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Systemic Review of Critical Incidents in Intact Family Services
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Executive Summary

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

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

Background

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

Services provided to families while they remain intact offer an opportunity for the child welfare system to continue to engage and observe a family while avoiding the trauma associated with separating children from their parents. While preventive service models are in place all over the country, they vary considerably in their organization, structure, program components, and eligibility requirements. The recommendations included in this Review rely on a set of core elements found in the research literature that should be part of evidence-based, in-home preventive service programs. These key elements include: direct teaching and problem-solving skills, the provision of concrete emergency services/resources, cultural competency, quality

worker–client relationship, family engagement, assessment of family strengths, and safety planning.

In Illinois, Intact is offered to a subset of families of children with both indicated and unfounded allegations of abuse or neglect following investigation. In 2012, the program was privatized, meaning that IDCFS began referring the majority (>80%) of cases previously served by the Department to private provider agencies. However, this change was not accompanied by the rigorous approaches to monitoring quality and incentivizing best practice that characterized the privatization of foster care services in the late 1990s. Since then, a shift to decentralize supervision and oversight has disrupted a clear line of accountability and inhibited checks and balances in the referral and case closure processes.

Methods

This Review used four approaches to understand the systemic factors contributing to critical incidents among children in families receiving Intact: (1) analysis of contributing factors in a review of Child Death and Serious Injury Investigation (DSII) reports produced by the Illinois Office of the Inspector General (OIG); (2) systems analysis of three recent child death cases; (3) document reviews of policies, transmittals, protocols, forms, and evaluations concerning Intact; and (4) stakeholder interviews with administrators, leaders, providers, monitors, and advocates.

Findings: Child Fatalities

Nationally, 1,750 children died of abuse or neglect in 2016; this represents a 7.4% increase over the 2012 rate of child maltreatment deaths. In 2016, the rate of death due to child maltreatment was 2.36 among 100,000 children in the population; in Illinois, the rate was 2.16 per 100,000. The number of child maltreatment deaths in Illinois has decreased every year since 2014, while the number of child abuse or neglect victims has increased. Over the last five years, Intact cases represented 15% of the 41 deaths included in the OIG's Death and Serious Injury Investigations.

Findings: Systemic Issues

Findings highlight systemic influences that create barriers to effective service delivery for Intact families, including interrelated *structural, procedural*, and *cultural* challenges. These challenges also present opportunities for improvement.

- *Structural issues* refer to the way in which teams and individuals are organized and the varying degrees of accountability they hold for system outcomes, such as the supervisory misalignment described below.

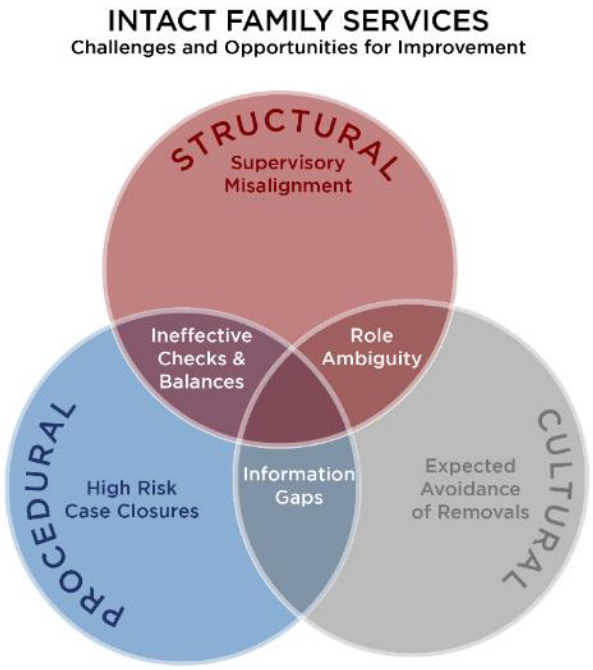
- *Procedural issues* relate to case flow and business processes. The unmonitored closure of high-risk Intact cases that have not been effectively engaged by providers is an example of a procedural issue that is a barrier to safe and effective service delivery.

- *Cultural issues* are commonly held beliefs and values expressed by multiple stakeholders representing different perspectives. The pervasive expectation that child removals will be

avoided is an example of a cultural issue that undermines critical thinking around safety decisions.

Issues in all three areas have challenged IDCFS to apply critical thinking, sensitive assessment, and effective engagement of families. The figure below illustrates six strategic priorities for improvement overlaid on the interplay of the three types of challenges.

Figure: Conceptual Model



In addition to these six systemic issues, the Review identified a list of problems and challenges that might be addressed using technology, fiscal contracting levers, monitoring, training, and policy refinements. Please see the full Review for more detail.

Recommendations

Nine recommendations were generated to address these and other issues (described in detail in the Review):

1) develop and refine a protocol for closing Intact cases;
2) clarify goals and expectations across staff roles;
3) utilize evidence-based approaches to preventive case work;
4) improve the quality of supervision;
5) adjust the preventive service array to meet the needs of the population:
6) restructure preventive services, including Intact;
7) work with courts and State's Attorneys to refine criteria for removal in complex and chronic family cases;

8) redesign assessment and intake processes; and
9) direct attention to cases at greatest risk of severe harm.

Conclusion

The implementation of some of these recommendations, such as improving supervision and deploying evidence-based strategies, will build upon and leverage work currently underway. Other recommendations will require that the Department revisit and adjust current strategies to accommodate innovative and best practice approaches tested in other child welfare systems. The Department is working to design an implementation plan that will sequence and prioritize action steps in order to address shortcomings and provide more effective services to children and families.

References

Commission to Eliminate Child Abuse and Neglect Fatalities. (2015). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office.

Covington, T., & Collier A. (2018). *Child maltreatment fatality reviews: Learning together to improve systems that protect children and prevent maltreatment*. National Center for Fatality Review and Prevention. Retrieved from www.ncfrp.org.

The Family First Prevention Services Act, Division E, Title VII of the Bipartisan Budget Act of 2018, Public Law 115-123. February 9, 2018.