 to 1,239 days. Although caseworkers are supposed to complete a CANS at least once every 6 months for every young person in care, we were missing any post-index placement CANS assessments for 123 young people in the intervention group and 143 young people in the comparison group. Additionally, even when a CANS was completed, data for at least one of the four Transition to Adulthood items were often missing. This has two implications for our analysis. First, it means that the size of both the intervention and comparison groups is different for each CANS outcome. Second, although we could limit our analysis to the matched pairs for whom we have data for both members of the pair, this would reduce our sample size, and hence, our statistical power to detect an effect. Because a balance test including only youth with a CANS indicated that the unmatched groups were still balanced, we chose to treat the intervention and comparison groups as independent samples for our analysis of the outcomes that relied on CANS data.

Postsecondary Educational Outcomes

In addition to measuring outcomes using DCFS administrative data, we also requested data on college enrollment and graduation from the National Student Clearinghouse (NSC). The NSC is a nonprofit organization that receives college enrollment and graduation data from more than 36,000 participating colleges and universities across the U.S. We provided the NSC with a data file that included the names and birthdates of the 286 young people who first enrolled in LifeSet and the 454 young people who enrolled in a non-LifeSet TLP or ILO between July 1, 2019 and June 30, 2022. The NSC matched those data against its database (through mid-December 2022) and returned a file that included college enrollment and graduation records for all the young people for whom it found a match. We then linked those records to a propensity score matched sample that included the 272 young people who were enrolled in LifeSet and the 272 young people who were enrolled in a non-LifeSet TLP or ILO between July 1, 2019 and June 30, 2022 to create our analytic sample. We used the June 30, 2022 cutoff date to ensure that we would have NSC data for at least 6 months after the young people enrolled in LifeSet or after the start of their index placement.

[31] Other items in this domain only apply to youth with certain characteristics, such as youth who are parents.

WHAT DO GUIDETREE DATA SAY ABOUT LIFESET IN ILLINOIS?

Figure 2 shows the age at which the 338 young people who were enrolled in LifeSet between December 1, 2019 and March 31, 2023 first entered the program. Two-thirds of these young people first entered LifeSet when they were 18 or 19 years old.

Figure 2. Age at First LifeSet Enrollment

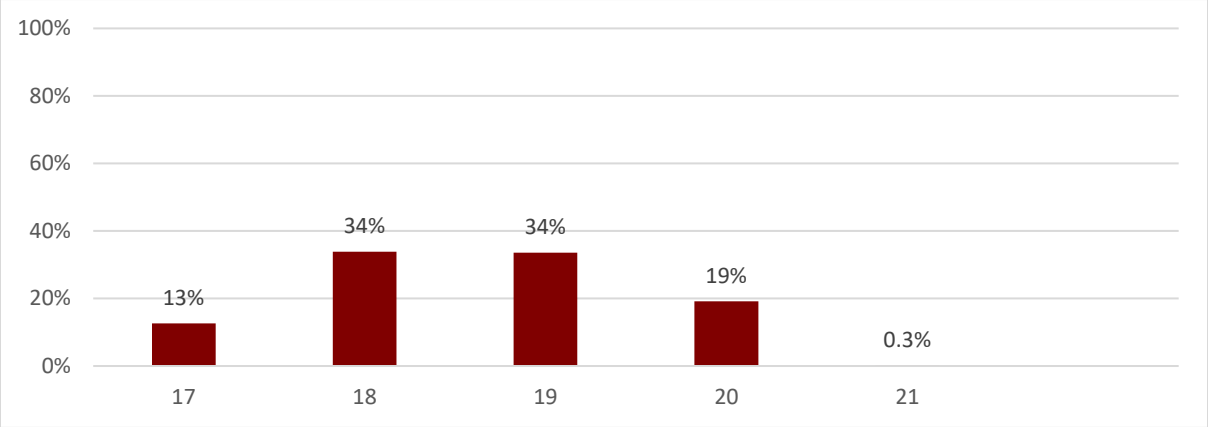


Figure 3 depicts the race of the 338 LifeSet participants. These young people were predominantly African American. In April 2023, Black youth comprised 70% of the population of youth in care age 18 and older in Cook County but only 35% of the population of youth in care age 18 and older elsewhere in the state. Conversely, White youth comprised 64% of the population of youth in care age 18 and older elsewhere in the state but only 28% of the population of youth in care age 18 and older in Cook County. The racial composition of the LifeSet participants reflects the fact that four of the five LifeSet teams are located in Cook County.

Figure 3. Race of LifeSet Participants

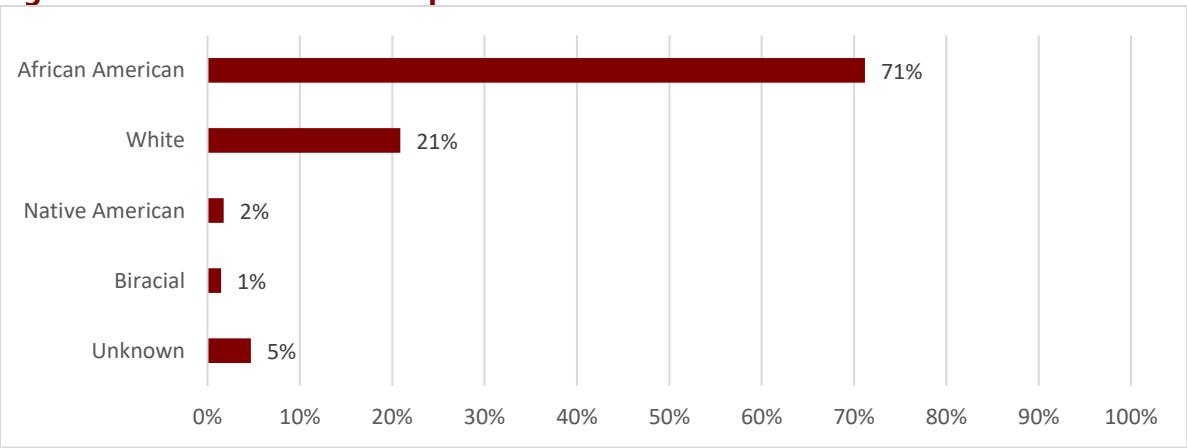


Figure 4 shows the ethnicity of the 338 LifeSet participants. Eleven percent of these young people identified as Hispanic.

Figure 4. Ethnicity of LifeSet Participants

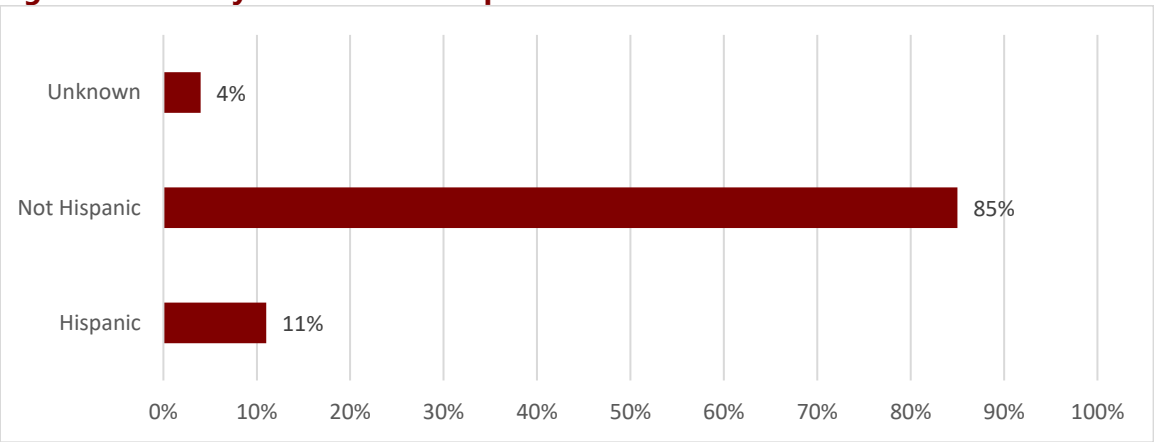
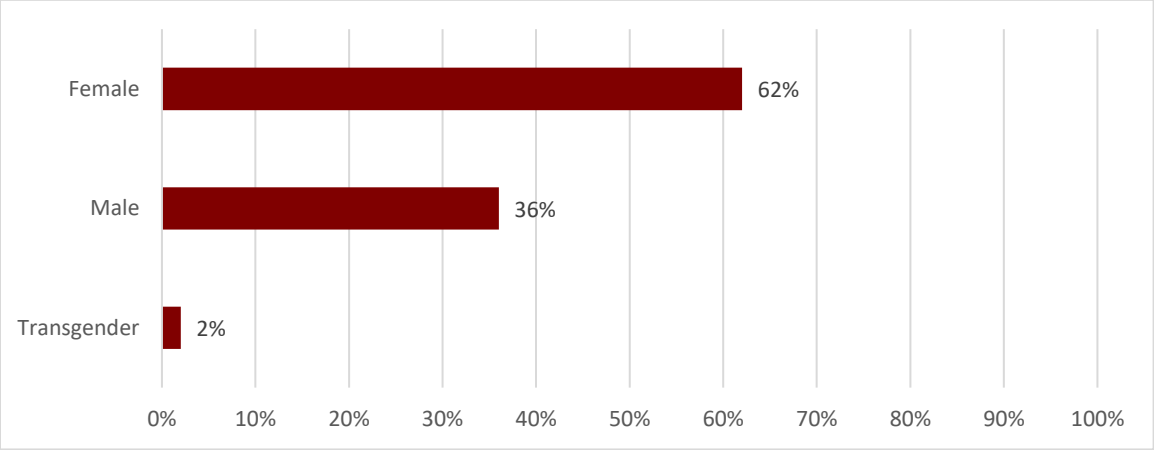


Figure 5 shows the gender of the 338 LifeSet participants. Sixty-two percent of these young people are female, 36% are male, and 2% are transgender.

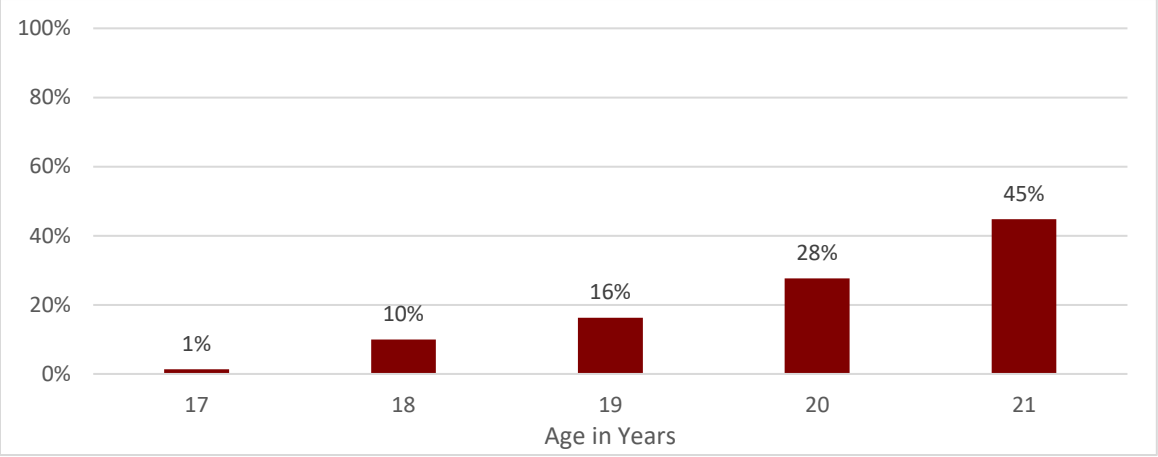
Figure 5. Gender of LifeSet Participants



Sixty-four percent (*n* = 217) of the 340 young people who were enrolled in LifeSet between December 1, 2019 and March 31, 2023 exited LifeSet before March 31, 2023. Figure 6 shows their age at exit.[32] Nearly three-quarters of these young people were either 20 or 21 years old when they exited LifeSet.

[32] Seven young people enrolled in LifeSet two times, and six of those seven exited twice. Only their first exit is represented here.

Figure 6. Age at Exit from LifeSet



We calculated the number of months the 217 young people who exited LifeSet before March 31, 2023 had been enrolled.[33] Figure 7 shows the distribution. About half of the young people were enrolled in LifeSet for less than 12 months. Only 9% were enrolled for at least 2 years.

Figure 7. Number of Months Enrolled in LifeSet Before Exiting

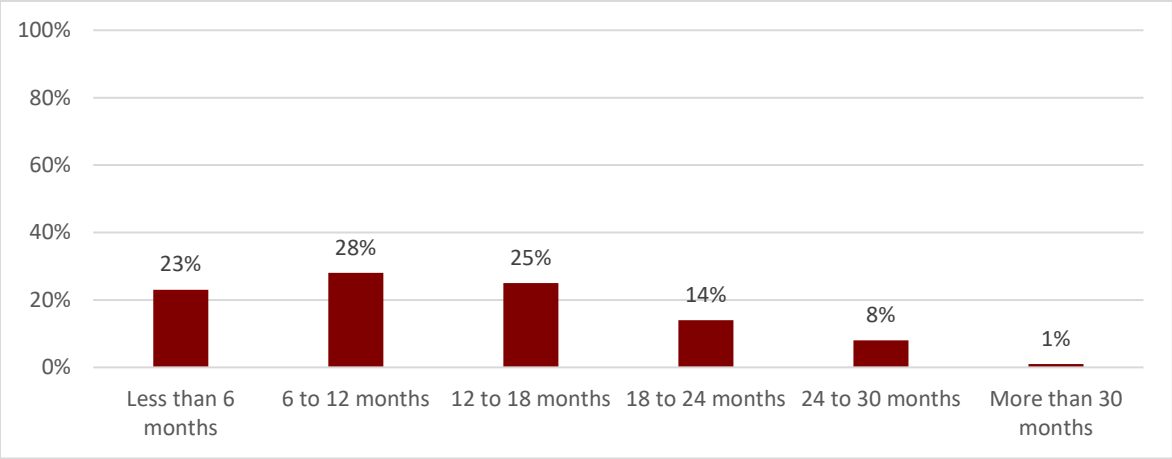
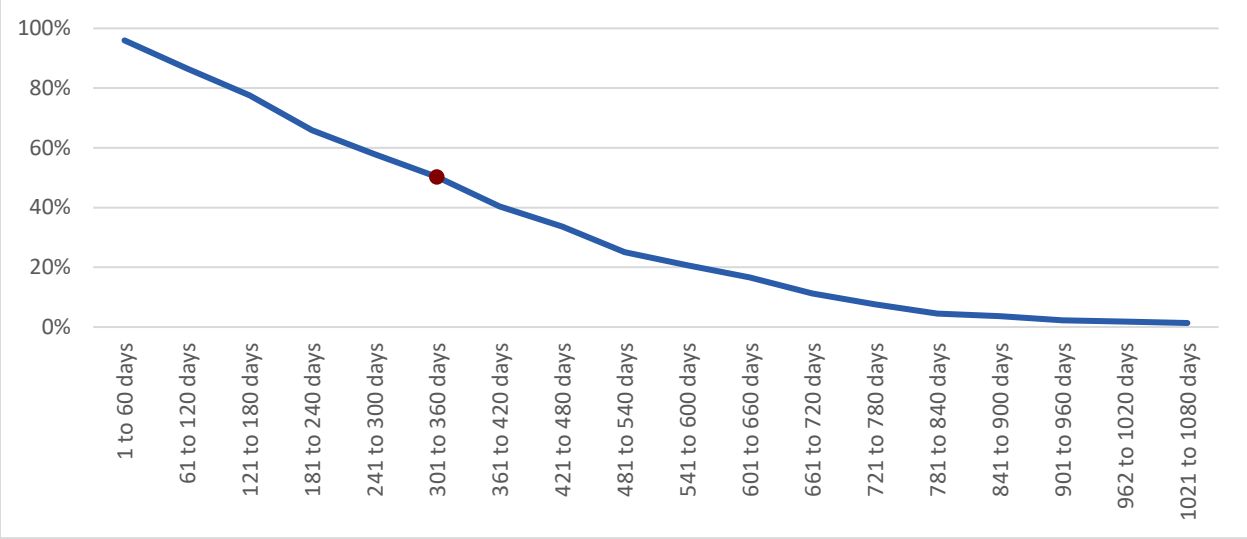


Figure 8 displays the same data shown in Figure 7 in a different way. It shows the percentage of young people who were still enrolled in LifeSet at 60-day intervals. Fifty percent of the young people had exited LifeSet within 1 year of enrolling. After nearly 2 years, only about 10% were still enrolled.

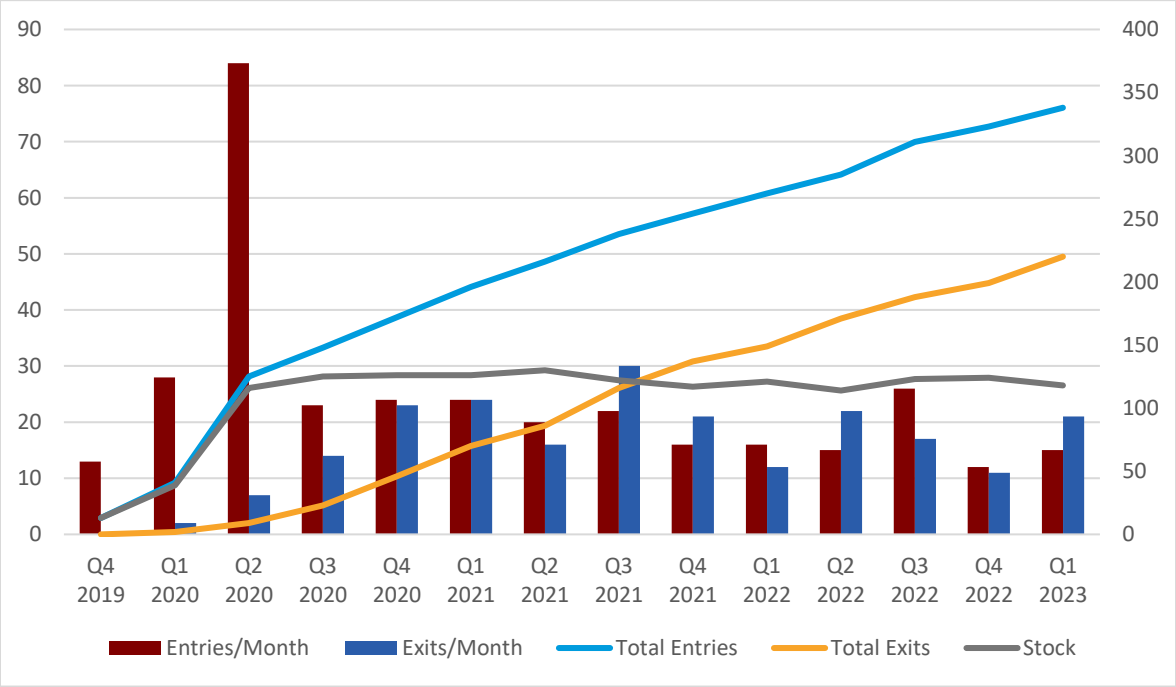
[33] We only counted the time from first entry to first exit for the six young people who enrolled and exited twice.

Figure 8. Percentage of LifeSet Participants Still Enrolled in LifeSet, by Days since Entry



Finally, Figure 9 shows the number of entries, both quarterly and cumulative, the number of exits, both quarterly and cumulative, and the total caseload at the end of the quarter from the 3rd quarter of 2019 (July 1, 2019) through the first quarter of 2023 (March 31, 2023). More young people were enrolled in LifeSet during the second quarter of 2020 than in any other quarter by far. Since that quarter, the total LifeSet caseload at the end of each month (that is, the stock) has hovered around 125.

Figure 9. Entries, Exits, and Caseloads



WHAT SETS LIFESET APART?

Our interviews with young people, specialists, supervisors, and LPEs revealed four key differences between LifeSet and services as usual for transition age youth in care. These include differences in (1) the placement options available to youth, (2) the relationships between youth and their caseworkers, (3) the nature of youth engagement, and (4) the supports provided to staff. We discuss each of these key differences below.[34]

Placement Options

One key difference between LifeSet and "services as usual" for transition-age youth in care is that DCFS relaxed some TLP and ILO eligibility criteria for young people enrolled in LifeSet. Young people in traditional TLP placements must be enrolled in school if they don't have a high school diploma or GED. Young people in traditional ILO placements must have a high school diploma or GED and be employed for at least 45 days.[35] These requirements are waived for young people enrolled in LifeSet, and the eligibility age for ILO was lowered from 19 to 18 years old. This means that supervised living—TLP—and community-based living—ILO—are options for some LifeSet participants who would not otherwise be eligible.

The supervisors and specialists we interviewed lauded these changes in eligibility criteria and recommended that they be continued. Several of the specialists noted that eliminating the educational requirement allows young people who may not be "school-oriented" to "still move forward with [their] life." However, it does not preclude specialists from discussing the consequences of not completing high school with LifeSet participants who lack a high school diploma or GED. Likewise, most of the specialists viewed lowering the age of eligibility for ILO as a positive change, particularly if it reduced the number of young people who go AWOL from a TLP. One exception was a specialist who expressed concern that relaxing the traditional ILO eligibility criteria could result in young people living in the community without the maturity or independent living skills needed to succeed.

The young people we interviewed also supported these changes. One young person was able to live with her partner and their child even though she was not yet 19 years old. Another young man described being discouraged when he learned that it would be another 2 years before he would have enough credits to graduate from high school. Enrolling in LifeSet allowed him to move into an apartment, even without a high school diploma. He shared that LifeSet provided an opportunity "to shine" for young people like himself who "didn't do everything that was expected" such as graduate from high school.

[34] To maintain confidentiality, we have chosen to omit some identifying details.

[35] See IL DCFS Procedures 301, Placement and Visitation Services, https://dcfs.illinois.gov/content/dam/soi/en/web/dcfs/documents/about-us/policy-rules-and-forms/documents/procedures/procedures-301.pdf

In addition to relaxing some eligibility criteria, DCFS also gave LifeSet participants who are unable to sign a lease the option to enter into a shared housing agreement. That agreement spells out the expectations for and responsibilities of the young person and the homeowner or renter with whom the young person is living.[36] Some specialists told us that young people were more open to sharing information about their living situation when they had chosen where to live. They also believed that giving young people more of a say in their living situation could be empowering.

Specialists described some of the shared housing agreements into which young people had entered. One young person lived with a former foster parent under a shared housing agreement. This allowed the foster parent to care for another foster child. Several young people lived with relatives while they looked for their own housing. And some young people entered into a shared housing agreement with a biological parent.

Specialists from all three agencies expressed support for allowing young people to enter into shared housing agreements with a biological parent under certain circumstances. One specialist explained that it is better for young people to figure out whether living with a biological parent is a viable option while they still have support from an agency rather than waiting until after they age out. However, specialists' understanding of whether shared housing agreements with biological parents were allowed varied by agency. Specialists at one agency were not aware that this was an option. Specialists at a second agency thought that it had been an option but was now frowned upon. And specialists at the third agency thought that it was still allowed on a case-by-case basis.

Not all shared housing agreements work out. For example, we heard about a young woman who returned to her TLP after she became the only person in the shared household who was contributing to the rent.

Relationships

Both the young people and the specialists we interviewed spoke about the importance of relationships to the LifeSet model. Young people form strong relationships with their specialists, who they described using words like "caring," "consistent," "genuine," "reliable," "attentive," and "encouraging." One young woman appreciated how open her specialist was with her. Another young woman noted that no one had cared as much about her as her specialist in all the years she had been in care. A third young woman described her specialist as "checking up with me like I'm her daughter."

Some young people noted that they didn't automatically trust their specialist. One young woman who had been in LifeSet for less than 6 months explained that although her specialist

[36] DCFS, Bureau of Operations. *FY 2021 LifeSet Pilot Program: Program Plan*. (See Exhibit 7: Community Shared Housing, Rental Agreement.)

"hasn't let me down yet. . . . I'm not gonna depend on her 100% because any time I depend on someone in my corner, they always disappear."

Most of the specialists also valued the opportunity to build strong relationships with youth. This relationship building, which one specialist described as the best part of LifeSet, was facilitated by their weekly visits. Weekly visits allow specialists to understand and develop positive relationships with the young people on their caseloads. Weekly visits can also result in young people becoming attached to their specialist and getting used to the support their specialist provides.

Several specialists spoke about how difficult transitioning from one specialist to another can be for young people. A supervisor described how one young woman "shut down" and announced that she wouldn't talk with anybody else after her specialist left. Although she agreed to meet weekly with her new specialist so she could remain in LifeSet, they never developed good rapport. One LPE also observed that young people can "kind of fall off" when their specialist changes and that it can take time for good rapport with the new specialist to develop.

One specialist described hearing from a young man that he was used to "workers" leaving. This young man's experience was common. Eight of the 13 young people we interviewed reported that they had been assigned to more than one specialist. How they responded to their specialist leaving varied widely. One young woman who not had positive experiences with her prior caseworkers was apprehensive about getting a new specialist when the specialist with whom she had a good relationship left. Another young woman was "really mad" when her specialist left because she lost her "go-to person." A third young woman reported crying when the specialist—to whom she looked as an older sister and role model—left.

Their initial reactions notwithstanding, most of these young people reported that they were able to forge a strong relationship with their new specialist. For one young woman, this relationship building was facilitated by her familiarity with the entire LifeSet team. Another young woman noted that she connected better with her third specialist than she had with the first two.[37]

Youth Engagement

We consistently heard from supervisors and specialists that young people need to be engaged in LifeSet to reap the full benefits of the model. As one supervisor said:

> This only works if [youth are] engaged. It does not work if you're not. It just does not. I'll argue that with anybody. Because you just have to have the youth involved consistently and not sporadically or when they want to for this whole thing to work.

Young people also recognized the importance of engagement. For example, one young woman, who had gone on run multiple times since enrolling in the program, only realized with the

[37] The second specialist only worked with the youth for a few weeks until the third specialist could be assigned.

benefit of hindsight that, "I need to sit down and listen to" her specialist who had consistently reached out to her while she was on run. At the time of her interview, she was meeting with her specialist several times a week to explore housing options. She added that "I just love [specialist] because she's trying to help me."

Frequency of Visits

LifeSet requires weekly visits between young people and their specialist. These weekly visits help develop rapport, allow specialists to do more with young people, and increase specialists' awareness of what is happening in young people's lives. One specialist explained that "a lot can transpire in a month. You see issues emerge in real time when you see them weekly."

This might explain why some specialists were so committed to visiting with the young people on their caseload. One specialist explained that "with DCFS [you] say 'I did my attempts. . . I texted, I emailed, I called, I showed up.'" By contrast, when working with young people enrolled in LifeSet, "you're going to put forth that much more effort to make sure that you're seeing your kids."

Several specialists told us that they are in touch with young people on their caseload more frequently than once a week, often through phone calls or text messages. One specialist described being in contact with the young people on their caseload as often as needed. Another noted that contact can be daily because "a lot of times things happen outside of our visits that we help them with."

Substance of Visits

Several of the specialists and young people we interviewed noted that visits between young people and their specialist are not only more frequent than typical caseworker visits, but also longer and more substantive. One specialist appreciated being able to spend additional time with the young people on her caseload:

> The reality is there's very little I can do with that youth in 20-30 minutes. . . besides a stern conversation every now and then. . . but to have the LS program we're meeting them every week and having extended time with them.

Another specialist pointed out that having additional time allows her to explore issues with young people that might otherwise "have slipped through the cracks." A third specialist noted that young people appreciate the additional time that their specialists spend with them:

> You're seeing these youth every week for about an hour. . . . That's what they've been longing for, for so many years. Somebody to kind of come by to actually spend some time with them other than just kind of doing a safety look over and be out of the door.

This was supported by the young people we interviewed. They drew a sharp contrast between the visits they had with their specialist and the visits they had with case workers before enrolling in LifeSet. Young people characterized the visits with their former caseworkers as cursory; they,

sometimes lasted only 10 to 15 minutes. One young woman described her former caseworkers as coming in to "[make] sure like I wasn't living in a slob house or something, and they were there for maybe 10 minutes." Another young woman characterized her former caseworker as "just kind of. . . checking in on you, [to] make sure you're not running away in the streets, [to make sure you are] going to school. That was it." By contrast, the young people felt that visits with their specialist weren't rushed. One young man noted that his specialist would never say "Oh I gotta go; I've got somebody else." And another young woman described LifeSet as "guid[ing] me more than just babysitting me."

Goal-Driven Visits

Setting goals and monitoring progress toward goal achievement provide structure to the weekly visits. One specialist explained that their weekly visits are "just more structured. We know exactly what we're working on. It's not all over the place because we've already set a goal in the beginning of the month."

During their weekly visits, specialists and young people focus on goals that the young people have set for themselves. Allowing young people to set their own goals is fundamental to youth engagement. Several specialists told us that they ask young people what they want to accomplish. As one specialist explained, "I kind of ask the youth, what is it that you want to focus on or what are you looking towards?" Allowing young people to choose their own goals means that young people who have not been successful in school can focus on other areas in which they might be more successful. As one specialist noted, "we let them choose their route. . . . Not everybody's success story is the same." The young people we interviewed agreed. One young woman explained that her specialist provided guidance but never told her, "'Oh this is what you need to do when it comes to your life' or 'You can't do this when it comes to your life.'"

Many specialists talked about breaking large goals down into smaller, more achievable goals:

> It's important for us to come up with . . . her goals and make sure they [are] doable. . . . We can talk about what you need to do in [the] long term, but we need to make goals that she can reach, you know, achievable goals so she don't feel like "I can't do that" . . . just making sure that we're supporting what she wants to do, and making sure her goals are reachable.
>
> I've never seen a model quite like this one, where it's very specific, which helps. I mean usually, like at my other job would be like, "Yeah, just help me get a job." Yeah, just but never talked about the steps, like what do we need to do?

Several young people also noted being encouraged by their specialists to set short-term goals that they could realistically achieve. One young person described how he benefitted from setting short-term goals as part of his monthly service plan:

> It would help me too because it's like structuring out my month, so like within this month, this is what I said I wanted to be done. So it's going to be done. . . . I feel the short-term goals help a lot.

Another young man explained that the LifeSet monthly service plan was helpful because it laid out how he was "going to achieve this goal and. . . it's your own thinking and your own words."

Focus on Life Skills

Both the specialists and young people we interviewed valued LifeSet's focus on developing life skills and preparing for independent living. Specialists emphasized that their weekly visits help young people develop life skills, which bolsters their self-confidence:

> I'm able to teach them a lot of skills that they don't have that they can do on their own and build on their own self-confidence and their own skill set and be able to say, "I did that by myself." They'll call me now and say, "Hey, guess what? I just went and picked up my own medication."

All the young people described learning life skills from their specialist. Among the examples they cited were obtaining vital documents, managing their healthcare, and budgeting their money. Several young people also talked about how LifeSet helped them prepare for the "real world." One young woman explained that LifeSet "allow[s] me time to grow and get used to what the real world is gonna be like." Another described learning "a lot about being in the real world, financial-wise and relationship-wise, that I didn't know before. I'm glad I learned it before I move [at 21]." A third young woman cited wanting to be more independent as a reason for enrolling in LifeSet, "I'm a young adult now, so I wanna be able to take care of myself and not have to depend on nobody."

Staff Support

Supervisors, specialists, and LPEs talked about three types of support available to LifeSet specialists: group supervision and clinical consultation, the GuideTree toolbox, and training. Each of these supports is described below.

Supervision and Clinical Support

Supervisors lead a weekly group supervision for the specialists on their team that lasts 60 to 90 minutes. Group supervision provides dedicated time for specialists and their supervisor to talk about the progress of the young people on their caseload and engage in peer-to-peer learning. As one specialist put it:

> You're able to talk about clients and situations that occur with coworkers that you may not [have] even dealt with yet. You can hear from their experience and get some feedback . . . it's really beneficial, and then you get a chance to express feeling[s] which is important, you get a chance to talk about it. You realize that you're not alone, that you're not the only one experiencing that, and realize that somebody else got through it, and what did they do.

Another specialist echoed the benefits of peer-to-peer learning:

> A specialist might have experienced that, 3 months ago, and she may have a great idea of what she used on her youth, and we might be able to implement that to work on our youth. So, that group setting allows us to kind of talk and brainstorm [together].

The LPEs facilitate a weekly clinical consultation for each team that is attended by both the supervisor and the specialists. During these consultations, LPEs provide model-specific clinical support and feedback on cases discussed during weekly group supervision. One LPE described it as "a really collaborative process where I leverage their skills and their knowledge of the youth and then I utilize my clinical experience and my knowledge of the model to kind of give them feedback."

Specialists and supervisors talked about the importance of the clinical perspective and model-focused support that the LPE provides. One specialist explained:

> We will talk about that in group and then we'll take it to LPE the next day. . . and [explain] what we came up with, and LPE can probably look at it and say, "Okay, well, I like that idea, how about we try to add this to it? Or why do you think that was the best way to do it?" . . . [and] have us explain why we thought [that] was the best line of action, and then. . . give us a critique or. . . give us a thumbs up, based on what we talked about. So collaboratively we work together as a team, and then with [LPE] to kind of come up with a solution to kind of help break those barriers with that youth.

Specialists and supervisors also talked about support provided by their LPE outside of the weekly clinical consultations. One specialist described being able to "reach out to [LPE] and say, 'Hey, I'm struggling with this youth or I'm struggling with that youth, what can we do differently?'" Another appreciated having the LPE's extra set of eyes "because a lot of our youth can get into some very risky situations. And so, the more eyes, the more point of views, then we can usually come up with a better solution." A third specialist explained:

> The LPE helps you think about how to work with the youth to see what the barriers are intrinsically. It's not just that they didn't do it [update their resume or apply for the jobs], it's trying to see what is the reason behind why they didn't do it, and why they were not motivated or interested. It helps me look at issues and barriers from a trauma lens.

Most of the specialists and supervisors with whom we spoke saw value in the group supervision and clinical consultation and appreciated the support. One said, "Meeting with them weekly helps us to express how we're feeling, what the case is doing to us mentally. . . it is helpful with them difficult clients."

GuideTree Toolbox

The GuideTree toolbox is an online platform that specialists use to select one or more "drivers" that are contributing to the "referral issue" a young person wants to address as part of their monthly service plan. As one specialist explained, "You go into GuideTree, you click what your referral issue is, and it basically gives you all possibilities of things that might be going on." Specialists' experiences with selecting drivers were mixed. Some found the available referral issues too limiting, particularly when young people are doing well and on the right track. Others found GuideTree to be flexible. One specialist explained, "I think the [drivers] in GuideTree are like a skeleton suggestion, but you can fine tune it more to what you need." Specialists from one team proudly reported that some updates in GuideTree were based on the unique drivers they created with their LPE's help.

Most of the specialists we spoke with found GuideTree to be valuable for accessing resources that they can use to help young people work towards their identified goals. For example, one specialist described using information from GuideTree about different types of communication to talk with a young person about ways to communicate appropriately at work. Another specialist reported using a vocational assessment in GuideTree to help a young person plan for employment. Specialists also turn to GuideTree to access information, including links to external resources, about mental health disorders, intimate partner violence, or other issues with which young people may be struggling. One specialist expressed appreciation for the information:

> There was one about like how to work with youth within an intimate partner violence relationship, and like what you can do as like a social worker specialist in that role, I like things like that, that it's not just interventions you can do with your youth, but like also things to kind of like support us as workers.

One specialist disagreed about the value of GuideTree's resources, saying "there aren't too many resources in GuideTree, so now I have to make up my own resources or figure out or research other resources."

Quarterly Booster Trainings

Specialists are expected to attend quarterly booster trainings facilitated by the LPE. Comments about the booster trainings from the specialists we interviewed were largely positive. One specialist described the booster trainings as "really help[ing] us build our skills and strengthen what we can bring to the kids." Another specialist described how the boosters expanded her knowledge on a variety of topics:

> I didn't know anything about sex trafficking, I didn't know really too much about suicide signs. . . . There's a lot of kids that are involved in either or both. So, to be able to get that information. . . I have a better eye. So, I love to take the information and then even educate my own youth.

Some specialists did note that attending the booster trainings in addition to their regular weekly meetings can be a challenge.

WHAT IMPLEMENTATION CHALLENGES REMAIN?

During our interviews and focus groups, specialists and supervisors shared their perspectives on several challenges that continue to affect the implementation of LifeSet in Illinois. We have grouped these challenges into three categories: (1) referrals; (2) exits; and (3) workload, turnover, and caseload size. We discuss the challenges in each of these categories below.

Referrals

During Phase I of our evaluation, some supervisors and administrators expressed frustration about receiving referrals for young people for whom LifeSet would not be a good fit based on the LifeSet exclusionary criteria.[38] They also identified other problems with the referral process, including receiving referrals for youth who "will tell you what you want to hear just to get into the program but aren't willing to do the work," receiving multiple referrals at a time, and receiving referrals for young people outside of their service area.

Our follow-up interviews suggested that the referral process had improved. Three of the five supervisors noted that they were receiving only one referral at a time and more referrals for young people in their service area. However, supervisors also acknowledged some ongoing referral problems. These include referrals for young people who are (1) living in unapproved placements in the community; (2) placed outside of the agency's catchment area (which can be a barrier to weekly visits); (3) being discharged from residential care and do not meet TLP or ILO eligibility criteria;[39] and (4) on electronic monitoring and can't leave their placement. Regarding this last group, one supervisor asked rhetorically, "They can't go to work and can't go to school. So what exactly are we supposed to do with the kids that don't have any movement?"

Another ongoing problem is the lack of knowledge about LifeSet among the young people being referred. One of the LPEs observed that young people's understanding of LifeSet is often "wildly off base." This was confirmed by some of the young people we interviewed. Several young people told us they did not know they were being referred to LifeSet. As one young woman put it, "[I] didn't even know what a LifeSet TLP program is." Other young people mistakenly believe that LifeSet will connect them with a placement. In fact, many of the young people we interviewed reported hearing about LifeSet while discussing placement options.

Exiting LifeSet

During our focus groups with specialists, we heard about three circumstances under which young people exit LifeSet: (1) they turn 21 and age out of care; (2) they achieve their goals and remain on their specialist's caseload as EFC; and (3) they are disengaged and not meeting

[38] See Appendix D for information on Exclusionary Criteria.

[39] After we completed our interviews, the agencies implementing LifeSet began serving young people with more complex needs who were referred to LifeSet as Complex Care Coordination (CCC) cases. These young people are not enrolled in LifeSet but are part of a specialist's caseload.

program requirements and remain on their specialist's caseload as EFC or get transferred back to DCFS. We discuss each of these circumstances below.

Aging Out

Although LifeSet services are typically provided for 6 to 9 months,[40] many of the specialists we spoke with told us that young people routinely remain on their caseload until they age out. One specialist said, "I've never had a youth discharge [from LifeSet] before [age] 21." Another added, "I haven't discharged anybody after 9 months because they were doing great. They just stay until they're 21."

Specialists and supervisors offered several justifications for keeping young people in LifeSet until they age out:

- Young people's circumstances can change. A young person who has been holding down a job or attending school may experience a crisis. One specialist shared the example of a young person who struggled with mental health issues after "doing amazing."
- Young people who are "performing very well [or] functioning at a high level" still have some type of need.
- Young people value the support that LifeSet provides. One specialist observed that "LifeSet is super elite for a lot of kids who have nothing. So they don't really want to get out of it."
- Guardians ad litem (GALs) and attorneys pressure specialists to keep young people in LifeSet. One specialist described "getting a lot of heat from my GAL, the attorneys in the court. . . . Even if these kids run out, they're like, 'No, you have benefits that only LifeSet offers.'"
- Keeping young people in LifeSet until age 21 helps maintain the census required under their agency's LifeSet contract with DCFS. One supervisor told us that "because of census, we have not discharged anyone [before age 21]." However, one specialist was against keeping young people in LifeSet "just to keep them on." This specialist also saw no reason for young people who experienced a change in circumstances, such as a mental health crisis, to re-enter LifeSet after successfully exiting because "LifeSet is so ingrained in me. . . . I know what I need to do."

Successful Discharge/Achieving Goals

1. Some specialists shared examples of young people "successfully" exiting LifeSet because they "hit their goals." This includes young people who transitioned to EFC so they would be eligible for Youth in College or a housing voucher. However, "successful" transitions to EFC were not the norm for at least four reasons. First, as already noted, some young people are staying in LifeSet until they age out of care. Second, specialists lack clear

[40] https://youthvillages.org/services/lifeset/

guidelines for when young people who have achieved their goals should be transitioned to EFC. In fact, some specialists were not even aware that transitioning these young people to EFC was an option. Third, some specialists understand that they have a limited number of EFC caseload slots and they can't transition a young person from LifeSet to EFC if all those slots are occupied. One specialist described being unable to transition a young person who was eligible for Youth in College (YIC) to EFC because no EFC "slots" were available. Finally, specialists who transitioned a young person from LifeSet to EFC would be assigned a new LifeSet case if they had fewer than six LifeSet youth on their caseload. This could put them over the recommended maximum caseload of eight.

Unsuccessful Discharge/Disengaged

When young people are not engaged in services and not meeting weekly with their specialist, their specialist notifies them that they are at risk of being discharged from LifeSet. If they remain disengaged or fail to meet weekly with their specialist for at least a month, these young people may be transitioned from LifeSet to EFC. Specialists expressed frustration that they were required to carry these young people on their caseloads as EFC cases. As one specialist put it:

> Our biggest struggle has been when they don't work out with LifeSet. We can't, I hate saying get rid of them, but they're on our caseload and they may stay on our caseload until they age out. If we get lucky, this happens when they are 20 so it's not that long.

These specialists were also frustrated with DCFS for not "taking these kids back." From their perspective, carrying these disengaged young people on their caseloads as EFC cases prevents them from transitioning young people who had achieved their goals from LifeSet to EFC or from being assigned new LifeSet youth. One specialist questioned also whether young people would "understand the difference between LifeSet active and EFC because they have the same worker."

Workload, Turnover, and Caseload Size

We heard about three interrelated challenges during our interviews with supervisors and focus groups with specialists: workload, turnover, and caseload size. We discuss each of these in turn below.

Workload

We heard from multiple specialists about the demanding, stressful, and sometimes overwhelming nature of their job:

> We have a training, then we have two meetings, and then I got to do paperwork. So it can be overwhelming.
>
> My biggest struggle is home and work balance. This job demands a lot.
>
> I feel more stressed with this YV LifeSet stuff than I ever felt [with] just the basic DCFS.

Some of the supervisors and specialists also felt that the weekly required team meetings (clinical consultation, group supervision) could be combined. Some reasoned that having a "solid 2-hour meeting" rather than two 1.5-hour meetings would be "super-efficient and effective" and "give us another day to kind of get with our youth and do some things that we want to do with our youth." At one of the focus groups, specialists expressed that it could be better to have a combination meeting because they might "get stuck" on how to work something out at the supervision meeting and want the LPE's input and clinical perspective.

Some specialists expressed concern that they could not continue in their role due to the heavy workload. One told us that "I can't see myself working in this high intensity every year." Another explained:

> I'm easily [working] a 10-hour day, every single day. We're available on the weekends; we're available at night. I do more for [agency], and LifeSet, and DCFS than I do for my own family. So that sometimes wears me down and says maybe this job is not for me, because it's a lot of work that I can't seem to keep up with.

Specialists from all three agencies noted that meeting the requirements of their agency, Youth Villages, and DCFS is challenging.

> It's like three full times job. . . . There's [Agency A] responsibilities, there's the DCFS legal responsibilities, and then there's the LifeSet responsibilities. . . . If I could just be a LifeSet specialist. . . but for us, and like our contract, we have to tie in the other two.
>
> We still have obligations and trainings to DCFS; we have obligations to training to [Agency B], our private agency, as well as now where we're entering mandatory trainings that we have for LifeSet. So it's a lot.
>
> Because we have LifeSet demands, DCFS demand, and then [Agency C] demands.

From the specialists' perspective, some of these demands involve performing what is essentially the same task more than one time. For example, specialists are required to enter similar information into different forms—one for their agency, one for Youth Villages, and one for DCFS.

Turnover

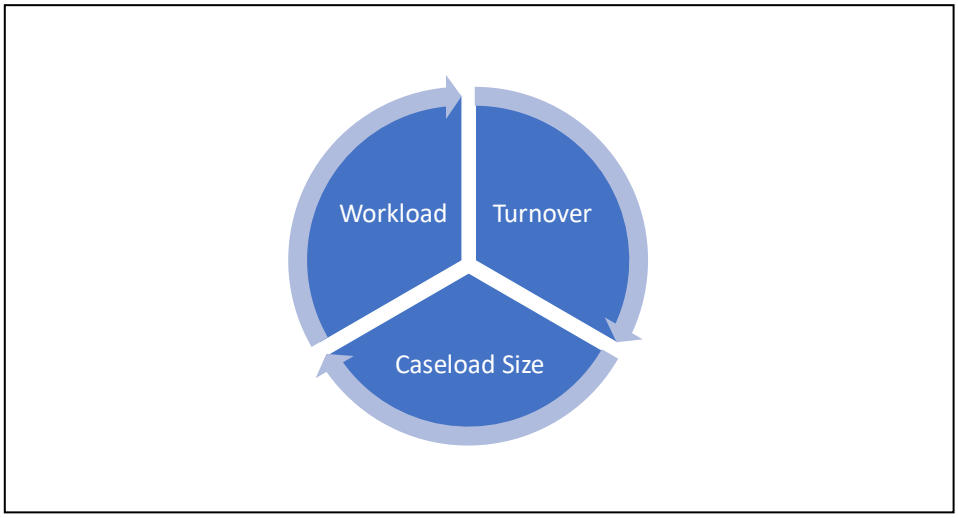
One consequence of the specialists' heavy workload is a high turnover rate. One supervisor explained that having "to manage the DCFS/LifeSet model at the same time. . . the documentation, having to do things twice, and also having difficulties managing the work/life balance" led some specialists to seek work elsewhere. All three agencies experienced turnover among the specialist positions. A supervisor at one agency lamented that she had never had a full team of five specialists because filling vacant positions was so difficult. One of the LPEs highlighted the importance of finding a specialist who is "a good fit" for the position, noting that "it's much more damaging" to keep on staff who feel that the job is not right for them. We

have already discussed the negative effects that this turnover has on the young people who count on their specialists for support. It also affects the size of the remaining specialists' caseloads.

Caseload Size

Because of staffing shortages tied to specialist turnover, some specialists have had as many as 10 or 11 young people on their caseload when their teams were not fully staffed.[41] Specialists talked about being required to carry more than the recommended number of young people on their caseload. Increased caseloads inevitably translate into more work, thereby continuing the cycle depicted in Figure 10.

Figure 10. Cycle of Workload, Turnover and Caseload Size



Lack of "Buy-In"

Specialists talked about colleagues who didn't seem to "buy into" LifeSet. These specialists were frustrated that not all of their colleagues had fully embraced the model, and, hence, that some young people in LifeSet were not receiving the same level of service as their LifeSet peers. Some of the other specialists at this agency explained that they weren't interested in trying new approaches. One explained, "[LifeSet] is just another program. We've seen a bunch of programs in our experience." Another specialist from this same agency questioned whether young people in Illinois appreciate LifeSet:

> I don't think they [Youth Villages] understand our kids. In other [LifeSet] programs, the kids need to be in the program or they will be on the streets. Those kids want to be in the program. Wards of the state have their own mentality. They are used to getting things taken care of. It doesn't matter to them if they engage in this program because they are in care until they are 21.

[41] At least one supervisor has carried cases due to the shortage of staff.

DOES LIFESET LEAD TO BETTER YOUTH OUTCOMES?

Here we report the results of our analysis of LifeSet's effects on youth outcomes.

Nonplacement Events

Table 1 shows the mean occurrence (per 100 days in care) and the mean duration (per 100 days in care) of unauthorized absences, detentions, and psychiatric hospitalizations since the index placement. On average, young people in the intervention group experienced significantly more unauthorized absences but significantly fewer detentions per 100 days in care than young people in the comparison group.[42] Both groups experienced about the same number of psychiatric hospitalizations.

Young people in the intervention group spent fewer days in detention and fewer days in a psychiatric hospital per 100 days in care than young people in the comparison group, although neither difference was statistically significant. The two groups were absent from their placement without authorization for about the same number of days per 100 days in care.

Table 1. Nonplacement Events: Intervention Group and Comparison Group

	Intervention (*n* = 315)		**Comparison** (*n* = 315)		
	Mean	SD	Mean	SD	***p***
Unauthorized absence					
Occurrence	1.41	2.14	0.63	1.73	***
Duration	14.48	22.57	13.49	23.93	
Detention					
Occurrence	0.01	0.05	0.05	0.19	*
Duration	0.69	6.62	1.73	8.01	
Psychiatric hospitalization					
Occurrence	0.03	0.15	0.03	0.12	
Duration	0.24	1.63	0.45	2.13	

Time Living in the Community

Table 2 compares the intervention group to the comparison group on several metrics related to placement type. First, the percentage of time young people were living in the community rather than a supervised placement was about the same for the intervention group (49%) as for the

[42] Although we include unauthorized placement (UAP) as an authorized absence, young people in a UAP were able to participate in LifeSet. Excluding UAP from the list of unauthorized placements did not change the results. Young people in the intervention group still experienced significantly more unauthorized absences.

comparison group (47%).[43,44] Second, the percentage of young people whose index placement was an ILO rather than a TLP was the same for the intervention group (38%) as for the comparison group (40%). This reflects the fact that placement type was one of the variables on which the intervention and comparison groups were matched. Third, the percentage of young people who were ever in a TLP and the percentage of young people who were ever in an ILO since the start of their index placement were higher for the intervention group than for the comparison group. However, neither of these differences was statistically significant. Fourth, the percentage of young people whose last placement in care was an ILO was higher for the intervention group (72%) than for the comparison group (64%), but this difference was also not statistically significant. Finally, the percentage of young people who moved from a TLP to an ILO and the percentage of young people who moved from an ILO to a TLP were higher for the intervention group than for the comparison group, and both of these differences were statistically significant.

Table 2. Metrics Related to Placement Type: Intervention Group and Comparison Group

	Intervention (*n* = 315)	Comparison (*n* = 315)	p
% of days in an ILO placement	49	47	
% ILO index placements	38	40	
% of young people ever in a TLP since start of intervention	73	69	
% of young people ever in an ILO since start of intervention	80	71	
% ILO last placement in care	72	64	
% ever transitioned from ILO to TLP	12	2	*
% ever transitioned from TLP to ILO	45	31	*

Transition to Adulthood CANS

Table 3 shows the mean CANS scores for each of the four Transition to Adulthood items for the intervention and comparison groups.[45] We found statistically significant differences between the two groups for two of the four outcomes: independent life skills and educational attainment. In each case, the mean for the intervention group was significantly lower than the mean for the comparison group. This means that young people in the intervention group were less likely than their counterparts in the comparison group to have any deficits in independent living skills or to be experiencing problems related to a lack of educational attainment.

[43] To limit the effect of outliers, we measured this outcome by computing the percentage of time each young person spent living in the community and calculating the mean of these percentages.

[44] Accounting for temporary absences (lasting less than 30 days) from TLP or ILO placements did not substantively change the results.

[45] Additional information about scoring Transition to Adulthood items can be found in Appendix J and at https://sites.northwestern.edu/cans/cans-manual-by-domain/.

Table 3. Mean CANS Scores on Transition to Adulthood Items

	Intervention			Comparison			
CANS item	***n***	**Mean**	**SD**	***n***	**Mean**	**SD**	***p***
Independent life skills	185	0.55	0.6	169	0.69	0.6	0.02
Transportation	184	0.29	0.5	168	0.22	0.4	0.16
Educational attainment	172	0.62	0.8	125	0.90	1.0	0.01
Victimization	177	0.19	0.5	155	0.31	0.7	0.07

Postsecondary Educational Outcomes

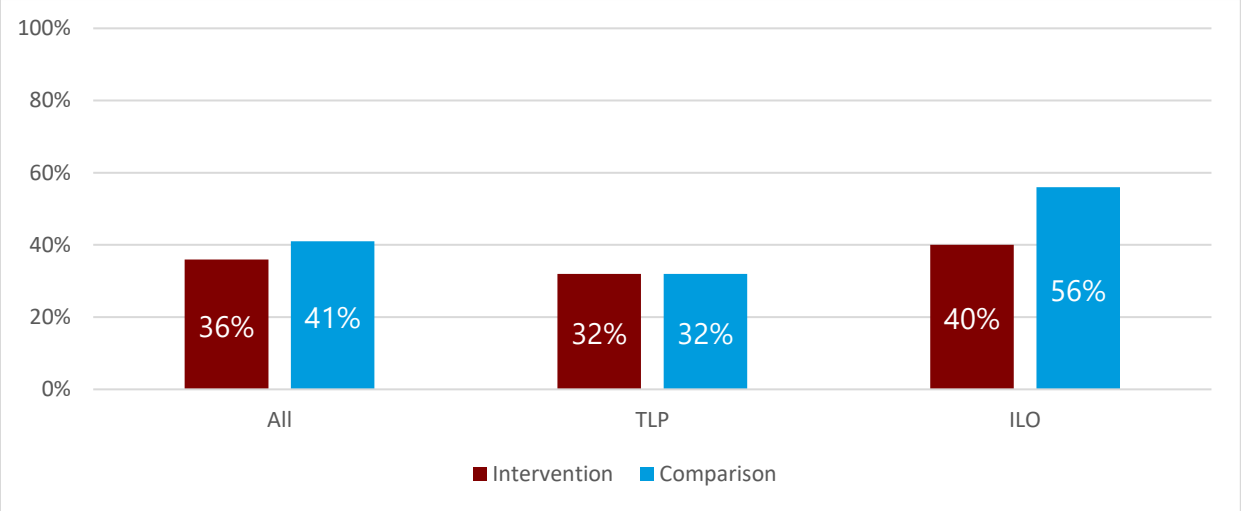
We began our analysis of the National Student Clearinghouse (NSC) data by examining the percentage of young people who were ever enrolled in college.[46] Overall, 36% (*n* = 97) of the 272 young people in our intervention group and 41% (*n* = 111) of the 272 young people in our matched comparison group had ever been enrolled in college (see Figure 11). This difference was not statistically significant.

As already noted, young people enrolled in LifeSet are eligible to live in the community without supervision even if they have not completed high school, whereas other young people must have a high school diploma or GED to live unsupervised in the community. Consequently, one might expect lower rates of college enrollment among LifeSet participants whose placement is ILO than among young people not participating in LifeSet whose placement is ILO. To test this hypothesis, we looked at college enrollment within each group by placement type.[47] Of the young people whose placement type was TLP, 32% of the young people in the intervention group (*n* = 55) and 32% of the young people in the comparison group (*n* = 54) had ever been enrolled in college. Of the young people whose placement type was ILO, 40% of the young people in the intervention group (*n* = 42) and 56% of the young people in the comparison group (*n* = 57) had ever been enrolled in college. This difference is statistically significant and supports our hypothesis.

[46] We did not have access to data on high school completion so we were not able to limit our analysis to young people with a high school diploma or GED.

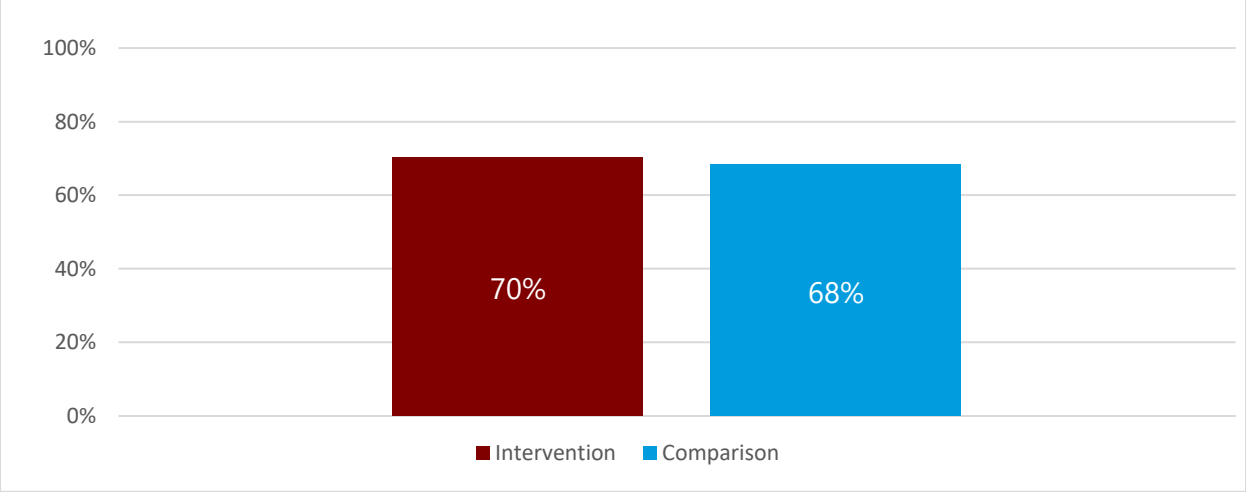
[47] Placement type was defined as placement type at LifeSet enrollment for young people in the comparison group and as the index placement for young people in the comparison group.

Figure 11. Ever Enrolled in College, by Placement Type



Next, we looked at the timing of first college enrollment among the young people who had ever been enrolled in college. Overall, 70% (*n* = 68) of the 97 young people in the intervention group who ever enrolled in college first enrolled in college before they enrolled in LifeSet, while 68% (*n* = 76) of the 111 young people in the comparison group who ever enrolled in college first enrolled in college before the start of their index placement (see Figure 12).

Figure 12. First Enrolled in College Before LifeSet Enrollment/Start of Index Placement

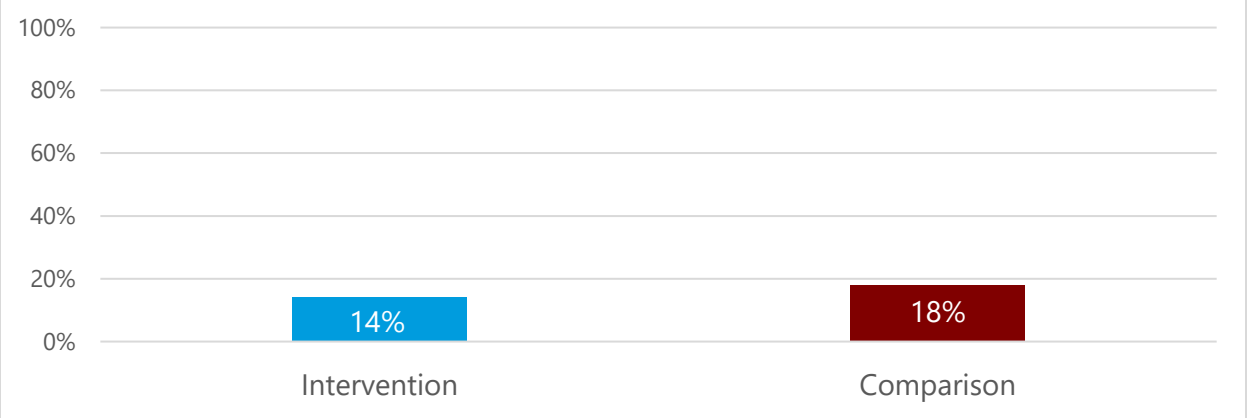


Because some young people had enrolled in college before they enrolled in LifeSet or before the start of their index placement, we conducted two sets of analyses. One set of analyses assessed the impact of LifeSet on college enrollment among young people who *had not* enrolled in college before they enrolled in LifeSet or before the start of their index placement. The other set of analyses assessed the impact of LifeSet on college persistence among young people who *had* enrolled in college before they enrolled in LifeSet or before the start of their index placement. We could not assess the impact of LifeSet on college graduation because the number of young people who earned a college degree or other credential was too small.

Impact of LifeSet on College Enrollment

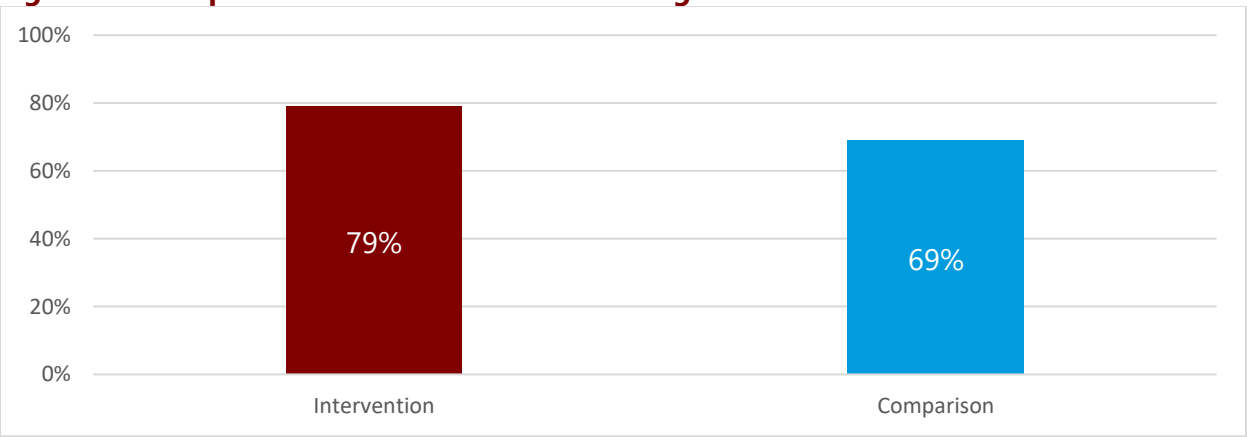
To assess the impact of LifeSet on college enrollment, we focused on the 204 young people in the intervention group who had not enrolled in college before they enrolled in LifeSet and the 196 young people in the comparison group who had not enrolled in college before the start of their index placement. Fourteen percent (*n* = 29) of the young people in the intervention group who had not enrolled in college before they enrolled in LifeSet enrolled in college after they enrolled in LifeSet. Eighteen percent (*n* = 35) of the young people in the comparison group who had not enrolled in college before the start of their index placement enrolled in college after the start of their index placement (see Figure 13). A chi-square test indicated that this difference was not statistically significant.

Figure 13. Enrolled in College for the First Time After LifeSet Enrollment/Start of Index Placement



We also looked at whether the students who enrolled in college for the first time after they enrolled in LifeSet (*n* = 29) or after the start of their index placement (*n* = 35) completed their first term (that is, they did not withdraw or take a leave of absence). Of the 29 young people in the intervention group, 79% (*n* = 23) completed at least one term while 69% (*n* = 24) of the 35 young people in the comparison group completed at least one term (see Figure 14). A chi-square test indicated that this difference was not statistically significant.

Figure 14. Completed At Least One Term of College



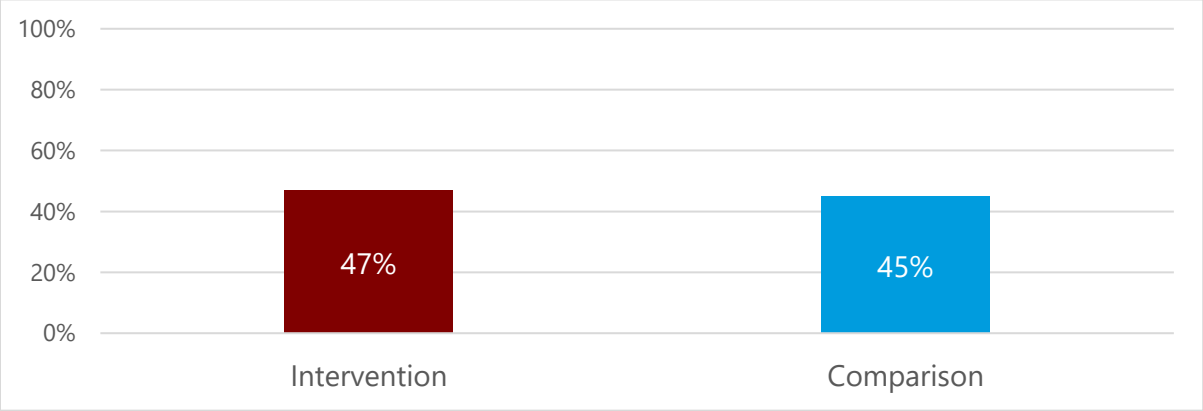
Impact of LifeSet on College Persistence

The NSC distinguishes between persistence and retention (National Student Clearinghouse, 2022). It defines the first-year persistence rate as the percentage of students who start college in the Fall of Year 1 and return to college at any institution for their second year in the Fall of Year 2. It defines the first-year retention rate as the percentage of students who start college in the Fall of Year 1 and return to the same institution in the Fall of Year 2.

To assess the impact of LifeSet on college persistence, we focused on the 71 young people in the intervention group who first enrolled in college before they enrolled in LifeSet and the 77 young people in the comparison group who first enrolled in college before the start of their index placement. We also adopted a broader definition of persistence than that used by the NSC. We did this for three reasons. First, some of the young people in our intervention and comparison groups enrolled in college for the first time during a Spring or Summer term. Second, some of the young people in our intervention and comparison groups had already completed more than one term before they enrolled in LifeSet (intervention group) or before the start of their index placement (comparison group). And third, much of our observation period coincided with the first 2 years of the COVID-19 pandemic. Some students may have taken a term or a year off rather than continue their studies remotely.

For these reasons, we counted young people in the intervention group as persisting if they enrolled in at least one term that began after they enrolled in LifeSet. Similarly, we counted young people in the comparison group as persisting if they enrolled at least one term that began after the start of their index placement. Of the 68 young people in the intervention group, 47% (n = 32) were enrolled in at least one term that began after they enrolled in LifeSet while 45% (n = 34) of the 76 young people in the comparison group enrolled in at least one term that began after the start of their index placement (see Figure 15). A chi-square test indicated that this difference was not statistically significant.

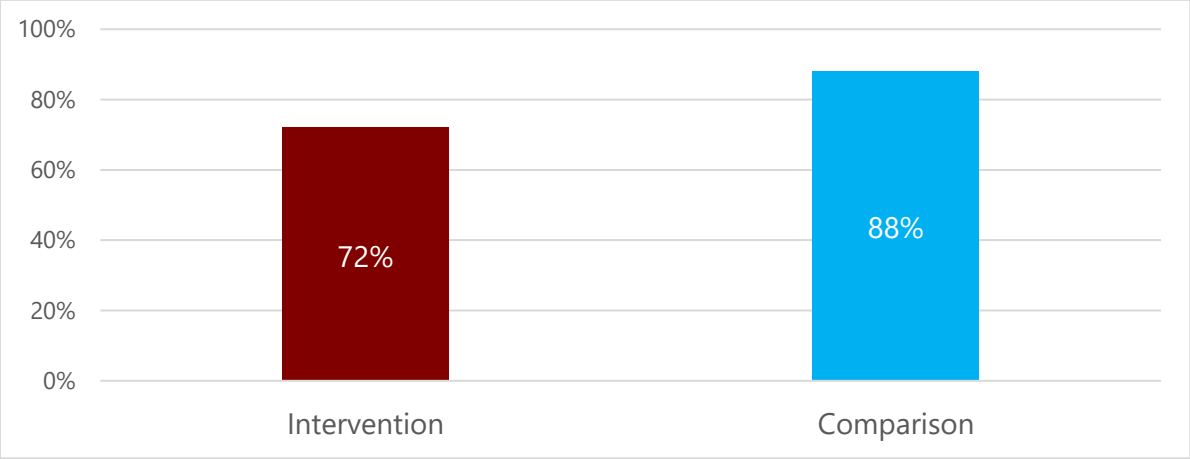
Figure 15. Enrolled in at Least One Term of College after LifeSet Enrollment/Start of Index Placement



We also examined whether the young people who enrolled in at least one term that began after they enrolled in LifeSet or after the start of their index placement completed at least one term

that began after they enrolled in LifeSet or after the start of their index placement. Of the 32 young people in the intervention group, 72% (*n* = 23) completed at least one term that began after they enrolled in LifeSet while 88% (*n* = 30) of the 34 young people in the comparison group completed at least one term that began after the start of their index placement (see Figure 16). A chi-square test indicated that this difference was not statistically significant.

Figure 16. Completed at Least One Term of College after LifeSet Enrollment/Start of Index Placement



DISCUSSION

Phase II of our evaluation of LifeSet in Illinois addresses three main questions: (1) What do specialists and supervisors think about LifeSet and what implementation challenges have they experienced? (2) How do young people experience LifeSet? (3) What is the effect of LifeSet on the outcomes of young people in care? Below, we summarize our main findings related to these questions and discuss their implications for policy and practice.

The specialists and supervisors we interviewed seemed to approve of the changes that had been introduced as part of LifeSet's implementation. They appreciated the expansion of placement options, the opportunity to develop stronger relationships with youth, the frequency and focus of youth engagement, and the availability of resources to support their work. They also identified ongoing challenges related to workload, turnover, and caseload size.

The experiences of the LifeSet participants we interviewed were overwhelmingly positive. Young people valued the support they received from their specialist, recognized the benefit of setting short-term, achievable goals, and perceived the program as helping them develop critical life skills. Additionally, although LifeSet is not a placement program, enrolling in LifeSet opened up options for community living that some young people might not otherwise have had.

Our impact analysis found two statistically significant differences in the occurrence of nonplacement events between young people who participated in LifeSet and a matched comparison group of young people in traditional TLP and ILO placements. Since their index placement, LifeSet participants experienced fewer detentions but more unauthorized absences from their placement per 100 days in care than their peers. Importantly, these findings cannot be attributed to preexisting differences between the two groups because number of days in detention and number of days absent from placement without authorization per years in care were two of our matching variables. Moreover, LifeSet participants who are absent from placement without authorization may continue to engage with their specialist.

Despite the expanded placement options available to LifeSet participants, we also found no difference between the two groups in the proportion of time young people spent living in the community rather than a supervised placement or in the proportion of young people whose last placement was in the community. However, we did find that LifeSet participants were more likely to have moved from a TLP into the community and from an ILO into a TLP than their non-LifeSet peers. The latter finding may indicate that the expanded opportunity for LifeSet participants to live in the community comes with an increased risk that some young people who are placed in the community will not be able to maintain that placement, and hence, may need to transition back to a placement with supervision.

We did find statistically significant differences between the intervention and comparison groups on two of the four outcomes we measured using CANS data: independent living skills and

educational attainment.[48] In each case, actionable needs were less common among young people enrolled in LifeSet than among their counterparts in the comparison group. Although we did not find any differences in our measures of college enrollment or persistence, this is likely due, at least in part, to the fact that LifeSet participants who have not completed high school are still eligible to live in the community whereas other young people must have a high school diploma or GED to live without supervision.

A couple of factors may have contributed to these mixed results. One is that most of our outcomes were measured using DCFS administrative data. This limited what we could measure. MDRC's evaluation of LifeSet in Tennessee found positive impacts on employment and earnings (Skemer & Valentine, 2016; Valentine et al., 2015)). However, we were unable to access quarterly wage data from the Illinois Department of Employment Security. Relying heavily on DCFS administrative data also limited our follow-up period. We had no data for young people after they aged out. Another explanation for these mixed results is that implementation of LifeSet in Illinois is relatively new. Our sample included the first cohort of young people to enroll in the Illinois program. The MDRC evaluation involved young people who enrolled in the program a decade after it was first implemented in Tennessee.

Finally, although young people are expected to participate in the intensive services that LifeSet provides for 6 to 9 months, 49% of the LifeSet participants in Illinois were still in the program more than 12 months after they enrolled. Additionally, 45% of the young people who enrolled in LifeSet stayed in the program until they aged out. Although some young people may require intensive services for longer than expected, our interviews with specialists and supervisors suggested that some young people who could be stepped down to extended foster care are being kept in LifeSet in response to pressure from judges or GALs, due to concerns about census, or in case they backslide and need additional support.

This practice of keeping young people in LifeSet rather than stepping them down to extended foster care could be having two unintended consequences. First, young people who are still in LifeSet when they age out will experience a sudden loss of intensive support. Second, young people who might benefit from LifeSet are unable to enroll because only a finite number of young people can participate at one time. The latter problem is exacerbated by the fact that young people remain on their specialist's caseload after being stepped down to extended foster care. Young people who exit LifeSet may benefit from maintaining the relationship they have developed with their specialist. However, keeping young people on their specialist's caseload after they are stepped down to extended foster care may prevent other young people from enrolling in the program.

[48] Finding an effect of LifeSet on educational attainment as measured by the CANS but not on college enrollment or persistence might seem like a contradiction. However, the CANS item measures educational attainment in relation to each young person's goals, which may not include attending or completing college.

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Appendix A. LifeSet Providers

	Hoyleton	Lawrence Hall	UCAN
Geography	Southern Illinois	Cook County	Cook County
First enrolled	12/20/2019	3/10/2020	3/25/2020
Fidelity achieved	June 2020	September 2020	March 2021
Team structure	1 team	2 teams	2 teams
Foundations training	November 2019	February - March 2020	February - March 2020

Appendix B. DCFS Traditional TLP and ILO Eligibility Criteria

TLP Eligibility Criteria	ILO Eligibility Criteria
Age 17 ½ to 20 ½ at entry	Age 19 or older (Youth 17½ or older who reside in locations where TLP is not available may qualify for ILO if certain TLP criteria are met)
Has been assessed for risk and protective factors to determine the course of treatment and the most appropriate housing type	
Treatment needs are manageable with the support of community-based treatment resources	Treatment needs are manageable with adult support and the support of community-based treatment resources
Foster care is not a viable option for meeting the young person's needs	Foster care is not appropriate
Court-ordered goal of independence	Permanency goal of independence
	Stable placement for 1 year prior to referral
Working on their high school diploma, GED, vocational training, or a program that will help them move towards employment	Diploma from an accredited high school or GED
	6-month steady work history is recommended. Some post-secondary education and/or vocational training is preferable.
	Basic skills necessary for self-sufficiency
	Demonstrated capacity to save money, some savings preferred
	Ready, willing, and able to engage in discharge planning

Appendix C. LifeSet Matching and Admission Process

Caseworker sends a referral to Central Matching Team (CMT) for matching to a TLP or ILO level of care	
CMT determines whether a referral to LifeSet is appropriate	
If a LifeSet referral is appropriate, the youth is matched to ONE LifeSet Provider	
CMT sends an email to the LifeSet provider with referral documents attached. These include up to 6 months of significant event reports, the most recent integrated assessment, the young person's contact information, and a CIPP referral form. The provider may request referring caseworker's contact information.	
Within 24 business hours of receiving the CMT email, the LifeSet Supervisor assigns a Case Specialist (CS) who will review the referral packet, contact the young person, and schedule the Pre-Enrollment Assessment (PEA).	
Within 3 business days of receiving the CMT email, the CS must complete the PEA (in-person) with the young person and determine LifeSet eligibility.	
If the young person is eligible for LifeSet and the CS has no concerns, the CS informs the young person (before ending the session) and the CMT of that decision.	If the CS has concerns and/or the young person meets at least 2 of the exclusionary criteria, the CS informs the young person that a decision will be made within 2 business days and immediately follows up with the Team Supervisor and Clinical Consultant.
	If the CS and Team Supervisor agree that the young person is inappropriate for LifeSet and wishes to decline the young person, the CS emails the Clinical Consultant, the DCFS assigned monitor, and the DCFS LifeSet Project Manager to request a meeting within 24 hours and outline the reason for the decline.
	The admission decision made during this meeting must be communicated to the young person and the CMT within 24 hours of the meeting.
If the young person is accepted and accepts the admission offer, the CS begins to determine whether supervised or community-based housing is the best option.	If the young person is declined or declines admission, the CS will inform the CMT within 24 hours. CMT matches the young person with 2 ILO or TLP providers.
The housing type is determined within 3 business days of the admission decision and an estimated admission date is scheduled and shared with the CMT.	
CS works with the young person to secure housing. CS considers relatives or other supportive adults with a space that is appropriate for rent by the young person for community-based housing. Supervised housing options are available TLP units.	
Once housing and a move-in date have been identified, Universal Placement Approval (UPA) form must be requested at least 2 business days before the move-in date and the Housing Agreement must be completed upon move-in. If the young person decides to stay where they were living when they were matched to the LifeSet provider, the UPA must be completed immediately after that decision is made to avoid the 48-hour fine	
Once the young person moves into their housing unit and completes the LifeSet consent forms, they are officially admitted. The CS relays this information to the CMT.	

Appendix D. LifeSet Exclusionary Criteria[49]

Exclusionary criteria	Protective factors
• Gang involvement resulting in violent behavior (victim hospitalized or killed) • Youth unwilling to detach from the gang or gang involvement provides significant means in meeting basic needs • Primary systemic supports are actively involved in and/or support violent gang activity including the use of weapons • Possession of and/or access to weapons	• Willingness to sever association with the gang and engage in safety planning related to gang involvement (to include cooperation with a specialist to ensure staff safety) • Connection with prosocial support systems; willingness to consider engaging with pro-social supports
• History of violent criminal behavior (such as severely injuring someone with a gun or other weapon, rape, armed robbery) • Systemic supports that encourage possession and use of weapons in general or in relation to resolving conflict • Abuse of substances in connection with weapons use	• Youth expresses remorse or understanding concerns related to injuring another • Understanding sequences and risk factors that contributed to the incident and willing to safety plan to ensure no injury to others • Systemic supports that promote safe, responsible possession and use of weapons • Willingness to surrender weapons or engage in safety planning, to include securing weapons and providing evidence of such to specialist
• Current homicidal ideations/threats/attempts or extreme aggression within the past 90 days • Acute ideations or attempt within 30 days at the time of assessment • History of acting on ideations/threats • Substance abuse, access to firearms or other weapons • Systemic supports that encourage homicidal actions in response to real or perceived injustice or threats	• Systemic supports are available and encourage youth's positive behavior • Willingness to seek mental health treatment; verbalization of intent to comply with provider recommendations and history of compliance with mental health interventions • Willingness to engage in safety planning to include securing or removal of weapons
• Current suicidal ideations/threats or attempts within the last 30 days • Active suicidal ideation that limits a person's ability to think and act positively or limited insight into triggers for suicidal ideations • History of rejecting safety planning around suicidal ideations	• History of or evidence of compliance with mental health treatment • Willingness to seek mental health treatment and implement safety plans • Systemic supports promote safety planning with the youth
• Significant impairment in youth's ability to meet independent living goals as a result of chronic mental health issues (drug use that	• Willingness to consider changes in lifestyle as means of stabilizing mental health (cessation of substance use and compliance with medication management)

[49] Extracted from the "LifeSet Specialists Foundations Guide" (2020)

Exclusionary criteria	Protective factors
engenders dependence and frequent hospitalizations) • Youth exhibits pervasive impairment in multiple areas of development which may include disordered, disorganized, and confused thinking that hinders independence and create additional activity limitations • Substance use that may mask mental health symptoms • Limited utilization of systemic supports in safety planning	• Systemic supports promote safety planning with the youth
• Intellectual disabilities or developmental delays that impede a youth's ability to complete LifeSet goal • Functioning level impedes ability to complete daily living tasks	• Systemic supports are in place and utilized by youth • Ability to remember basic instructions or utilize tools with basic reminders
• Psychotic behavior not controlled by medications (such as hallucinations, delusions, paranoia) • Systemic supports that encourage noncompliance with mental health care	• Systemic supports are in place and utilized by youth • Open to considering changes in lifestyle as means of stabilizing mental health (such as medication management) • Willingness to engage in safety planning
• Youth not committed to consistently meeting with LifeSet specialist • Systemic supports that encourage youth to not meet with the specialist • Long-term custody cited as a reason for resistance to meeting • Limited insight into positive personal goals for independence	• Systemic supports encourage youth to meet with the specialist • Youth verbalizes desire for future-oriented goals • Youth willing to meet again to discuss the benefits of meeting with the specialist
• Untreated problem sexual behavior within the last 12 months	• Completion of treatment for problematic sexual behavior (PSB) • Systemic supports are in place and utilized by youth • Knowledge of high-risk behaviors and commitment to safety planning

Appendix E. Balance Test Table

Measure	Comparison Mean	Intervention Mean	p
Permanency goal of independence	0.919	0.945	
Black	0.670	0.692	
White	0.279	0.276	
Other	0.051	0.032	
Hispanic	0.098	0.124	
Male	0.362	0.375	
Index placement in Cook County region	0.746	0.771	
Index placement in Southern region	0.063	0.216	***
Index placement in Central region	0.187	0.003	***
Different region immediately before index placement	0.224	0.122	
Congregate care immediately before index placement	0.079	0.073	
Unauthorized placement immediately before index placement	0.143	0.162	
Any prior unauthorized absence from placement	0.594	0.641	
Any prior detention	0.213	0.165	
Any prior psychiatric hospitalization	0.413	0.448	
Number of days absent without authorization per years in care	16.673	20.903	
Number of days in detention per years in care	1.784	2.346	
Number of days in a psychiatric hospital per years in care	3.994	3.867	
Age at start of index placement	19.123	19.141	
Number of prior out-of-home care spells	0.248	0.222	
Total number of years in care prior to index placement	6.973	7.248	
Total number of placements prior to index placement	8.908	9.263	
Number of prior placements per years in care	1.450	1.351	
CANS1: Sexual abuse	0.844	0.717	
CANS2: Physical abuse	0.896	0.790	
CANS3: Emotional abuse	0.834	0.840	
CANS4: Neglect	1.246	1.201	
CANS5: Medical trauma	0.223	0.155	
CANS6: Witness to family violence	0.618	0.680	
CANS7: Community violence	0.346	0.457	
CANS8: School violence	0.213	0.233	
CANS9: Natural or manmade disasters	0.057	0.091	

Measure	Comparison Mean	Intervention Mean	p
CANS11: Terrorism affected	0.005	0.000	
CANS12: Witness/victim to criminal activity	0.531	0.493	
CANS13: Parental criminal behavior	0.558	0.630	
CANS14: Adjustment to trauma	0.858	0.826	
CANS15: Traumatic grief/separation	0.588	0.543	
CANS16: Re-experiencing	0.227	0.274	
CANS17: Avoidance	0.564	0.507	
CANS18: Numbing	0.289	0.333	
CANS19: Dissociation	0.209	0.247	
CANS20: Family	0.900	0.840	
CANS21: Interpersonal	0.588	0.548	
CANS22: Educational setting	0.858	0.781	
CANS23: Vocational	0.448	0.532	
CANS24: Coping and savoring skills	0.720	0.714	
CANS25: Optimism	0.450	0.493	
CANS26: Talents/interests	0.510	0.423	
CANS27: Spiritual/religious	0.362	0.362	
CANS28: Community life	0.450	0.493	
CANS29: Relationship permanence	0.755	0.667	
CANS30: Resilience	0.466	0.353	
CANS31: Family	0.867	0.817	
CANS32: Living situation	0.559	0.584	
CANS33: Social functioning	0.583	0.461	
CANS34: Developmental/intellectual	0.223	0.169	
CANS35: Recreational	0.262	0.284	
CANS36: Legal	0.493	0.457	
CANS37: Medical	0.299	0.329	
CANS38: Physical	0.109	0.078	
CANS39: Sleep	0.183	0.174	
CANS40: Sexual development	0.185	0.178	
CANS41: School behavior	0.432	0.321	
CANS42: School achievement	0.710	0.524	
CANS43: School attendance	0.669	0.532	
CANS44: Language	0.009	0.005	
CANS45: Identity	0.057	0.059	
CANS46: Ritual	0.009	0.027	

Measure	Comparison Mean	Intervention Mean	p
CANS47: Culture stress	0.038	0.073	
CANS48: Psychosis	0.123	0.091	
CANS49: Attention deficit/impulse control	0.445	0.342	
CANS50: Depression	0.829	0.781	
CANS51: Anxiety	0.642	0.548	
CANS52: Oppositional behavior	0.559	0.484	
CANS53: Conduct	0.412	0.338	
CANS54: Substance abuse	0.488	0.447	
CANS55: Attachment difficulties	0.284	0.297	
CANS56: Eating disturbances	0.064	0.064	
CANS57: Affect dysregulation	0.246	0.242	
CANS58: Behavioral regression	0.104	0.084	
CANS59: Somatization	0.069	0.047	
CANS60: Anger control	0.697	0.583	
CANS61: Suicide risk	0.306	0.256	
CANS62: Self mutilation	0.142	0.128	
CANS63: Other self harm	0.161	0.119	
CANS64: Danger to others	0.275	0.192	
CANS65: Sexual aggression	0.104	0.046	
CANS66: Runaway	0.495	0.505	
CANS67: Delinquency	0.352	0.251	
CANS68: Judgment	0.634	0.502	
CANS69: Fire setting	0.021	0.033	
CANS70: Social behavior	0.296	0.201	
CANS71: Sexually reactive behaviors	0.152	0.128	
CANS87: Independent living skills	0.699	0.564	
CANS88: Transportation	0.276	0.341	
CANS89: Parenting roles	0.409	0.518	
CANS90: Intimate relationships	0.421	0.430	
CANS91: Medication compliance	0.475	0.625	
CANS92: Educational attainment	0.663	0.620	
CANS93: Victimization	0.277	0.266	
CANS94: Job functioning	0.494	0.319	

*** $p < .001$

p-values are adjusted using the Bonferroni correction

Appendix F. Guide for Interviews with Young People Enrolled in LifeSet

Referral and enrollment

1. For how long have you been participating in LifeSet?
2. How did you learn about LifeSet? (e.g., caseworker, friend, TLP staff)
    a. What did they tell you about LifeSet?
3. Why did you decide to participate in LifeSet?

Relationship with case specialist

4. Tell me about your relationship with your case specialist.
    a. What kinds of things do you and your case specialist talk about?
    b. What kinds of thing does your case specialist do with you/for you?
    c. Is your specialist available when you need to talk? (example)
    d. Is this relationship different than the one you had with the case worker you had before you were in LifeSet? How?
5. How often do you meet with your case specialist?
    a. Is that too often, often enough, not often enough?
    b. How does the frequency with which you meet with your case specialist compare to the frequency with which you met with your case worker before you were in LifeSet
6. Do you and your case specialist usually meet/communicate in-person? (phone, text, video
    a. Has covid impacted how you have been able to meet or communicate?
    b. Do you meet with your specialist less often since leaving LifeSet?
    c. If yes, how do you feel about that?]

Placement

7. Tell me about your current living situation.
    a. For how long have you been in your (CURRENT LIVING SITUATION)?
    b. (FOR non-TLP youth) Did being in the LifeSet program help you get to your (CURRENT LIVING SITUATION)?
8. Where did you live prior to this?

9. Did the opportunity to choose where to live influence your decision to participate in LifeSet? In what way?

Program experience

10. How is LifeSet different from other programs in which you've been involved?
    a. What's good about it?
    b. What's not so good about it?
    c. What, if anything, do you wish were different about it?
11. Do you have goals that you are working toward?
    a. If yes, who came up with your goals? How were they selected?
    b. If no, have you talked with anyone about setting goals?
    c. ADD EFC – Did your goals change when you stopped being part of LifeSet?
12. Do you have a monthly service plan?
    a. If yes: Is having a monthly service plan helpful? Why or why not?
13. What do you do most days?
    a. Are you in school?
    b. Are you working?
14. If in school: What, if anything, is your case specialist doing with you to help you continue your education?
15. If not in school: Are you interested in returning to school?
    a. If yes: What, if anything, is your case specialist doing with you to help you get back in school?
16. What, if anything, is your case specialist doing with you to help you keep your job/find a job?
17. What is your case specialist doing to help you find support in your community? (e.g. identify resources, connect with services)
18. What is your case specialist doing to help you improve your relationships with family and others?

Leaving LifeSet

19. Have you talked with anyone about leaving LifeSet?
    a. If yes, what is your understanding of what it will be like to leave LifeSet?

20. When do you think you will leave LifeSet?
    a. How do you think you will feel about leaving LifeSet?
21. How do you feel about staying on your case specialist's team?

Program satisfaction

22. Is/Was the LifeSet program what you expected? Why or why not
23. What do/did you like most about LifeSet? Why?
24. What do/did you like least about LifeSet? Why?
25. If you could change anything about LifeSet, what would you change? Why?
26. Would you recommend LifeSet to other young people in care? Why or why not?
    a. What should they expect if they get in the program?
27. On a scale of 1-5, with 1 being it's very bad and 5 being it's great, how would you rate LifeSet?

Conclusion

28. Is there anything about your experiences with LifeSet I haven't asked about that you would like me to know?

Appendix G. Guide for Interviews with LifeSet Supervisors

LifeSet and Your Work

1. How is being a LifeSet supervisor different from being a traditional TLP or ILO supervisor? (Talking points: differences in training, supports, supervision, service intensity, responsibilities)
2. How are the opportunities for supervision, training, and professional development afforded by LifeSet different from those afforded by traditional TLP/ILO programs?
3. What do you see as the difficulties and/or benefits of the case specialists having a dual role as LS case specialist and legal case worker?
4. What do you see as the difficulties and/or benefits of supervising case specialists who have a dual role as LS case specialist and legal case worker?
5. We learned in our Phase I interviews about some challenges regarding referrals, for example referrals for young people whose needs might exceed the parameters of the LifeSet model, or, on the flip side, not being able to accept youth with higher needs that a program would have been able to serve prior to LifeSet, are challenges like this still present? What, if any, challenges surrounding referrals is your program currently experiencing
6. We also learned in our Phase I interviews about challenges around discharges, for example young people with high needs not engaging with the program and being discharged from LifeSet and not being part of LifeSet supports such as clinical consultation but remaining on their specialist's caseload as EFC for case management, are challenges like this still present? What, if any, challenges surrounding discharges is your program experiencing?
7. In our Phase I interviews, we learned about the different meetings that happened each week: red flag, group consultation, group supervision with the case specialists, professional development with your case specialists, and your professional development with your supervisor.
    a. Do you still have these meetings weekly?
    b. How do these meetings help support you, case specialists, and youth?
    c. Do you have any recommendations for changing or improving these meetings?
8. What would you say is the best part about being a LifeSet supervisor?

    (Talking Points: What do you like most about the program/what elements of the program would you like to keep? How is it different from traditional ILO/TLP?)
9. What about the most challenging part? (attrition, fidelity

Suggestions for Program Improvements

10. Would you recommend that DCFS continue to invest in LifeSet after the pilot ends? Why or why not?
11. Is there anything you would ask DCFS or your agency to do differently to improve LifeSet?
12. Is there anything I have not asked you about LifeSet that I should know?

Appendix H. Guide for Focus Groups with LifeSet Specialists

Ice breaker: Please go around the room and introduce yourselves. Say how long you've worked at (Hoyleton, Lawrence Hall, UCAN) and how long you have been a case specialist. Also, describe the young people with whom you work in just one word.

Once everyone has answered: By a show of hands, how many of you have worked as a caseworker with transition age youth prior to working in the LifeSet program?

LifeSet and Your Work

Q1: **How is being a LifeSet case specialist different from being a legal case worker for youth in traditional TLP or ILO?** (Talking points: differences in training, supports, supervision, service intensity, responsibilities)

Q2: **How does having to be both a case specialist and legal case worker impact your work?**

Q3: **What would you say is the best part about being a LifeSet case specialist?** (Talking points: What do you like most about the program/what elements of the program would you like to keep? How is it different from traditional ILO/TLP?)

Youth Engagement and Achievements

Q3: **How does having that dual role impact your relationships with the young people on your caseload?** (Talking points: How would you describe your relationship with the youth on your caseload? How is it different from relationships you had with transition age youth on your caseloads outside of the LS program?)

Q4: **What do you do when a young person on your caseload does not stay engaged? (**Talking points: How often does this happen? What are some of the reasons these young people are not a good fit for LifeSet? If they become EFC, what is the impact of that for you, for them, for your relationship with them?

Q5: **How do you help youth prioritize and achieve their goals?** (Talking points: monthly service plans/ Why/what assessments; youth agency – how is this different from goal planning in traditional programs)

Suggestions for Program Improvements

Q8: **Would you recommend that DCFS continue to invest in LifeSet after the pilot ends? Why or why not?**

Q9: **Is there anything about being a case specialist that you don't like?**

Q10: **Is there anything you would ask DCFS/your agency to do differently to improve the program?**

If Time: Youth Experience with LifeSet

Q11: **From your perspective, what aspect(s) of LifeSet do young people like the most?** (placement options, flexibility, increased agency)

Appendix I. Guide for Interviews with Licensed Program Experts

Background

1. How long have you worked at Youth Villages as an LPE?
2. Do you have experience working with YV in other states?
3. If yes, how does your experience with YV in IL compare with your experience working in other state(s)?

Referrals/Discharges

4. What makes a young person in IL a "good fit" for LifeSet in IL
5. Can you walk me through your role in the referral process?
6. How do you work with the specialists/supervisors during the referral/PEA processes
7. What are some of the challenges you have seen with the referral processes for [agency]?
8. How long do young people at [agency] typically stay in LifeSet?
9. Why do young people typically leave LifeSet (e.g. age out at 21, discharged to EFC/high acuity, incarceration, hospitalization)?
10. Where do young people typically go when they leave LifeSet?
11. What are some of the issues presented by young people remaining in LifeSet until they reach 21? a. How are these issues addressed through consultation, supervision, PD?
12. What is your experience/perspective about young people discharging from LifeSet to EFC either because they are not maintaining the program requirements or because they successfully met their goals?
13. What is the impact on the specialist of maintaining young people on their caseloads through EFC without access to the complement of LifeSet supports?
14. What about the impact for the youth?

Staff Responsibilities

15. Through our interviews with the supervisors and specialists, we've heard a lot about the various meetings that are held. Can you tell me about the consultation, red flag, and PD meetings in which you are involved?
16. What type of issues are being addressed?

17. How are the meetings received by the specialists and supervisors?
18. Some people have asked about combining the supervision and consultation meetings, can you talk about the pros and cons of that?
19. We've heard a lot about the challenges posed by having responsibilities for DCFS, [agency], and Youth Villages. Can you talk about what you've seen as the challenges or opportunities the specialists have being the legal case worker and LS specialist?
20. Do you have any insight into the staff turnover at [agency]
21. What are your observations/perspectives on the impact that has had on the remaining staff and on the youth?

Youth

22. What do you see as the benefits/challenges of working within the LifeSet model for case specialists in IL?
23. What do you see as the benefits/challenges for youth of participating in the LifeSet model in IL?
24. From your perspective, what aspect(s) of LifeSet resonate the most with the young people? (placement options, flexibility, increased agency)

Suggestions for Program Improvements

25. Would you recommend that DCFS continue to invest in LifeSet after the pilot ends? Why or why not?
26. Is there anything you would ask DCFS or your agency to do differently to improve LifeSet?
27. Is there anything I have not asked you about LifeSet implementation in IL that I should know?

Appendix J. CANS Scoring Guide

87. Independent Living Skills. This item is used to rate the presence or absence of skills and impairments in independent living abilities or the readiness to take on those responsibilities. This item supplements information from the Ansell-Casey assessment.

Score	Description
0	This level indicates a person who is fully capable of independent living. No evidence of any deficits or barriers that could impede maintaining own home.
1	This level indicates a person with mild impairment of independent living skills. Some problems exist with maintaining reasonable cleanliness, diet and so forth. Problems with money management may occur at this level. These problems are generally addressable with training or supervision.
2	This level indicates a person with moderate impairment of independent living skills. Notable problems with completing tasks necessary for independent living are apparent. Difficulty with cooking, cleaning, and self-management when unsupervised would be common at this level. Problems are generally addressable with in-home services and supports.
3	This level indicates a person with profound impairment of independent living skills. This individual would be expected to be unable to live independently given their current status. Problems require a structured living environment.

88. Transportation. This item is used to rate the level of transportation required to ensure that the individual could effectively participate in his/her own treatment and in other life activities. Only unmet transportation needs should be rated here. This item supplements information from the Ansell-Casey assessment.[50]

Score	Description
0	The individual has no unmet transportation needs.
1	The individual has occasional unmet transportation needs (e.g., appointments). These needs would be no more than weekly and not require a special vehicle. The needs can be met with minimal support, for example, assistance with bus routes to facilitate independent navigation, or provision of a bus card.
2	The individual has occasional transportation needs that require a special vehicle or frequent transportation needs (e.g., daily to work or therapy) that do not require a special vehicle. Individual can self-transport with a med-van service.
3	The individual requires frequent (e.g., daily to work or therapy) transportation in a special vehicle. He or she is completely reliant on others for transportation and cannot self-transport.

[50] This item rates if the child's transportation needs are being met, not necessarily if they are able to drive. This could include whether they have access to public transportation and/or someone is able to give them a ride to their appointments.

92. Educational Attainment. This item is used to rate the degree to which the individual has completed his/her planned education.

Score	Description
0	Individual has achieved all educational goals OR has no educational goals and educational attainment has no impact on lifetime vocational functioning.
1	Individual has set educational goals and is currently making progress towards achieving them.
2	Individual has set educational goals but is currently not making progress towards achieving them.
3	Individual has no educational goals and lack of educational attainment is interfering with individual's lifetime vocational functioning.

93. Victimization. This item is used to rate history and level of current risk for victimization.[51]

Score	Description
0	This level indicates a person with no evidence of recent victimization and no significant history of victimization within the past year. The person may have been robbed or burglarized on one or more occasions in the past, but no pattern of victimization exists. Person is not presently at risk for revictimization.
1	This level indicates a person with a history of victimization but who has not been victimized to any significant degree in the past year. Person is not presently at risk for re-victimization.
2	This level indicates a person who has been recently victimized (within the past year) but is not in acute risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, extortion or violent crime.
3	This level indicates a person who has been recently victimized and is in acute risk of re-victimization. Examples include working as a prostitute or living in an abusive relationship.

[51] This item scores if the teen child is in a position to be victimized. A history of being a victim of any kind of abuse or neglect should be scored at least a 1.