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**Family Assessment in
Child Welfare**

**The Illinois DCFS
Integrated Assessment
Program in Policy and
Practice**

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Child
Welfare
Assessment

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Executive Summary

In recognition of the need for comprehensive family assessments, and in response to the concerns raised by the Child and Family Service Review (CFSR), the Illinois Department of Children and Family Services (DCFS) developed the Integrated Assessment (IA) program. The IA program partners child welfare caseworkers with licensed clinicians to provide better information about the functioning of children entering foster care and about child and family strengths, support systems, and service needs. The information-gathering activities and the collaborative process between the caseworker and IA screener are intended to produce better-quality child and family assessments, which in turn facilitate the development of better service plans. In short, it is anticipated that the IA process contributes to earlier and more appropriate interventions being identified and provided to the family. This report outlines the key components of the IA model and presents data on the extent to which the program as implemented adheres to the model. This report also draws on the experiences of frontline caseworkers to explore how the model is being utilized and implemented in practice.

Caseworkers articulated an understanding of the IA program that extended beyond producing the IA report, emphasizing a connection between the information gathered and the goals of identifying family strengths, developing a service plan, and facilitating family reunification. Analyses of administrative and interview data were used to identify challenges in adhering to certain components of the IA model.

- Meeting the 45-day timeline is a struggle, with statewide rates of on-time completion peaking at just over 50 percent in 2008.
- The inclusion of the IA screener in family team meetings is not occurring in approximately 50 percent of the cases, with some variation across the four regions. The primary reason provided was that the screener was not invited, with scheduling conflicts cited in a small percentage of cases.

There are also indications that over time some improvements have been made with respect to certain components of the assessment model:

- The proportion of assessments being completed within the 45-day timeline has increased from 2005 to 2008, despite program expansion and increases in the screener workloads over that same time period.
- Alongside other DCFS efforts to engage biological parents and specifically fathers, IA screeners and caseworkers were strongly encouraged to include fathers—resident or nonresident—in the IA process. The overall percentage of cases in which a father has been interviewed has increased from 40.5 percent in 2005 to 55.4 percent in 2008.

The collaborative approach between the IA screener and the caseworker is central to the process of conducting interviews and integrating the information gathered. A closer examination of this collaboration—primarily through interviews with caseworkers—indicates both strengths and weaknesses to this approach as it is currently being translated into practice. Efforts to coordinate schedules and complete interviews with multiple family members have led to lengthy “one-day” interviewing practices, which some workers find efficient, yet exhausting. Some workers express concerns about the impact of short-term screener involvement on their rapport with clients, while other workers provide examples of how they capitalize on the collaboration to engage parents or elicit better information.

Findings of this study also revealed variability in whether the assessment recommendations are incorporated into service plans. In some cases, there were prerequisites or an order in which recommendations needed to be carried out; other times constraints were imposed by other systems or providers involved with the family. Service availability and attention by the courts also influenced whether the assessment recommendations were kept and incorporated into the service plan. To the extent the discrepancies between service availability and need are documented, it facilitates DCFS’s ability to track identified yet unmet service needs and to leverage additional resources to meet those needs. However, some practices—such as modifying the recommendations to exclude those that cannot be enacted—limit those more system-wide efforts to address resource gaps.

Caseworkers presented mixed opinions about the value of conducting assessments with IA screeners. In several interviews, the same worker would express frustration about completing every step of the IA process and meeting the 45-day timeline and then proclaim that the IA process yielded better information, faster. While some workers identified specific types of cases for which the IA process is particularly useful, such as those involving young children or sexual abuse cases, many workers expressed broader support and appreciation for using the program with all types of cases. Lastly, some caseworkers noted that they picked up valuable strategies or insights from having collaborated with and observed screeners, suggesting that this collaborative assessment process may have potential as a model for caseworker training or professional development.

Introduction

Children and families involved with the child welfare system have been found to have high rates of physical and mental health and developmental problems or disabilities—problems that frequently go undetected or untreated (Horwitz, Simms et al., 1994; Rosenberg & Robinson, 2004; Stahmer, Leslie et al., 2005). Since the Child Welfare League of America (CWLA) and the American Academy of Pediatrics (AAP) called for mandatory health assessments for children entering foster care (Child Welfare League of America, 1988; American Academy of Pediatrics, 1994) in the 1990s, researchers and practitioners have offered many suggestions to improve the assessment of the mental and physical health of children in foster care. There are consistent recommendations that all children entering foster care receive routine assessment for mental health and developmental needs (Halfon, Mendonca et al., 1995; Glisson, 1996; Schneiderman, Connors et al., 1998; Hartnett, Falconnier et al., 1999; Nugent & Glisson, 1999; Simms, Dubowitz et al., 2000; Burns, Phillips et al., 2004). Researchers also agree that child assessments should be comprehensive (e.g., include mental, physical, and developmental health screenings); individualized for each child; and should assist workers in planning needed services (Hartnett, Falconnier et al., 1999; Armsden, Pecora et al., 2000; Leslie, Landsverk et al., 2000). Although much of the focus has been on children involved with the child welfare system, some have suggested that parental assessment data may be used to help make better decisions about required interventions and services recommended for parents (Barber & Delfabbro, 2000). Furthermore, research indicates that child welfare systems that incorporate the use of early family assessments are associated with many positive family outcomes, including higher levels of reunification, reduction in re-abuse, increase in kinship placements, and increased placement stability (Merkel-Holguin, Nixon et al., 2003; Titcomb & LeCroy, 2003; Wheeler & Johnson, 2003; Child Welfare League of America, March 2002).

In 2002 and 2003, the Illinois Department of Children and Family Services (DCFS) developed the Integrated Assessment process. According to the DCFS Integrated Assessment executive summary that outlines the goals and activities of the program, Integrated Assessment is a model designed to “incorporate the comprehensive assessment and case planning activities into an integrated multidimensional understanding of the client and his or her needs.”¹ In the concept paper, DCFS

¹ DCFS’s Integrated Assessment executive summary is one of several internal documents that were reviewed as part of this evaluation.

specifically noted that this model was developed “in response to on-going national research findings and outcome studies related to unmet behavioral, mental, and developmental health needs of the child welfare population.” DCFS also recognized that IA had potential as a child welfare training model, noting that it “provides a structure and a process to foster in-depth clinical and casework training of child welfare staff.”

Launched in 2005, the Integrated Assessment (IA) process aims to provide better information about the functioning of children entering foster care and about child and family strengths, support systems, and service needs. In addition, DCFS strongly believes that comprehensive assessment of family needs is a fundamental principle of child welfare practice and a critical early activity that is necessary for proper service provision to children and their parents. Although the child welfare system has traditionally focused on ensuring the safety of children first, determining the needs and assets of parents and children is another critical activity if the goal of either family reunification or another permanency option is to be achieved.

The Integrated Assessment program in Illinois has been in place statewide for *standard* placement cases since 2005.² In 2007, DCFS received a grant from the Children’s Bureau to evaluate and refine the model and to adapt it for use with intact-family services cases. Activities in the first year of the evaluation focused on understanding the development and functioning of the program since its launch. The information garnered from these activities and presented in this report is a critical step toward program monitoring and rigorous evaluation, which can then be used to inform efforts to improve, sustain, and expand the program.

This report outlines the key components of the IA model and presents data on the extent to which the program as implemented adheres to the model. This report also draws on the experiences of frontline caseworkers to explore how the model is being utilized and implemented in practice. Findings suggest that workers have mixed opinions of the program, such that the areas where the program is experiencing challenges might overshadow the practice benefits. Consideration is given to ways in which DCFS may capitalize on the program benefits and adjust resources to support the program so as to maximize the likelihood of achieving the intended outcomes for children and families.

² DCFS uses the term *standard* to refer to new cases not opened for services in the home, but for which a child needs out-of-home placement at the time of case opening; or an adopted child for whom out-of-home placement is required; or a previously closed DCFS case that is reopened based on new findings and for which the child requires a new placement. Data indicate that between 2005 and 2008, *standard* placement cases comprised 46 to 53 percent of all DCFS placement cases.

Methods

This evaluation utilizes a mixed-methods approach, drawing on several administrative databases maintained by the Illinois Department of Children and Family Services as well as in-depth, semi-structured interviews with a random sample of caseworkers. The databases and sampling procedures are described below. The evaluation was further informed by a review of several program documents produced by DCFS, including the initial concept paper, the Integrated Assessment Program Brochure (Department of Children and Family Services, 2007), and an internal program audit conducted in 2007.³

Statewide Administrative Data Systems

In conducting this evaluation, Chapin Hall staff worked with staff from the DCFS Office of Information Technology Services to extract and analyze relevant data from several statewide databases maintained by DCFS.

When the IA program was launched, DCFS constructed an administrative database for the purposes of tracking the assignment of cases, the completion and timing of interviews, and other benchmark steps in the IA process. These data are entered and maintained by the intake coordinators and used to monitor workloads and indicators of program functioning. This evaluation drew on data from over 9,000 IA cases completed between January of 2005 and March of 2009 to assess program implementation and fidelity to the program model.⁴

Data on case openings, child demographics, and foster care placements were extracted from the Child and Youth Center Information System (CYCIS). Data were also extracted from the Illinois Statewide Automated Child Welfare Information System (SACWIS). SACWIS is a case management computer application that supports the work of agency staff and contains information from the initial phone call of

³ Both the concept paper and the internal program audit were produced by DCFS for program development and monitoring; however, DCFS provided evaluators with access to these documents so that they might better understand the model and any changes made since implementation. The two documents will be referred to throughout this report as the “concept paper” and the “internal program audit.”

⁴ Cases are tracked at the child level. The roughly 9,000 IA cases represent approximately 6,000 families.

suspected abuse or neglect and throughout the life of a case until the child and family are no longer receiving services from the agency. Copies of the IA reports that receive final approval from the IA screener, caseworker, and supervisor are entered into SACWIS.

Caseworker Interview Sample

The IA database was used to identify all caseworkers who had done assessments with an IA screener for at least two families in a 6-month period during 2008. From this set of 130 workers, approximately 35 were randomly sampled and stratified by region so as to ensure statewide representation. Between March and July of 2009, in-depth, semi-structured interviews were completed with 22 caseworkers. All completed interviews were recorded, transcribed, coded, and analyzed using Atlas.ti software. The primary reason for not completing all 35 interviews was inability to establish contact within the study timeframe, a process that was impeded by a context of state budget crises resulting in reportedly higher workloads and temporary program disruptions. With respect to demographic characteristics, no significant differences were found between those who did and did not participate in the interviews.

The final group of interview participants, which included bilingual caseworkers, represented all regions of the state and both public and private child welfare agencies (see Table 1). By virtue of the selection criteria, even those workers with less than a year of experience had completed assessments with IA screeners for at least two families, and some had completed as many as 5 in just that year. Several more-experienced workers completed as many as 30–50 assessments over time and worked with several different IA screeners.

Table 1. Characteristics of Interviewed Caseworkers

Region	<i>N</i>	%
Central	3	15.0
Cook	5	25.0
Northern	8	40.0
Southern	4	20.0
Agency		
DCFS	13	59.1
POS (private)	9	40.9
Length of time with agency		
0–1 year	6	27.3
1–4 years	7	31.8
4+ years	9	40.9
Education		
Bachelor's degree	10	45.5
Currently enrolled in Master's program	4	18.2
Master's degree	8	36.4

The Illinois Model

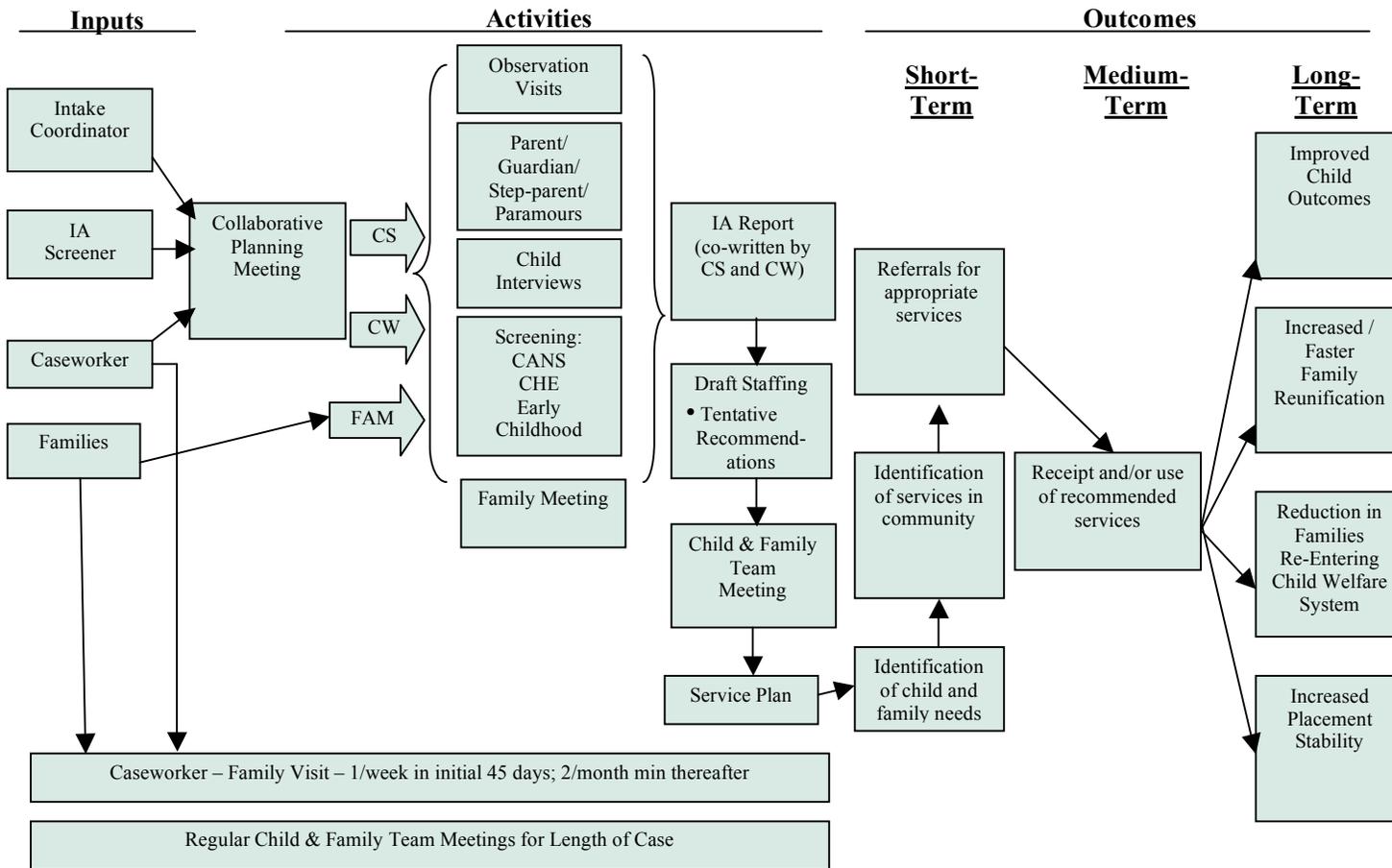
The Illinois Integrated Assessment (IA) process streamlines the collection of important family information within the first 45 days of a child entering DCFS care. The process was designed to provide casework staff with front-end assistance for coordinating information gathered through health evaluations, collaborative comprehensive record review, and interviews with the child and his or her family members, guardian, and substitute caregivers. The information is used to complete the integrated assessment report; to identify the strengths and needs of each child and his or her family system; to address risk and safety factors; and to develop precise and comprehensive service plans for reunification or permanency. The integrated assessment report serves as a foundation to drive creation of the service plan and is regularly reviewed and revised as necessary to reflect the changing needs of the child and family.

The portion of the process in which an IA screener provides this front-end assistance occurs in the second of three phases of assessment, which begin when a child first comes into care and continue throughout the life of the case. These three phases include:

- The Initial Assessment, or the assessment process used by child protection service workers during their investigations.
- The Integrated Assessment, or the interview and screening process used by the caseworker, supervisor, and IA screener during the first 45 days of a case.
- The Ongoing Integrated Assessment, or the activities the caseworker and supervisor engage in from day 45 through case closure.

While the first and third phases are conducted independently by the child protection service worker and the caseworker, the caseworker and an IA screener together conduct the “Integrated Assessment” phase. A logic model representing the inputs, activities, and outcomes of this second phase are presented in Figure 1, and the remainder of this section details the process depicted in this model.

Figure 1. The Illinois Integrated Assessment Model



For each case referred to the IA program, an intake coordinator and an IA screener are assigned to work with the caseworker and his or her supervisor. The role of the intake coordinator is to assist the worker by coordinating and contacting parties for the scheduling of interviews. The IA screener is a licensed clinician whose role is to assist the caseworker in collecting up-front clinical information about the family and then integrating all available information from the intake coordinator, caseworker, and other professionals. IA screeners are hired through partnerships that DCFS has established with four institutions around the state. The child welfare caseworker bears primary responsibility for the case; however, the IA screener and caseworker are encouraged to share the responsibility for conducting interviews and work collaboratively throughout the 45-day integrated assessment phase.

The investigative worker, caseworker, and intake coordinator coordinate the gathering of information for standard placement cases by requesting records and documentation, including investigative notes, safety assessments, risk assessments, outcome of child protective investigations, Law Enforcement Agencies Data System reports (LEADS), and all screening tools (domestic violence, Alcohol and other Drug Addictions, Adolescent Risk Factors, and initial health screenings.). The intake coordinator shares this documentation with the IA screener assigned to the case. After all available case information has been reviewed, interviews with family members take place. This communication and planning phase in preparation for the interviews is represented in the logic model as the Collaborative Planning Meeting.

Interviews with the child and his or her family members, guardian, and substitute caregivers occur as soon as possible. The information gathered is used to complete the social history background, to identify strengths and needs of each child and his or her family system, and to address safety and risk factors. During the interview process, developmental screenings are conducted with children and information needed to complete the Child and Adolescent Needs and Strengths (CANS) is obtained from parents, caregivers, and children. The CANS provides a structured assessment of children along a set of dimensions relevant to service planning and decision making.⁵ The caseworker and IA screener continue to collaborate before and after interviews to discuss results, identify issues of concern, and revise assessment strategies as necessary. The family plays an integral part in the Integrated Assessment process, not only during interviews but also later on when recommendations are agreed upon. As depicted in the logic model, the IA screener, caseworker, and family members are all involved in the activities at this point in the IA process.

⁵ For more detailed information on the development, use, and psychometric properties of the CANS, please see Lyons, Sokol, Khalsa, & Lee, (1999); Anderson, Lyons, Giles, Price, & Estle, (2003); Dilley, Weiner, Lyons, & Martinovich, (2003).

As interviews, screenings, and observation visits are completed, the screener begins drafting the Integrated Assessment report. The IA screener is responsible for an analysis of the clinical impressions of the family focusing on the underlying conditions and contributing factors specifically related to the reason for child welfare involvement. The IA screener also completes the on-line CANS assessment tool. After the initial draft of the IA report has been completed, the screener's supervisor reviews the draft and then the caseworker, supervisor, and IA screener meet to review the report. Changes and tentative recommendations are discussed by the team and subsequently developed and finalized with all members.

Following completion of the IA report, a family team meeting is held, where the caseworker and clinical screener discuss the report findings and recommendations with the family and other invited parties. At this point, the specific service interventions are developed in discussions with the family. The service plan is drafted and the parent is asked to sign the service plan. Children, when age-appropriate and clinically indicated, participate in the family meeting and pertinent discussions. Children age 12 and older are also asked to sign the service plan. Necessary revisions to the Integrated Assessment report may be made to incorporate any agreed-upon recommendations.

After meeting with the family, the caseworker writes the final draft of the service plan based on the IA report and the recommendations agreed upon with family members. The caseworker then enters the developed service plan into Statewide Automated Child Welfare Information System (SACWIS). In many jurisdictions, the service plan and the Integrated Assessment report are submitted to the court. These steps in the process are all listed in the activities section of the logic model in Figure 1.

In the current implementation of the IA model, the IA screener's involvement typically ends when the final IA report is approved and entered into SACWIS. The assessment process, however, is ongoing and the caseworker, with support from his or her supervisor, continues to gather information, analyze the information, and incorporate decisions into subsequent Integrated Assessment reports and service plans throughout the life of the case.

These activities and inputs are intended to produce better-quality assessments, which in turn lead to the development of better service plans. Assuming the families are connected with and engage with services and that the services are effective, the process is expected to yield positive system outcomes for children and their families (as outlined in the logic model). In short, it is anticipated that earlier and more appropriate interventions will be provided to the family. More specifically, the anticipated long-term outcomes relevant to the child welfare system include: (1) shorter case duration; (2) decreased incidence of placement or family disruptions; (3) reduction in the number of families reentering the foster care system; and (4) improved child outcomes.

How comprehensive is the Integrated Assessment process?

In DCFS's brochure describing the IA program (DCFS 2007), the Deputy Director overseeing the program described it as follows:

Integrated Assessment creates the perspective and provides the instruments to conduct a thorough clinical assessment for families facing challenges of neglect or abuse. We now have a process that looks at the medical, social, developmental, mental health, and educational domains of both the child and the adults who figure prominently in his or her life. That assessment, which begins early in the life of a case, creates a foundation for more informed decisions to bring the case to an appropriate conclusion.

The process detailed in the section describing the Illinois model notes the comprehensive record and document review; the interviews with parents, stepparents, paramours, children, and caregivers; the health evaluation; and developmental and mental health assessment tools. In later sections of this paper, we address how workers use this report and their assessment of its content and usefulness. In this section, we draw on the IA database and caseworker interviews for information on the completion of the health evaluation, the utility of the developmental screenings, the number of individuals interviewed, and the roles of interviewees—all useful indicators of the sources and scope of information available for inclusion in the IA report.

In Illinois, DCFS collaborated with Department of Human Services to create the Healthworks of Illinois program, which assures that children in substitute care receive comprehensive, quality healthcare services as mandated by the BH Consent Decree. As part of this program, an initial health screening must be completed within 24 hours of a child's entry into DCFS custody, and a comprehensive health evaluation (CHE) must be conducted within 21 days. Information from the CHE is incorporated into the IA report. According to data in the IA database, the CHE occurred in 94 percent of the IA cases, and in another 5 percent the CHE was not required, due to the type of initial placement, such as hospitalization. The data indicate that in fewer than 1 percent of cases, the child had run away or the court closed the case before the CHE occurred.

The interviews with children, parents or guardians, paramours, other persons in the household, and foster parents or caregivers are a critical source of information in the assessment process. As stated in the concept paper, the interviews with parents, paramours, household members, and children (where age-appropriate)

... will reveal psychosocial history, functioning and strengths. In addition, interviews will identify problematic behaviors related to substance abuse, sexual abuse, sexually problematic behaviors, domestic violence, developmental issues, mental illness and other mental health concerns.

The interviews with foster parents or caregivers are intended to

...gather information related to functioning and resources, as it pertains to each caregiver’s willingness and ability to meet the child’s emotional and physical/material needs.

The concept paper specifically notes that information gathered from the caregiver is intended to inform the development of the service plan, not to determine the appropriateness of a given placement.

According to the IA database—used by intake coordinators and screeners to track completion of interviews with family or household members and caregivers—the average number of adults interviewed per family case ranges from 1.9 to 2.6 depending on region (see Table 2).

Table 2. Number of Interviews Completed in All Regions per Family Case

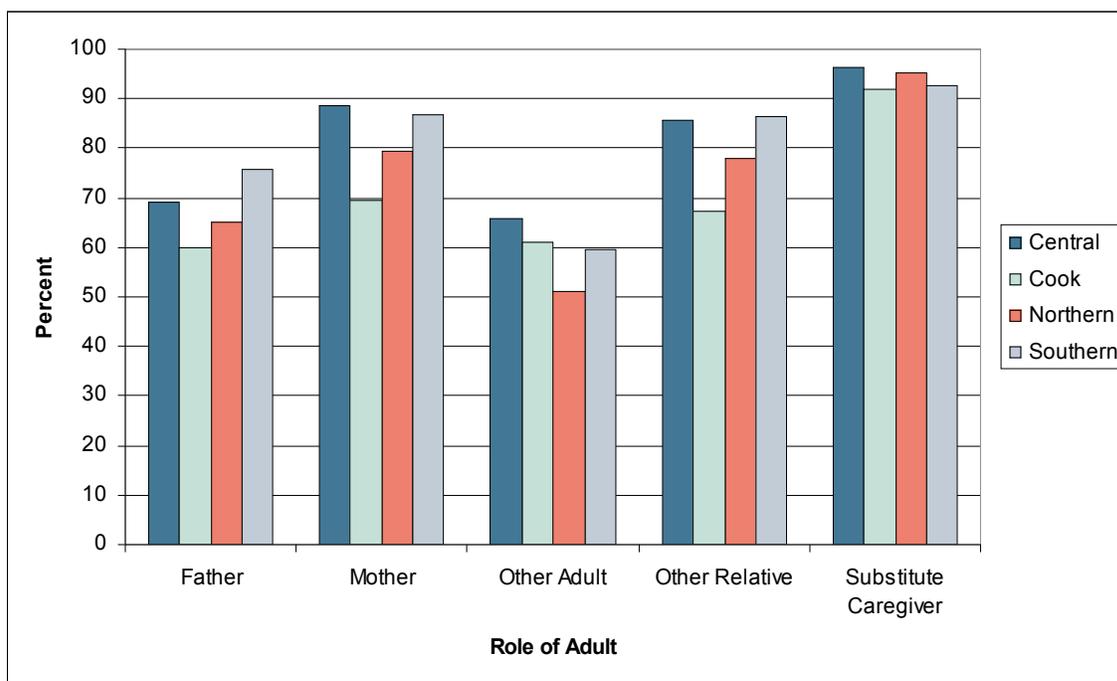
Number of interviews completed per family	Region											
	Northern			Central			Southern			Cook		
	mean	med	max	mean	med	max	mean	med	max	mean	med	max
Adults	2.2	2	8	2.8	3	14	2.6	2	14	1.9	2	16
Children	1.6	1	9	1.7	1	10	1.6	1	8	1.5	1	10
Total	3.8	4	16	4.4	4	18	4.2	4	18	3.3	3	22

med = median; max = maximum

The IA database also tracks the role of the adults with whom interviews are completed. Figure 2 depicts completion rates by role as a function of who is identified for a family case. Interview completion is highest among substitute caregivers, where rates are over 90 percent across all four regions. Rates are lower and more variable across regions with respect to completion of interviews with biological parents—that is, where a father has been identified for a family case, interview completion rates range from 67 to 76 percent, compared to interview completion rates of 70 to 88 percent among mothers.⁶

⁶ For more discussion on interviewing fathers as part of the IA process, see *Identifying, Interviewing, and Intervening: Fathers and the Illinois Child Welfare System* (Smithgall, et al., 2009)

Figure 2. Interview Completion Rates in All Regions, by Role of Adult



In the 2003 Child Family Service Review findings, Illinois received an overall rating of Area Needing Improvement on Item 20, worker visits with parents. A key concern identified pertained to the lack of sufficient face-to-face contact between caseworkers and fathers. Alongside other DCFS efforts to engage biological parents and specifically fathers, IA screeners and caseworkers were strongly encouraged to include fathers—resident or nonresident—in the IA process. According to the IA database, the overall percentage of cases in which a father has been interviewed has increased from 40.5 percent in 2005 to 55.4 percent in 2008.

In the interviews, workers spoke of the value of obtaining information from multiple family members, including fathers, who may have different perspectives on the family’s strengths, problems, and circumstances.

...Now we’ve got dad... got him involved... and now we’re moving forward to returning home the baby, and so it’s very beneficial to have that assessment done because it gave me insight on the family and the background and stuff on this baby. **[Cook Region]**

But when it’s relative foster parents, it’s like they can give you more depth on the family history and background. It’s also... I guess you could say checks and balances, because you can see if the stories add up with relatives. They’re like, “Okay, well mom told us this,” and you know, so yeah. **[Cook Region]**

In addition to the value of information collected from family members during interviews, caseworkers spoke of the value of obtaining developmental screening information during the IA interview process. Workers used the developmental screen to rule out developmental concerns, to determine whether further screening is needed, or to refer children to early-intervention services if necessary. That being said, workers' knowledge about the tools being used was variable, and some caseworkers perceived some screeners to be more thorough in completion of the screenings than others.

I think she was like 11 months, and not a very talkative child. Very quiet... The IA screener did a screen, and she found her to be on target but a little slow on problem solving and just recommended continual screening, which—that's good, to have the screening done up front.

[Central Region]

I'm not sure what all tools they use. I know that the boy...they did a developmental screening on him, but I don't really know what all they used. **[Northern Region]**

I didn't get the Denver, and I needed a copy of the Denver. That's something that's not always passed over for some reason... I don't know because I had to ask for that Denver because you know what the Denver's not in the system. They can put the IA in the SACWIS system, but there's no place for that Denver to go in there. That has to be hand mailed over to us. **[Central Region]**

When the integrated assessor had the opportunity to screen the child, she was two, so the recommendations were correct for her being two. But once we had gotten the report back and everything was said and done, she had turned three... And we really wanted to get the eldest child into [all the services that we offer] but because she had turned three, we couldn't and everything had to go through the school system there... They could, perhaps, go through the state and get some of those early intervention services but most early intervention services do stop at three and you know, the state and the system, I guess feels that the school is supposed to take over that's what's really it. **[Cook Region]**

Some screeners do sit down with the kid, play, do the putting together the blocks and getting the children to do the thing—especially for the younger kids. But some screeners just talk to the foster parents—“So, does she say words? Does she go up the steps?” So it's all reported, and I don't think that's very accurate... I think most of them do it. I would say maybe 25 percent don't do it. The screens have to be completed I think every 6 months anyway, so I

don't think it's a big issue. I just wait for the next time when I have to have it done, and then the health department or the school district will do it. **[Northern Region]**

Depending on the assessment tool being used and the age and developmental ability of the child, gathering information from the caregiver may be appropriate; however, the experiences that workers shared suggest that there may be opportunities to improve communication between workers and screeners around not only the administration of developmental screenings, but sharing and using the results. Furthermore, the issue of multiple types of assessments being conducted by different providers does raise questions about opportunities to improve cross-system coordination around developmental assessments.

Together, the information obtained from the health evaluation, family interviews, and developmental screening is integrated into the Integrated Assessment report, a template for which appears in Appendix A. In later sections, we discuss how that report is produced and used, but first we explore caseworkers' understanding of the program and experiences in executing this assessment process in collaboration with clinical screeners.

How do workers describe IA?

Caseworkers exist at the point where policy is translated into practice. Therefore, it is extremely helpful to examine how caseworkers understand the IA process and the extent to which that understanding is congruent with the conceptual underpinnings of the model developed and endorsed by the administration and codified in policy. When asked in the interviews how they describe the IA process to families or how they would describe it to “outsiders” to the child welfare system, most caseworkers emphasized the comprehensive nature of the information gathered about the family.

We ask a lot of questions about your background, how you were raised, what your family was like growing up, what is your education, what issues may or may not be in your background regarding mental health, substance abuse, what is your education, what is your work history like, what are your likes and dislikes, and what can we do to positively identify your strengths and identify any services you may or may not need to help get the child returned to your home. **[Northern region]**

We look at all dynamics of the family going all the way back to grandparents, any kind of mental health issues, any kind of substance abuse, how the parents grew up, parenting discipline of their parent with them and even some of the parenting discipline of their grandparents, how it may have led up to their being in the system now, whatever the situation

is, whether it be substance abuse, whether it be abuse or whatever, and then also be looking at the family dynamics and try to get a feel on what it would take to get this family back together and what services that we need. It gives us an outlook on what services we need to put into place and what we should expect from the family... **[Cook Region]**

Well, it's a comprehensive report, assessment, that goes over basically your knowledge from your childhood, your birth, your parents, how it was raising you, and then all up until what you did yesterday—going into your substance abuse life, your sex life, your personal life, your mental health. Every aspect of a person—if you're allergic to anything—so that I have a knowledge and understanding of what the person's about to provide them with accurate services that will meet any need that a person might have. To then flow into the service plan so that we can correct what needs to be addressed to help them safely parent their child.

[Southern Region]

Importantly, many workers articulated an understanding that extended beyond producing the report, emphasizing a connection between the information gathered and the goals of identifying family strengths, developing a service plan, and facilitating family reunification.

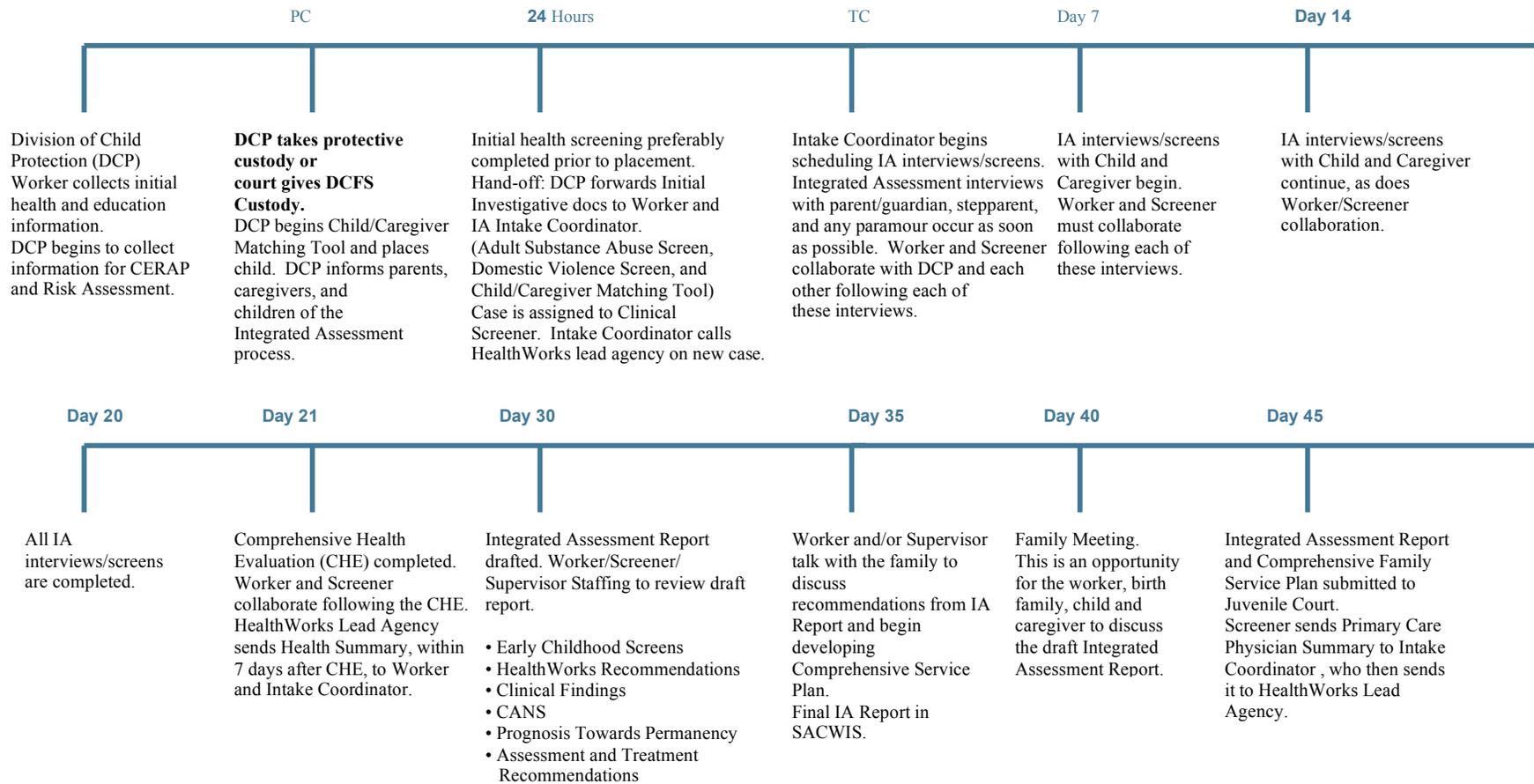
Timing is critical

Departmental policy mandates that the service plan be completed within 45 days after DCFS takes protective custody, and since the primary purpose of the IA process and report is to inform the development of the service plan, all activities conducted as part of the Integrated Assessment process in which the IA screener is involved occur within the first 45 days after a child is placed in DCFS custody. This creates intense pressure to adhere to a very tight timeline in completing all the activities and tasks in the model. As described in the introduction of the internal program audit,

The Integrated Assessment program...depends on almost split-second timing and coordination between schedulers, screeners, caseworkers, parents, and caregivers to go from [child] placement, to interviews and information gathering, to report writing, to approval by supervisors, to meetings with parents, and finally to court presentation within a window of 45 days.

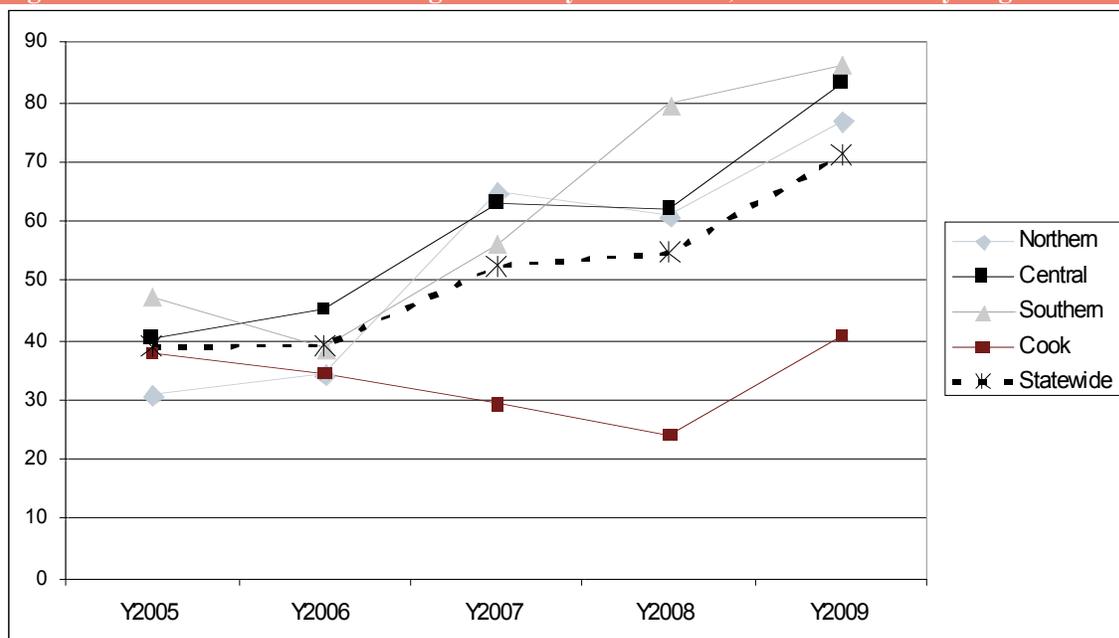
Figure 3 provides a detailed breakdown of the timeline, creating markers for the completion of the IA activities within those first 45 days.

Figure 3. Timeline for Integrated Assessment Activities



An analysis of report-completion timelines in the Integrated Assessment database confirm that meeting the 45-day timeline is a struggle, with statewide rates of on-time completion peaking at just over 50 percent in 2008 (see Figure 4). There is also considerable regional variation in completion rates, perhaps reflecting differences in case composition as well as caseworker and IA screener performance and staffing levels. A more detailed analysis of the critical steps in the process revealed no one stage in the timeline where significant delays were occurring—rather, one or two day delays at each stage seemed to have a domino effect. That being said, trends over time do suggest that improvements have been made despite what might be considered considerable program constraints. In 2007, DCFS expanded the IA program by allowing cases other than “standard” placements to be referred to the IA program. The data indicate that in 2008 these others types of cases represented a 9–12 percent increase in the number of cases being completed, and according to program staff there was no commensurate expansion in program resources or staffing capacity. The strain on program resources is further reflected in available data on screener workloads, which show the average number of cases per IA screener increasing from 8 or 9 cases per quarter, per screener in 2005, to 13 or 14 cases per quarter, per screener in 2008. In the internal program audit, it was estimated that with document review, travel, interviewing, and writing, each case takes a screener more than 30 hours to complete.

Figure 4. Percent of Cases Meeting the 45-day IA timeline, Statewide and by Region



The pressure created by the timeline and the challenges in meeting the timeline were clearly reflected in the interviews with caseworkers.

Sometimes there's a conflict with the integrated assessment coming in in a timely manner to get the service plan done...well, after the screener does the interview process, they submit, they, you know, type a report and then that has to get approved by their supervisor. They have to make corrections and then submit it to us to get it approved... and sometimes—and I know with other caseworkers it's a problem too—they just don't get it in a timely manner for us to get our stuff done within the 45 days. **[Southern Region]**

One of the challenges is meeting the deadline, the 45-day deadline...it's always a challenge to meet that because of course they're wanting the report by a certain date, and it's always difficult—if there's more than one father or if it's hard to schedule the appointments it's difficult to meet that deadline. ...I still think it's important to get everything in and done in a quick period of time, but just 45 days—if everything runs smoothly that's fine 'cause we'll make that deadline, but the majority of the time with foster care you're dealing with kids, people who just lost their kids—when you're dealing with a crisis situation nothing usually goes smoothly, so that deadline is very tough to meet unless the ball just moves slowly without any... roadblocks. **[Northern Region]**

...It took quite a while; actually I think I had three IA screeners. I had a lead IA screener, and then I had 2 kind of associates that were filling in because there were so many kids and people to interview that we didn't make the 45-day deadline. But we had—it's not your typical mom and dad and 3 kids-type interview...It took me longer to do the service—the interviews were right on time, right on schedule and she had it written up, but there was so much, so many recommendations that I wanted to make sure I was doing a thorough job on the service plan. So like the meeting went as planned, but my part of doing it, because I had to figure out how I was gonna do what and establish what for what kid—it took longer. **[Southern Region]**

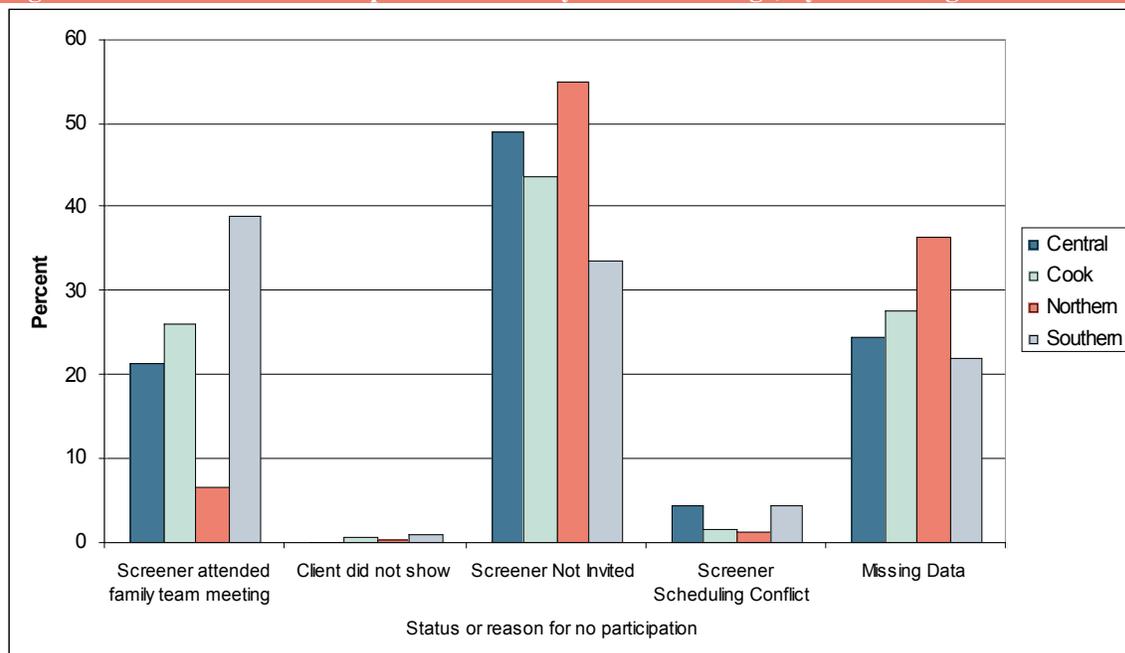
The challenges in meeting the 45-day timeline stemmed not only from the complexity of individual cases and the number of interviews that needed to be scheduled, but also from the screeners' workloads. Some workers pointed out that the screeners' heavy workloads and their need to juggle several complex cases at the same time can sometimes hold up progress on cases that would otherwise be feasible to complete within 45 days.

Engaging the Family

DCFS recognizes that it is important for the family to be involved in substantive discussions throughout the full range of activities, from identification of problems and needed services to recommendations and an exploration of barriers that might prevent successful implementation of the service plan. One specific point of engagement in the IA model is the initial child and family team meeting, which should occur approximately 40 days after temporary custody, with a specific purpose of providing an opportunity for all parties to discuss the draft IA report and recommendations. The IA screener is to be included in the list of participants and the caseworker and supervisor are to co-facilitate this first family meeting.

Both the IA database and the interviews with caseworkers, however, reveal that the inclusion of the IA screener in family team meetings is not occurring in approximately 50 percent of the cases, with some variation across the four regions (see Figure 5). Aside from missing data, which presumably indicates there was no record of participation, the primary reason provided was that the screener was not invited, with scheduling conflicts cited in a small percentage of cases.

Figure 5. IA Screener Participation in Family Team Meetings, by DCFS Region



The interviews with caseworkers confirmed what was seen in the database; however, several caseworkers did indicate that they felt it would be beneficial to have the screener present at the Family Team Meeting.

Caseworker: I think [family team meetings] are very helpful because it gives the parents an idea about what's happening or, you know, what to expect. It allows us to share information and it kind of lets us know how they feel where they are in the process...so yeah, I think child and family team meetings are beneficial. Always.

Interviewer: Do you think that the screener would get anything out of being there? Or would it be helpful for you?

Caseworker: Oh, I think it would. I think it would be for the screener as well.

Interviewer: Okay, and in your experience, was the screener generally involved in the child and family team meeting or not?

No. **[Northern Region]**

Interviewer: So the screener was not present at this?

Caseworker: At the family meeting? They're never present.

Interviewer: And would it be helpful if they were present?

Caseworker: I think it would be helpful...because they can explain a little more if there's a discrepancy why it is that that's the way they feel and that's why their recommending [a service]. **[Northern Region]**

In discussing specific cases, several workers noted that the child and family team meeting happened without a lot of advance planning, sometimes capitalizing on other opportunities for gathering, such as court dates.

We need to come together relative to the child in family team meetings. To discuss in an informal setting with people relative to the case from everybody's standpoint—particularly from that of the child and the family's standpoint—those things that they feel need to be done and those things that we would like to see done...in an informal setting. ...The family team meetings that we had because of the nature of this particular case were more helter-skelter than anything ...because these kids were very needy and they were bouncing all over the place. It was hard to get them both in the same place. **[Cook Region]**

Actually, we would arrange it according to, say for instance, the court hearings, so we know everybody has to be in court. We would get one of the conference rooms in court and be like, Hey could we have our meeting since we're here? You know, ... with everybody's schedule....The most challenging [aspect of Family Team Meetings] is when we don't have court that day and we have to arrange and try to catch them at home...when everybody is spread out and we're trying to get this within the timeframe. That's the most challenging part. **[Cook Region]**

A lot of times scheduling the child and family team meetings are difficult...it's hard to get everyone's schedule to fit...a lot of times there's other situations that we fall into that I feel would count as a child and family team meeting...like if the client is coming to meet with the therapist here at the office and I happen to be here and we all meet together and talk.

[Southern Region]

The “helter-skelter” approach to convening family team meetings highlights the challenges regarding the inclusion of screeners, and it also raises questions about how the family team meetings is being used as a part of the IA process. If the family team meeting is aligned with a court date or therapy appointment, is it the right setting to provide space for open discussion and time for incorporating changes?

Collaboration in Practice

DCFS’s documentation of the IA program clearly emphasizes the significance of the collaborative approach between the IA screener and the caseworker. The IA brochure published by DCFS states, “The foundation of the Integrated Assessment is its collaborative approach to gather information, drive decisions, and track results.” The concept paper developed prior to implementation details the distinct, yet complementary roles for screeners and workers:

The caseworker and IA screener each bring their own expertise and perspective to the IA process. The worker, as a licensed child welfare employee, brings the ability to successfully balance concerns for child safety, emotional security and permanency guidelines. The screener, based on their licensure and prior work experience, offers clinical insight into the functioning of the child and his or her family system. Together, the two parties, caseworker and screener, will be better able to identify obstacles to the family’s obtaining reunification.

Collaboration between the IA screener and worker is a critical component of the IA process, and the fact that this program was only launched with standard placement cases (which typically represent only a portion of a worker’s caseload) afforded evaluators the opportunity to ask workers to reflect not only on the nature of the collaboration but on the perceived benefit in conducting an assessment with a screener versus without. In this section of the paper, we present caseworkers’ perspectives on the degree and nature of collaboration at each stage in the process, from the initial point of screener assignment, to scheduling and conducting interviews, to writing the IA report.

Scheduling Interviews

According to DCFS’s brochure on the IA program, the intake coordinator “is the lynchpin to the IA process.” As implied by the title for this role, the intake coordinator is supposed to coordinate the IA team, gathering documentation, scheduling interviews, screenings, and meetings, and entering or maintaining necessary information in the IA database.

In the interviews, some caseworkers noted that working with the intake coordinator was very helpful in terms of scheduling and getting questions answered about the IA process in general. Other caseworkers prefer to bypass the intake coordinator and work directly with the screener to schedule the interviews.

We have the intake coordinator who is supposed to help us with the scheduling, contacting the end saying, “Give me three days you’re available,” then she’ll contact the screener and say, “Here’s when the caseworker’s available. When are you available?” I think we’ve all found, including the intake coordinator, plus all the screeners that it’s best if we just exchange cell phone numbers and talk directly instead of just going through a third person. **[Southern Region]**

Although some caseworkers report that it was relatively easy to find times to conduct the interviews, others report that it can be very difficult, especially in cases where screeners have several other cases they are juggling at once. Some caseworkers note that in order to stick to the timeline, they often rearrange their own schedules and work around the screener’s schedule. Some caseworkers also mention that it is difficult to work around the schedules of the multiple family members.

The [screener], she was good... she was flexible with her time, as was I, so that was a good plus. We actually [were] able to conduct the clinical screening in three sessions. The three sessions [were] pretty much within I want to say two weeks of each other, so she was kind of, “Let’s do this,” which that was very helpful... **[Cook Region]**

Well, normally because of the timeline we’ll go off the screener’s schedule, and so I’ll pretty much work my schedule around theirs because we know —I mean the sooner we get this scheduled, the easier we’ll have to make the deadline. **[Northern Region]**

Most caseworkers note that they do touch base with the screener prior to conducting the first interview to go over the facts of the case or any notable family dynamics. Sometimes the caseworker has already begun working with the family and has made observations that are shared with the screener at that time. There was, however, considerable variability in the extent of communication that occurred before the first interviews; whereas some caseworkers felt it was necessary to do so because of the complexity of the case, others report that it is not necessary.

Interviewer: How much before this case, before you actually did these interviews, did you speak with the screeners about the case?

Caseworker: I'd say probably that there was a week between [taking protective custody] and the first interview, and we probably talked daily because of the extensive history and the criminal information. **[Southern Region]**

Interviewer: ... did you talk with the screener at all before going in and doing the interviews and the assessments?

Caseworker: Briefly.

Interviewer: And how did that take place?

Caseworker: We met outside the house and just gave each other a heads up as to what we knew about the case and where we were headed... **[Northern Region]**

Interviewer: Do you meet the screener prior to conducting the assessments?

Caseworker: Not a whole lot. You almost meet 'em at the door.

Interviewer: Really? How's that work? Does that generally work for you?

Caseworker: It seems to work fine. **[Central Region]**

Both the pressure of the 45-day timeline and the geographic location of workers and screeners sometimes led the team to develop strategies for the most efficient approach to completing the interviews—such as teaming up for a whole day and getting an entire case completed at once.

... We had a clinical screener come up from southern Illinois, and he did it all in one day because, you know, he had to drive four hours. So he started out in the morning at 9:00 with dad, moved to the kid at 11:30, and then moved to mom at 3:00. So he did it all in one day. Props to him. That's a lot of information to get. **[Central Region]**

... That particular [screener] was overwhelmed with attempting to do so many assessments... You've got one [screener] who may be assigned six cases during the course of 30 days. She's not gonna be able to do six integrated assessments... And so as a result of that, we try to squeeze in four or five appointments to see four or five different people around [her] schedule... **[Cook Region]**

I've enjoyed all of my experiences. Like I said, the only part is that they're so long and sometimes by the end of them... I understand that they have to be that long just to get all the information needed, but sometimes if you're sitting there through a few people, it's three to four hours, and so just after a while I honestly just daze out because you can't focus that long. We try to take a little break in between if we can, but everyone has time constraints, screeners and us...so it's almost easier to have as many in one day as you can, just to get them done, but like I said, it does get tiring. **[Northern Region]**

[The screeners] try to do the interviews in a marathon interview... They wanna get it all done in one shot because of scheduling issues and trying to get us all together at the same time, so we might be sitting with the biological parent for four hours, doing an interview, which is tedious anyway. **[Southern Region]**

In addition to the “tiring” or “tedious” nature of full-day interviewing, there may be other consequences as the team tries to balance the scope and number of interviews with the time allotted. In one instance, a caseworker mentioned that the screener chose not to interview the father because he was not available on the one day that had been set aside to conduct the interviews for that particular case. Furthermore, workers and screeners spend intense amounts of time together in a short period but less face-to-face time over a distributed period of time, perhaps providing fewer opportunities for skill development and learning.

Conducting Interviews

Although the design of the IA program gives caseworkers primary responsibility for all aspects of the child or family's case, it also indicates that the IA screeners are responsible for interviewing children, caregivers, and birth parents “along with” the caseworker. As already noted, the extent to which information is shared between the two in advance of the interview varies, and presumably the depth of their respective knowledge about the family varies as well. Furthermore, by design of the program, the workers and screeners have different educational backgrounds and experiences, and therefore bring different perspectives to their work. It is not surprising, then, that there is considerable variation in how workers and screeners enact their roles in conducting the interviews with families. Most caseworkers seem to find ways of negotiating a role that is comfortable to them.

I try not to interrupt or interject or anything like that. Basically I just like to listen because that's when you find out the most. I think the most information when you're first coming

into a case. So I do just like to listen. I mean if I do have a question I'll ask it or something like that but usually I just, I stay quiet. **[Southern Region]**

...Any information I wanted that wasn't coming out I would ask further questions, or else—like I said I had already been talking to him, so if they didn't tell the screener necessarily everything they told me I kind of prompted them to continued to tell him what they had already told me before about a question he asked. ...If I know something that they're not necessarily telling the screener I won't say it, but I'll have them—I'll kinda prompt them.”

[Northern Region]

I just—at times, I don't feel that they're asking the questions that need to be asked. And so I always tell them I don't wanna step on their toes, but could I ask this question? ...and sometimes, a majority of the time, I've been able to get other important information for the case. All the integrative assessors that I've worked with have always been outstanding. They've always given me the opportunity to ask questions. **[Northern Region]**

Some caseworkers, while clear about the screeners role versus theirs, expressed concerns about how they perceived the IA process and the short-term involvement of the screener to impact their rapport with the family, and some relayed examples of how clients felt the screener's questions were intrusive. Given the previously described efforts by some teams to accomplish the assessments efficiently and the lack of involvement of screeners in the child and family team meeting, caseworkers presumably have considerably more contact—and perhaps more of a relationship—with the children and families than do IA screeners.

That first 30-day period is huge in building rapport with clients. That's a crisis for the family. They need to connect with their worker. They need to trust their worker and to sit through a cold, clinical interview with someone that they're never gonna see again is very disruptive to the family. **[Southern Region]**

This case, I'm gonna follow from the beginning to the end...and I just think that getting all these [screeners] involved, for what, and then the client's asking... “Well, why am I gonna disclose all of this personal information to this person, and what are they doing for me?” ...So sometimes that becomes a problem. Explaining to them, you'll never see 'em again. “Well, I don't wanna give that person nothin'” See? ...how do they trust somebody that they just met five minutes ago? So I think that's another issue that needs to be addressed.

[Northern Region]

You know, you have to be very careful in that integrated assessment process that you don't allow that assessor to alienate your clients. They're gonna be in there once. **[Cook Region]**

The godmother and the grandmother, that was okay. It was the daughter—“Why I gotta talk to her [the screener]? She all up in my business.” I’m like, “Well, you brought us into your business, so here we are. So we’re here to assess you.” ... She just didn’t want to be bothered... I have more of a relationship with her than [the screener] did. So I had to kind of stop for a minute and then pull her to the side ... and I explained to her that this would be helpful to better service you. **[Northern Region]**

The above examples reflect caseworkers' awareness of the significance of the worker-client relationship. That relationship has long been held to be not only the foundation of casework but a key factor in the change process (Robinson, 1930; Biestek, 1957; Perlman, 1979; DePanfilis, 1992; Drake, 1994). Organizationally speaking, the relationship is “the *primary vehicle* through which information about the client is obtained, assessment of need is made, services are delivered, client responses are evaluated, and client compliance is attained” (Hasenfeld, 1992). It also serves as a primary method of relaying important information *to* the client.

Having noted those concerns, it is important to also point out that some caseworkers described the partnership as a specific advantage, capitalizing on the dual involvement in interviews as a strategy for engagement and information gathering.

Well basically, and it’s kind of like all of the screeners, they do the introductions themselves... typically they come out, which I think is a good job and say, “You know what? We are an entity not associated— we’re not DCFS.” And I think, I always think that’s good. Because I think that kind of opens the door a little bit for more honesty... Because I think at this point they are so anti-DCFS that if you said, “I’m DCFS,” you can forget it, you know. **[Northern Region]**

You can tell it’s what [the screeners] do... when I see a screener doing an IA assessment it’s usually they’re able to get the people to open up more than if I do it myself... I think that the parents really open up... Because maybe they’re a stranger and I’m the caseworker or whatever it may be but... the integrated assessment people they know how to get the answers they’re looking for. Rather than me doing it and I’m not experienced with it as much. **[Southern Region]**

So I’ve worked with the screeners well enough that we play good cop/bad cop sometimes. I work well with all the screeners, and they don’t mind if I jump in and ask other questions that are relevant, or if something’s said they don’t care if I say, “Well, you just said this ten minutes ago—why’d the story change?” I try to make the reviewers to be the good guys and me look like the bad guy so that they get more information. **[Southern Region]**

As reflected in the quotations in this section, some caseworkers were particularly attentive not only to the issue of rapport, but also to the dynamics of working with clients who might be perceived as resistant or reluctant to engage with the caseworker. In child welfare practice, the concept of a “negotiated relationship” may be more appropriate than the traditional practice notions of the “good relationship” or the therapeutic alliance (Rooney, 1992). In a negotiated relationship, the client and the practitioner acknowledge that choices are constrained by agency policies, legal mandates, or other external factors. Some specific strategies for clarifying the roles or relationship include the exploration of the client’s views of existing problems, and an agreement to work on an additional voluntary concern in exchange for client compliance on a non-negotiable one. In that context, the integrated assessment interviews may be valuable not only for their content but also for the way in which the interviewing process could be used to facilitate or support that negotiated relationship, particularly with clients who are otherwise difficult to engage.

Writing the IA report

In an internal audit of the IA program conducted in 2007, several concerns were raised regarding the structure and the process for writing the IA report. Revisions to the report template were made as were recommendations designed to both streamline the report writing process and also increase caseworker ownership—and thereby use—of the IA report.

Consistent with program documents, the caseworker interviews by and large revealed that the final IA report draft is typically written by the screener, reviewed by the screener’s supervisor, and then sent to the caseworker for review. After the caseworker and his or her supervisor review the draft, they discuss any changes that may need to be made and the screener produces the final report. Generally speaking, caseworkers reported that they are able to reach agreement with screeners after this discussion takes place and that they were satisfied with the final draft.

Yeah, well typically how we do it is at the conclusion of the interview, you know obviously the screener goes back, you know actually compile the information, put it together in hard copy form. Typically it’s emailed to me. I look at it. Review it. It’s the same thing with my supervisor. She reviews it. And then what we’ll do is schedule an actual date to actually... screen it. And we do it, you know via telephone. Teleconference. And we just sit there and we start at the top and we just go through it. And if there are some things, changes or additions or amendments we want to put in there they typically put it in there. [Northern Region]

Basically what we do is when the integrated assessment is all written, when the screener writes the assessment, then myself, the screener, and my supervisor all get together. We will all have read the IA prior to the meeting. We schedule a meeting and we discuss the IA and at that time we can discuss anything that we want, extra put in or taken out or corrected somehow. Once in a while we have to meet over the phone, but I'd say 99 percent of the time we're in person. **[Northern Region]**

...One of the things I thought needed to be added there is that the family had just immigrated to the United States from Mexico within the last 2 years. And apparently it was shortly after they got here that the abuse started, so I thought it would be important because the family was separated in order to come to the United States... So I thought it was a stressful time for them, so yeah, I remember I recommended that they add it, and they did add it. **[Northern Region]**

Nearly all of the caseworkers have stated that the writing of the report is really the culmination of the collaboration between screener and worker. There is little to no ongoing contact between screener and caseworker once the final draft of the IA has been produced.

Interviewer: Have you had to consult with the screener after completion of... the IA?

Caseworker: No, not really. If we're somewhere, we'll sometimes ask, 'Oh, how's so and so doing now on that case?' ...But nothing officially, no. **[Southern Region]**

Interviewer: And did you have any contact with the clinical screener after the IA report was completed for this case?

Caseworker: Just to staff it. See, like I said, we do have phone staff or any changes and what not, but generally I don't have any contact with them afterwards. **[Northern Region]**

The implications of ending the caseworker and screener collaboration after the IA report has been written should be considered. Although screeners engage the family in an in-depth exploration of their family history and current circumstances, there is apparently minimal follow up and potentially a lack of closure, factors that may impact screeners' job satisfaction. Additionally, effects on engagement potentially achieved through the successful collaborative strategies used during interviews might be sustained longer if screener involvement were continued for a longer period of time, perhaps through a point of clients' follow-through with service referrals.

Knowledge Transfer: Using the IA to Inform and Execute Service Plans

Developing the service plan

In a previous section, we noted that most caseworkers seemed to understand the intended connection between the IA process and the goal of identifying and delivering appropriate services to the families with whom they work. Caseworkers are involved throughout the assessment process and presumably accumulate information throughout that process; however, many caseworkers noted in the interviews that they draw heavily on the IA report when writing the service plan. It provides a blueprint, or road map, for what services to recommend, what goals the family should have, and what tasks should be outlined in order to meet the family's needs. Caseworkers also specifically noted that the developmental screenings are especially helpful in figuring out whether a child should be referred for early intervention services.

You know the IA... it's the road map. It lets you know, "Okay, this is the direction. This is where we need to travel with each individual member of this family." **[Northern Region]**

When I'm developing a service plan, I go back and I review the recommendations of the assessment and make sure all those recommendations are in the service plan. **[Northern Region]**

... We used to put services in place or recommend things that really just didn't fit those particular families, and so now we have a better feel on how this family exists, their dynamics, and now we kinda know exactly what may work for them. **[Cook Region]**

...In other cases where the baby or children, you know could be delayed but you don't know. That's real helpful to know and then to figure out, yeah, you know based on this assessment we do need to enroll them in early intervention and everything. So that's really helpful.

[Central Region]

Although caseworkers note that the IA makes writing the service plan relatively easy, they also note that the timeline for getting the IA report completed often conflicts with their own timeline to complete the service plan. They point out that when the IA report is late that also makes their service plan late. Another issue is the fact that they cannot get a head start on drafting the service plan before receiving the IA report because the SACWIS system will not allow a service plan to be drafted until the IA report has been submitted. Finally, another issue reported by a few caseworkers is that it is sometimes difficult to appropriately revise the lengthy passages from the IA report to fit into the service plan, which must be much shorter.

Oh yeah.... I think the biggest benefit is you see the needs of a family immediately, but like I said it has to be done within 45 days... In a perfect scenario the [interview] is actually done within 2 weeks of a case coming in... And so we're—within 2 weeks of a case coming in we're already seeing what needs a family [has], what emotional needs, what physical needs, what areas [are] lacking that would help the situation, and so we're able to address them immediately... And then like I said within a month they can start receiving services. Without that—I mean like I said it may take longer to get the information, so they might not start getting the services they need. They may get some, but it may not be what they actually need.

[Northern Region]

...The service plan has to be done within 45 days as well. So sometimes there's a conflict with the integrated assessment coming in a timely manner to get the service plan done. So we usually have—if it's sent within the 45 days we have like a week to get the service plan done. **[Southern Region]**

The whole process is slowed when the integrated assessment process is slow. I can't do the service plan until I get the integrated assessment... You can't go into creating a service plan in SACWIS unless you have an integrated assessment entered. **[Cook Region]**

Many caseworkers reported that they were able to bring all the recommendations from the IA report into the service plan without any problem. However, for a variety of reasons, many other caseworkers note that they may not be able to bring in all recommendations into a service plan. Sometimes there are prerequisites or an order in which recommendations need to be carried out; other times constraints are imposed by other systems or providers involved with the family.

When I first did it, the first service plan, there was a couple recommendations that I couldn't incorporate into the service plan just as yet but I can where I could in the future. For instance, one of the recommendations was to have a psychiatric exam, but after the person has been sober for 6 months, so a period of sobriety must take place, which I couldn't effectively write my service plan in August if, you know, her parent hasn't been sober for only 2 months. You know, if that come in the next 6 months, I add that, you know? **[Cook Region]**

The screener wrote things like the child should be having frequent, prolonged visitation with the parents. They were sitting in the county jail who doesn't permit us to bring the child up for visits... so for him to write that in his assessment, then it just looks like we're failing to do something that was written that was in the best interest of the child, and then also he had written—and this is his thing, 'cause I've seen this in other reports he's written, that if the child is not returned in the next 6 months, we should pursue termination of parental rights. Well, that—it doesn't work that way. I know he's thinking of attachment and child development, but it doesn't work that way. Parents have at least 9 months after an adjudication to work before we can even look at a legal screening to terminate parental rights, so that was totally inappropriate to have that written in the assessment. **[Southern Region]**

Another more commonly reported reason many caseworkers are unable to bring in all services is limited service availability within the area. While the assessment might support a certain recommendation being included in the IA report, some caseworkers felt they could not make a recommendation for a service that they cannot provide, and therefore, some caseworkers reported that during the process of writing and revising the IA report they attempt to ensure that services that cannot be provided in the region are not included.

...Some of the assessors were gung ho and... recommended services that we couldn't provide, and so then that created a whole 'nother realm because here's the judge saying "This integrated assessment [says] do that, I want... you to do that," and we don't have the resource to do it. **[Central Region]**

'Cause some of the recommendations that have been made on previous cases, not necessarily this one, but we just don't have the resources here for DBT [Dialectic Behavior] therapy. There's no one. Some of that has been recommended and we don't have any therapists that do that so if you recommend it in that IA and then can't follow through with it on the service plan because we don't have the resources, then that becomes a problem. That becomes an issue a lot of times with court. ...Generally we have the staffing and just say, "We understand why this is recommended, but we can't provide this because of not having the resources," and

most of the time we agree upon taking that out of the plan unless the service, later on down the road, comes around where we can get services. Then we can add that back in. **[Southern Region]**

I think just as we're reading the recommendations, if there are things that are so far out there, or so unrealistic... put him in Big Brother, Big Sister. Well, there's a 2-year waiting list so that's again, what's the point of doing that? I think it's when we're reading the recommendations is when we start to say, "Okay, you're way— this person's out in left field." They have no clue—concept as to what we can actually provide to this family so they're writing unrealistic expectations into our own assessment. **[Southern Region]**

Modifying the IA report due to unavailability of needed services is particularly worrisome in that the IA program was intended to inform DCFS's efforts to address service gaps; however, the utility of the IA report in that process is lessened if unavailable services or unmet service needs are not consistently documented. Although barriers to findings services came up in interviews across all regions, it seems caseworkers in the Southern region were particularly vocal about these concerns.

Sharing the IA Report

With Providers

Another service-related benefit that caseworkers note is the fact that the IA report can be shared with service providers who then have greater understanding of a family's dynamics, history, and needs, and thus the IA report can help them in setting treatment goals with clients. Caseworkers report that the therapists, school officials, and other service providers who receive the IA report appreciate the background information, which in turn enhances the services they are able to provide for the family. Although caseworkers report that not all providers request the IA report—in fact, some are not aware of the tool—those workers who discussed cases in which they shared the IA report with providers felt the service providers value the information in the report.

I think [IA] gives us the tool we need, especially when we are referring clients to other service providers, because just reading that I think they get the whole picture of the family—the dynamics of the family, all the types of problems that have been in the family, and even if they just came because of lack of supervision. I mean you can figure out where the history of abuse started and all the important aspects of if they were abused as children, or if they have

lack of support system, if they have problems with alcohol. I mean it just gives you the whole picture that someone like a service provider would not be able to get. **[Northern Region]**

The service providers also get a copy of the integrated assessment once it's signed to allow them to have background information as to why the case is being referred to them... The therapist. Substance abuse treatment providers... They look at it because that's the foundation of what all the background information is. So I mean that's probably one of the main things they look for when you send a referral is the integrated assessment because it's telling you why the kids came into care, you know, and the background on the client that they're seeing. **[Southern Region]**

With the Court

Caseworkers report varying experiences in submitting documents to the court, including the judge, lawyers, and GAL. In some regions, caseworkers report that judges expect to receive a copy of the entire IA. However, many others report that judges expect only to see the dispositional report, which is often an abbreviated version of the IA and service plan. Some caseworkers express frustration that they have to spend time revising the IA to create the dispositional report and do not understand why they cannot just submit the IA. Other caseworkers note that when the report has not yet been completed, the judge often asks to see draft copies until the final report has been submitted.

We just went to court today and the judge wanted the integrated assessment along with the service plan... When a new case comes, right, they want the integrated assessment as well as the service plan. **[Cook Region]**

The IA, when we get it we file it to the court, so the state's attorney, the judge, the guardian lined up for the kids, and the parent's attorneys. ...They definitely pay attention to the recommendations we make, and then they want to make sure that they're addressed. So when we do a service plan if they see a need in the IA that's not addressed in the service plan they'll ask us to add certain task to the service plan. So I mean they definitely pay a lot of attention to the IA. **[Northern Region]**

[The courts] don't get [the IA report]... I do not send them over. Will County doesn't get a copy of the [IA]. I think the other counties, Kent County and DuPage, they do. All the court wants is my report. **[Northern Region]**

On the dispositional report, it's stated as such. ... I do have a recommendation. I think it's ridiculous and absurd, yet another waste of resources and time that my dispositional report is

cut-and-paste from IA basically. It's a shorter version of the IA and submitted to the court, and I've never had a problem with any of the recommendations made, or anything like that. I think they've been pretty well on point, but I don't understand why the IA can't be submitted as the dispositional report, because to me it's just, again, a waste of time. Like I say, unless you have updated information, of course, you know, a supplemental report for that, or what not. **[Central Region]**

In addition to the variation in the degree to which reports are requested by or shared with the different courts across the state, caseworkers report considerable variation in the way in which judges receive and use the IA report. Some caseworkers report that judges do not appear to be interested in reading the IA, while others note that judges in their regions have reacted very positively to the IA. Some judges make sure the IA recommendations match those in the service plan. One caseworker spoke of a judge that likes the IA process so much, he mandated that a non-placement case go through the IA process.

Honestly, I think probably most of the time [the courts] don't even read it... Some of the attorneys, I can say they probably do leaf through it and read parts of it, but others, I have a feeling it just goes in their files... It's easier for them to interview us when we get to court on that case for that day rather than sit to read a 50 or 75 page report. **[Southern Region]**

When it's 30 or 40 so pages, they will read [the IA]. They will scrutinize it... but when it gets to 79 pages, they're like, "Okay, Miss _____, talk to me. Tell me right now what's going on. Give me unusuals. Give me what your recommendations are. Have you gone to the visits? Are you monitoring them? What is your opinion? Let's get away from this because this is paper. Let's go with what you're saying," or whatever and so they use them both, between your own personal recommendations and your own feelings and your own case management as well as the clinical screener because they are the clinician of the beginning of the case... **[Cook Region]**

I don't know that the court understands the difference between how, if the case was IA or not IA, 'cause they don't read the assessments. They look at the service plans but I don't think it really registers with them what we're doing as far as that goes. **[Southern Region]**

Some courts may receive the IA report and may not be aware of the fact that a screener was involved in the creation of the report. This may account for ambiguous response caseworkers have noted regarding judge's reactions to the IA report.

Ongoing Use of the IA Report

Many caseworkers note that they use the IA report as a reference throughout the life of a case. Sometimes workers indicated they look back and recall details from the family history that may shed light on any new patterns or developments exhibited within the family. The IA and the service plan may also be used to measure progress and ensure that the case is progressing as it should as well as noting past and current services that have been completed or are in place.

Interviewer: Do you ever go back to the IA to review it?

Caseworker: Yes.

Interviewer: What do you get out of doing that?

Caseworker: It just helps me keep my history of the family fresh... I know why the case came to the system, but just to get the recommendations to see if I'm on target on what the clinical screener has suggested, and see, does it still apply to the family now? I read it every so often, you know? **[Cook Region]**

We're looking at the service plan constantly to reassess, to make sure everyone's on board with the service plan and whether they're making progress in services. Every month, pretty much when we go out to see the family, we're reviewing what they're doing, and talking with the therapist, talking with the service provider... **[Southern Region]**

Although most workers indicated that the IA screener's involvement stops with the initial report, they also reported that they themselves update the IA report and the service plan on a 6-month basis for the administrative case review process. They also note that they are making amendments, revisions, and additions to the IA on a regular basis at any point that a situation changes in the family, a new family member is interviewed, or a new service is recommended. The document changes according to the needs of the family in order to best reflect the family's current situation and the progress that has been made.

It's always updated every 6 months with the administrative case review. So that integrated assessment is a continual part of the case, and we update those—the caseworker updates those. **[Central Region]**

I feel like my IA screeners, when they come and do their job and they give me their 20-page report, it makes me happy. It makes me so happy because it makes my job easier and allows me to just add things as I go along and, you know work it as the living document that it is... **[Cook Region]**

Value of the IA Process

In the caseworker interviews, we asked workers about their experiences with Integrated Assessment in both a general and a case-specific way. The analysis of these interviews revealed that the same caseworkers might hold both favorable and unfavorable opinions about the Integrated Assessment program. In this section, we delve into some of those seemingly contradictory views of the program, and explore which aspects of the IA process were more and less valued by caseworkers.

The Integrated Assessment Program brought considerable change to both the process and practice of conducting assessments. It is not surprising, then, that several workers described an initial, somewhat collective resistance to the launch of the program.

Well basically as with any change there was a lot of resistance and hesitancy. ... Why you gotta bring somebody in and tell us how to do our job? And so there was a lot of resistance. Me, I think I was probably right up there in that circle. I was resistant to have, you know, “the insult” to show me how to do that and to dictate if you will what I have to do to service these clients. **[Cook Region]**

Workers at one point thought, “Well, if we have a screener that's doing the IA then that frees us up,” but that's not true because you're there during the whole interview... if you don't have much time to do the case work you have and you've got to sit a few hours with a client while somebody else interviews them, then it's like, “This is kind of like a waste of my time. I can do something else.” **[Central Region]**

The 45-day timeline was a consistent source of frustration among caseworkers, and yet, often the very same caseworker would express frustration about completing every step of the IA process and meeting the 45-day timeline and then proclaim that the IA process yielded better information, faster.

With IA we got a whole lot of information right away so that we were able to get services put in place right away, and so without it we probably still would have gotten most of the information, but it would have been 5, 6, 7 months down the line, which means the services don't start until 5, 6, 7 months down the line, which means you know we can't address the needs right away...a lot of times I think [staff in my office] would say it's helpful, it's just a lot of times the challenges of getting everything scheduled overshadows you know the benefits...One of the challenges is meeting the deadline, the 45-day deadline. ...So I mean that's the only negative part of it... **[Northern Region]**

I think it's kind of annoying for all of us 'cause it can take a whole day. Especially if... you have to drive multiple places. But that's really the only frustration. ...But, you know [it's necessary] in order to get [the] IA... So yeah, I don't mind it as much... **[Central Region]**

...We're on the front line dealing with a lot of this stuff, and like I say, sometimes we as workers still feel like this is my case, this is my work, and I wanna get it done within my time. To say I'm on somebody else's time—sometimes it feels like that as far as getting some things done, but overall, to look at it, yeah, I think it is a helpful process. I'm not gonna say that it's not. I think it is a helpful process. **[Cook Region]**

Some caseworkers felt the dual involvement of workers and screeners was a waste of resources, expressing frustrations around the differentiation of roles and questioning whether the IA screeners were really contributing something more than what the worker could produce on his or her own.

...when this whole process started we were told that they were gonna do really in-depth mental health assessments on our parents, which at the beginning was great, because it takes us 6 months to get a psychological or it's taking us months to get them into a counseling to figure out what's going on with this parent, but I don't see them really doing mental health assessments, nothing deeper than what case workers are already doing. They're not doing any kind of testing... They're just giving their impressions by the way the parent is presenting, and that's not really a mental health assessment. **[Southern Region]**

I think most people feel that it's something we could do ourselves... So almost everybody has a master's degree and we can pretty much do interviews ourselves so—and the fact that we have to be there when the family is being interviewed it doesn't really help us much because we still have to be there and spend the time being there anyway so. **[Northern Region]**

We're out there with them anyway... we could probably do the same job as what they're doing... And the fact that we're having to sit there, and it's our day that we're using also, and

plus we're out there more often. They go the one time and they're done where we're out there definitely quite a bit for the first 45 days... so with the tools and the training on the tools that they provide, I almost think that we could do the same job. **[Southern Region]**

These mixed reactions to the IA program were detected early on in the evaluation process. We wondered if caseworkers might draw on their experiences to identify specific types of cases where it was particularly beneficial to have an IA screener involved, perhaps opening the door for a discussion of how to target the program to cases where the caseworker might feel the benefit would be greater.

I think the ones that have so many people involved in them, whether it be multiple children with multiple fathers, I think those ones are really beneficial because it's so hard to get in contact with everyone. I tried to get in contact, but sometimes if I can't, then the screener will be able to set up the interviews 'cause I know I've had some cases where the parents are in prison, and they've been able to set up interviews over the phone. I think those ones really are, because some of them, there's just so many people involved. It's just hard to find the time on my own to meet with them and interview them. **[Northern Region]**

It would probably work better with maybe sex abuse... Because I think that one's a little bit more sensitive. And I think you need to take a little bit more time. And you just really have to be sensitive to the questions that you're asking. Unfortunately, you have to get a better understanding of the individual's history in order to be able to cater services to their needs. And I'm sure a lot of sexual abuse cases have issues from, you know, childhood, that have fallen over to adulthood. If we don't address those issues, how can the family or that individual move forward? **[Northern Region]**

...Working with a screener is helpful when there are young children to assess, like I said, because they are trained in developmental screening, but it does help to get that information. **[Northern Region]**

While some workers identified specific types of cases for which the IA process is particularly useful, such as those involving young children or sexual abuse cases, many workers expressed broader support and appreciation for using the program with all types of cases.

...It's difficult to say which types of cases may be better in terms of utilizing IA. I think we gotta do it with all of them. **[Cook Region]**

I have to be honest. I think they all need it. **[Northern Region]**

Interviewer: Okay. Do you think there are specific types of cases that benefit more from using the IA screener?

Caseworker: I would say the more difficult cases. If I had one case that had six children, a mom, a dad in Louisiana that we did contact and interview over the phone. It was one of my very first cases that I had, so it was a very large case, had lots of dynamics within the case, and so I think being able to have somebody else help focus because whenever you're interviewing that case, we probably interviewed 12 people. **[Southern Region]**

Caseworkers make important points about the possibility that the IA process may be most appropriate and most effective with certain types of cases. The extent to which IA is indeed more effective with certain types of cases is a question that may warrant further exploration in the quantitative analysis of case outcomes, assessing subgroups of cases based on information known at the point of referral.

Effects on Casework Practice

In acknowledging the roles and distinct areas of expertise for workers and screeners, the developers of the IA model also recognized the value of this approach in providing additional training opportunities for caseworkers.

The integrated assessment model provides a structure and a process to foster in-depth clinical and casework training of child welfare staff. The use of an integrated assessment model, where child welfare staff join licensed clinicians in the gathering of information, conducting clinical assessments and interviews, and participating in family meetings will provide new opportunities for clinical and casework training. Ongoing consultation with licensed clinicians around case issues will also allow staff to gain increased knowledge of individual and family dynamics and systems.

In the interviews, we specifically asked caseworkers whether conducting the assessment with an IA screener had any impact on their own practice or professional development. Some noted that they have picked up valuable strategies or insights from having collaborated with and observed screeners. Others noted that they have realized that they are making the same connections and coming up with the same questions as the screeners and they appreciate this affirmation of their casework practice skills and abilities.

I feel like I can always pick up a tip, or a trick, or some way to get someone to open up, so I think that's always helpful, to observe the way other people do things and think of, "Oh, I do

that and that actually isn't good," or, "I should try that because that seems to really work with this type of client." **[Southern Region]**

Well, with every clinical screener every role that I play they would say, "Do you have questions?" and so I would jump in and ask, but I realize though and it's really amazing because as I'm listening and I'm coming up with questions they're coming up with the same question. So if I'm patient they're gonna ask the question that I have thought of. So you know it's kind of affirming because we're on the same page, so then that works out. To me I think that works out good. **[Central Region]**

I've learned more about...questions to ask and what to key in on, being the observer of these interviews, and I do think it always helps to have a second person observing... to have a second opinion of what you see. **[Southern Region]**

Well, I think this is very important. You know particularly if it's someone who does not have any experience. I think this is an excellent tool to help identify: Okay, what do we need to start? **[Northern Region]**

The idea that the IA process might be particularly beneficial for younger or less experienced caseworkers raises interesting questions about the potential long-term impact of this collaborative approach and whether there is a point of diminishing returns—that is, to what extent do the worker and screener continue to learn from each other, and if practice change or professional development is the goal, could the benefits be achieved by a 6-month partnering of new workers with IA screeners followed by periodic “booster sessions” where they again collaborate?

Conclusion

Launched in 2005, the Illinois Integrated Assessment (IA) program partners child welfare caseworkers with licensed clinicians to provide better information about the functioning of children entering foster care and about child and family strengths, support systems, and service needs. The Integrated Assessment model is consistent with Schene's (2005) definition of comprehensive family assessment; it also reflects the foundations of quality practice she notes within the Comprehensive Family Assessment Guidelines for Child Welfare.

In implementing the IA program, Illinois DCFS launched the program statewide—a significant endeavor in a large state with geographic variation not only in the population served, but also in the ancillary systems such as the courts and service providers. When the program was launched, administrators also developed a database for the purposes of tracking the assignment of cases, the completion and timing of interviews, and other benchmark steps in the IA process—a database that could be linked to case outcomes as well. Analyses of these data suggest some improvements in program performance have been made, particularly with respect to the percentage of cases meeting the 45-day timeline and the percentage of cases in which fathers are interviewed as part of the IA process. However, both administrative data and interviews with caseworkers indicate there is room to improve the implementation of several key components of the program, including meeting the timeline, inclusion of screeners in family team meetings, and incorporation of IA recommendations in the service plan (partially attributed to challenges around service availability). The struggle to adhere to some aspects of the model—particularly meeting the timelines and including IA screeners in family team meetings—reflects tensions between workloads and the degree of coordination required for cases, particularly those cases involving large or complex family structures.

In any program or service, time, quality, and cost must constantly be balanced. If specific components of the IA model, such as the 45-day timeline or IA screener attendance at family team meetings, are critical to achieving outcomes, then adequate resources should be committed to the program to sufficiently adhere to the model.

However, achieving positive outcomes may also hinge on the nature of the collaboration and exchange between the screener and caseworker and with the family. In addition to the efforts to adhere to timelines and meeting attendance, emphasis should also be placed on the quality of and opportunities for information and skill exchange.

In addressing the need for clinical supervision and mentoring, Schene (2005) notes the following:

Caseworkers need transfer of learning opportunities through observation, mentoring, evaluation, and feedback regarding the incorporation of training content into practice, and other ways to cement the understanding and incorporation of principles and practices associated with comprehensive family assessment.

Consistent with this idea of transfer of learning opportunities, the structure of the IA program with its pairing of caseworkers and licensed clinicians outside the child welfare organization, may also have value in supporting caseworker professional development. Further research might explore whether the IA program has added value for new workers or whether there is a point at which optimal training or professional development has been achieved. If this were the case, while all caseworkers might conduct comprehensive assessments, IA screener involvement in that process might be provided to new workers or assigned at periodic intervals, with caseworkers conducting the assessments on their own at all other times.

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Appendix A

Integrated Assessment Report Template

Case Name:

Case (SACWIS) ID:

County of Jurisdiction:

Permanency Worker:

Worker Supervisor:

Worker RSF:

IA Screener:

IA Screener Supervisor:

Completed IA Report Date:

Family (SACWIS) ID:

Docket:

Worker Agency:

Integrated Assessment Interview Activity

Date	Type (Interview, Screening, or Both)	Those Present	Screeener(s)

Children’s Identifying Information

Child’s Name, Gender, Date of Birth	SACWIS ID	Legal Status	Date of PC	Date of TC	Living Arrangement

Parents/Caretakers

Name	Relationship	Date of Birth	Preferred Language	Household Member?

I. Reason for DCFS Involvement

A. Case opening reason: (Please list the case opening reason, i.e. Neglect, etc.)

- Briefly summarize pertinent findings from reviewed DCP packet. In your discussion, cite reason for current involvement, and include identified safety threats and source of safety threats.
- Specify whether case is open for safety, well-being or permanency

- In your narrative, identify whether this is the family's first involvement with DCFS or the child welfare system. **NOTE:** For families who have a history of child-protective involvement, use the letter designation to identify this involvement.
- State date and current placement type (e.g., home of relative, shelter, foster care, intact, etc.) for minors.
- In some cases, a child may be moved after the interview but before the completion of this report. In these cases, state name of new placement, reason for placement change and date moved.

II. Family Composition

- Identify the key members in the family for the children taken into protective custody, noting who was a member of the immediate household.
- Note any other person(s) central in the lives of the child(ren), such as an extended family member, family friend, teachers, etc.
- If it is essential to an understanding of the case, briefly describe current issues or family characteristics that would have impact on the children's safety and well being, such as pattern of frequent relocation, fluid household membership, periodic homelessness. **NOTE:** This section could serve as a means to sensitize your reader to significant issues impacting the family's functioning, such as pattern of unemployment, substance use, legal problems, domestic violence, police involvement, repeated history of child welfare involvement.

III. Participant Assessment Information for (Insert name of Parent/Caretaker/Paramour)

Parent/Guardian Interview

Include in your narrative, the following information:

- Birth parent's age, ethnic background, physical appearance.
- Place of interview, participants in interviews. Document any failed or cancelled previous attempts at interviewing. Cite specific reason for failure.
- Quality of engagement with the Assessment Team.
- Note whether the client gave informed consent, i.e., willingly agreed to participate in the interview with a clear understanding of its purpose and the limits of confidentiality.

- Note primary language spoken and/or any communication needs (e.g., visually or hearing impaired, literacy issues, etc.)
- Note any factors which may have had an impact on the interview, such as:
 - Difficult environmental conditions (e.g., no privacy while talking) for interview
 - Gross characteristics of client's mental status, including signs of client being under the influence of some substance or client unable to understand questions or refusal to answer some or all questions.
- Characterize client's attitude toward/understanding of the reason for involvement.

Parent/Guardian Personal History

- Brief Account of Family of Origin
 - If relevant, include place of birth and cultural background and/or countries of origin
 - Number of siblings and age rank of client.
 - Client's parent's marital status, past and present
 - Client's perception of family functioning. Include brief description of clients' perception of his or her parents' relationship during childhood.
 - Client's history of positive family memories and experiences, such as family celebrations, etc.
 - Client's *current* relationship with family members.
- Note any family history of underlying conditions:
 - Mental Health
 - Substance Abuse
 - Developmental Disabilities
 - Domestic Violence
 - Sexual Abuse
 - Physical/Sexual Abuse

- Client's perception of his or her childhood and adolescence
 - Briefly document client's perception or description of him or herself as a youth (e.g., sociable, out-going, withdrawn, shy, etc.)
 - Document client's involvement in any of the following:
 - Gang Activity
 - Legal Difficulties
 - Conduct or behavior problems at home, school or community
 - Reported strengths during youth:
 - Civic, neighborhood or community organizations
 - Church activities
 - Social and/or after-school clubs, activities or organizations
- Any serious losses or traumatic events experienced during youth
 - Using the CANS Trauma Items and/or Adverse Childhood Experiences, note whether client experienced serious losses or traumatic events during youth (e.g., physical or sexual abuse, community violence, etc.)
- Education and cognitive functioning

Include in your discussion:

- Client's highest level of educational achievement— if prior to graduation state parent's reason for early departure.
- History of academic successes, such as Dean's list, certificates of honor, involvement in scholastic clubs, etc.
- History of special education, learning delays and/or academic failure in school
- History of behavior problems in school such as truancy, suspensions, or expulsions—include parent's believed understanding or reasons for behavior problems
- Vocational or military training
- Significant involvements and relationships

Include in your discussion:

- Age client begin dating
- Narrative should include history of marriages and/or significant partners and relationships. Include divorce, separation, and children born from each union.

Work History

- First job: Include age, type of work, and reason for leaving
- Pattern of employment [112]:
 - Positions held: Type of work held over the years and reasons for leaving jobs—e.g., better job, work reduction, etc
 - Longest job
 - Significant accomplishment, awards, or interpersonal pattern, e.g., conflict, lasting friendships developed through work.
 - Accomplishments, awards, or other recognition.
 - History of involuntary termination
 - Reasons for termination—e.g., substance use, fights with coworkers or supervisors, mental health problems, etc.
- Current employment status: note type of work, place of employment, length on job, any history of conflicts or difficulties on job, and present satisfaction with job.
- Career goals:

History of Abuse and Neglect

- History of maltreatment of children
 - History of Child Protective Services
 - Reason for past involvement
 - Services offered
 - Client's response to/compliance with services
- Acceptance of responsibility in maltreatment
 - Refers to parent/caregiver's level of awareness of own role in prior maltreatment.

- Ranges from, at one extreme, accepting responsibility and making changes to reduce risk of future maltreatment to staunchly denying any role in maltreatment, at the other extreme.
- Relationship with the abuser
 - If parent/caregiver not the abuser, characterize current level of contact with abuser or anyone known to have abused children in the past.
- Multigenerational History:
 - Abuse/neglect suffered by children's parents and/or perpetrated on children by members of parents' families of origin.

Domestic Violence

- Describe patterns in the use of power and authority in relationship with partners. Is power and control is used to intimidate the other? Use concrete, observable terms.[113 + 99]
- Cite your source of information.
- Police intervention? Injuries? Emergency room admissions?
- Does domestic violence pose a threat to a child in this client's home?

Criminal Behavior and Background Check

- Self-report history:
 - This section should include the client's history of convicted or admitted participation in criminal activity; frequency of offenses, types of offenses (felony vs. misdemeanor, violent vs. non-violent). Include client's ages and reported outcomes of all arrests, any time served in jail, and whether client complied with conditions of probation or parole.
 - Last arrest— reason, age of client, and outcome
 - Is client currently on parole or probation?
- LEADS report:
- Impressions:
 - Discuss any discrepancy between self-report and LEADS.

- Comment on any clear pattern observe in history, e.g., escalating violence, crimes all related to substance abuse, or client appears to have used consequences to alter behavior.

Medical Condition

- History of Medical Conditions:
 - Note client’s history of severe injuries or major illnesses – include type or diagnosis, client’s age at time of incident, and current problems related to incident, if applicable— e.g., client currently reportedly fell from a tree and lost consciousness while playing with friends at age 12.
 - Note client’s history of hospitalizations (non psychiatric)—include age and reason for hospitalization.
 - Pre-natal or birth complications, only if they affected mother’s health.
- Current Medical Status:
 - Note any medical condition which may significantly impact client’s functioning — e.g., client currently reports trouble hearing and headaches since falling from a tree and losing consciousness while playing with friends at age 12. [134]
 - Note whether client has been prescribed current medical treatment needs and note whether client is willing or able to pursue treatment—e.g., Client has been referred to a neurologist for evaluation by his physician but refused to comply.
- Current Medications:
 - List all medications (except for psychotropic) currently prescribed and assess client’s ability to comply with prescription.

Substance Use

NOTE: If the client reports little or no history of substance use, simply note that in narrative form, rather than addressing each bullet point.

- First drug or alcohol use:
- Drug of choice:
- Pattern of use:
 - Frequency

- Note impact of use on client’s functioning— based on client self-report and/or collateral information.
- Note any efforts at stopping or self-regulating use. If client has been unsuccessful, note client’s reason for failure.
- Assessment & Treatment history:
 - Note whether the client has ever been referred to or sought a substance abuse assessment. If the client has been evaluated by JCAP or similar type of substance abuse assessment, the writer should note date and place of assessment. If results are available, note findings and recommendations.
 - Comment on client’s follow through with treatment and/or assessment recommendations and/or outcome of treatment.
- Attitude toward current treatment:
 - Note whether client admits to a problem with alcohol or drug use.
 - Note whether client is willing to participate in evaluation and/or treatment at this time.

Mental/Emotional Health

- Mental Status/Behavioral Observations:
 - FOR CLINICAL SCREENER: Provide a very brief mental status— comment on client’s orientation, alertness, speech, memory, concentration and attention. Also comment on client’s general affect and mood at time of interview. Note any evidence and/or past history of hallucinations, delusions, and/or paranoia. Note any evidence and/or past history of suicidal/homicidal ideation or attempts.
 - FOR INTACT & NON-SCREENER PLACEMENT CASES: Present behavioral observation of client during interview. Note presence of hallucinations, delusions, paranoia, and/or suicidal/homicidal ideation.
- Current Symptoms:
 - FOR INTACT & NON-SCREENER PLACEMENT CASES:
 - Note client’s self-report of behavior problems, symptoms and/or mental health concerns.

FOR IA SCREENER CASES ONLY: In addition to client's report of behavior problems, symptoms and mental health concerns, report outcome of screening and interview tools.

Pay particular attention to symptoms that endanger self or others. Be sure to describe the circumstances surrounding those symptoms.

- Traumatic or Adverse experiences impacting mental health:
 - Identify life situations or events that the client experienced as traumatic.
 - Note client's reported response or adjustment to these traumatic events or incidents.
 - Note additional significant stressors currently affecting client's emotional functioning.
- Mental Health History:
 - Note history of psychiatric treatment – include type of treatment (e.g., outpatient therapy, inpatient hospital, psychotropic medication, etc.), age, reason for treatment and/or symptoms, and outcome of treatment

For each treatment reported, note client's age at the time symptoms began and reported precipitants (or events leading up) to treatment.

- Current treatment:
 - Type and place of treatment, include client's reported reason for treatment with noted complaints or symptoms, frequency of contact, date began treatment, and duration. If available and applicable, provide DSM diagnosis. Identify source and date of diagnosis.
 - Provide prior history of DSM diagnoses, if applicable. Identify source and date of diagnoses.
 - Psychotropic medication currently prescribed (note any evidence of noncompliance).
- Client's Attitude toward treatment:
 - Note whether client feels treatment is helping or not, and rationale or reason for belief. Provide concrete examples if possible. For example, client does not believe individual therapy has been helpful because "I do all the talking and he doesn't say anything, and I don't even know why I am going there."

- Impressions: (FOR IA SCREENERS ONLY)
 - Note whether any clear pattern of thought, feeling, and behavior that limits the client’s current functioning or causes significant distress to self or others.
 - If you believe the client’s current symptoms or behaviors are significantly interfering with the client’s functioning and ability to parent safely, provide specific examples from client’s history, your observations, or behavior/comments displayed during this interview.
 - If the client uses alcohol or illicit substances, note how his or her use is impacting client’s current mental health functioning.

Special Treatment Approaches related to Race, Ethnic, or Cultural Considerations

- Concerns or family issues related to race, ethnicity, religion, culture, gender, sexual preference or age; any special treatment approaches required as a result of racial, ethnic or cultural considerations; whether or not these factors impact risk and safety issues.

PARENTING

Safety

- Supervision
 - Parent/caregiver’s capacity to provide level of monitoring required by child
 - Assess whether supervision is both appropriate to child’s needs and adequately consistent to ensure safety
- Neighborhood safety and Resources
 - Characterize immediate neighborhood with respect to safety and note availability of any resources which could mitigate risk.
- Condition of the Home

NOTE: REFER TO ANY SIGNIFICANT FINDINGS FROM THE “HOME & SAFETY CHECKLIST”

- The physical state of the dwelling; is it adequate to the needs of the family?
- Who lives there

- Whether there are any apparent hazards for children, such as firearms in the home
- Community/Neighborhood
 - Describe the community
 - Comment on availability of resources
 - Any barriers to using resources (e.g., language, transportation)
- Marital/Partner Violence in the Home
 - Refers to the degree of conflict/coercion in the home and its impact on child
 - Ranges from no evidence (disagreements handled in an atmosphere of mutual respect/equal power), through moderate (children shielded from heated conflict), significant (intense but aggression remains verbal), to profound (violent conflict, children exposed to risk).

Family, Community, and Social Connections

- Partner Relations
 - Parent/caregiver's intimate relationship with another adult, whether married or not.
 - Can range from a strong relationship with a partner who functions as a member of the family to an unhealthy relationship which has a negative impact on the family (e.g., domestic violence)
 - If the absence of a partner relationship negatively impacts the parent/caregiver's functioning, note that here.
- Extended Family
 - Refers to relatives not currently living with the family
 - Can range from playing a central and predominantly positive role in functioning of the family, through supportive but problematic, to strained, absent, or substantially negative.
- Community Involvement
 - Broadly defined: could include any person, business, or institution in parent/caregiver's neighborhood, town, or county.

- o Involvement can range from active, through passive sense of identification, to none.
- o Naturally Occurring Supports
 - o Any form of help that is freely available to the parent/caregiver. Could include friends, family, church, etc.
 - o If supports exist, assess whether or not they are sufficient to assist in meeting most family and child needs.

Use of Concrete Supports

- o Involvement with child welfare and related services
 - o Characterize client's level of involvement with services delivered to child and family: e.g.: active, compliant, minimal, resistant?
- o Organizational skills
 - o Client's ability to participate in or direct the organization of the household and family-related services and activities.
- o Knowledge of rights and responsibilities as a parent
 - o Understanding of legal rights, entitlements, and protection as a parent.
 - o Level of awareness and acceptance of responsibilities as a parent.
- o Financial Status
 - o Refers to income, regardless of source
 - o Characterize in range from adequate/effectively uses meager resources to experiencing financial hardship/unable to meet family's needs.
 - o Client's source of current financial support. If SSI, note reason for benefits and length of time received. Note whether client also received public aid or general assistance for children.
 - o Offer your assessment of how secure/stable it is
- o Residential Stability
 - o Parent/caregiver's stability of housing, ranging from no known risks, through significant risks, and frequent moves, to homelessness.

- Resources
 - In addressing family needs, what assets and resources can the parent/caregiver bring to bear? Define resources broadly, e.g., extended family, social supports, community institutions, governmental agencies, etc.
 - May range from sufficient to severely limited.

Resilience

- Hygiene and Self-Care
 - Refers to parent/caregiver's ability to manage basic self-care, e.g., bathing, dressing, feeding self adequately, etc.
 - Ranges from no evidence of a problem to requiring 24-hour supervision or assistance.
- Independent Living Skills
 - Refers to broader range of life skills including money management, transportation, housekeeping, and cooking.
 - Can range from no evidence of impairment or risk, through problems which could be addressed with supportive services, to requiring a structured living environment.
- Recreation
 - Parent/caregiver's use of leisure time for legal recreational activities.
- Resilient Traits and Abilities
 - Individual Strengths—Consider the client's personal characteristics associated with resilience, such as sense of humor, optimism, intelligence, determination, motivation, perseverance, and creativity.
- Self-Regulation
 - Consider client's ability to self-regulate by commenting on the following areas:
 - Ability to manage own anger
 - Tolerance for frustration

- Capacity to delay gratification
- Ability to exercise foresight and planning
- Spiritual Orientation
 - Note whether parent/caregiver draws strength from his or her faith, actively participates in any organized religion, or expresses a spiritual orientation in other meaningful ways.

Knowledge of Parenting and Child Development

- Knowledge of child's needs
 - Can the parent/caregiver demonstrate an understanding of the specific needs and strengths of each child?
 - May range from showing intimate understanding, through being generally knowledgeable with gaps, to little or no understanding of child's current condition.
- Nutrition Management
 - Parent/caregiver's ability to understand child's nutritional needs and provide a reasonably healthy diet
- Discipline
 - Defined broadly: all parenting actions and strategies that support positive behavior in children
 - Can range from effective (sets age-appropriate limits consistently), through adequate (not always consistent or age appropriate in expectations), limited (rarely able to set or enforce appropriate limits), to showing significant difficulty in either direction (no limits or unreasonable, excessive, or physically harmful measures).
- Ability to create a learning environment
 - Refers to parent/caregiver's ability to set an atmosphere at home which encourages a child to learn.
 - Includes degree of parent/caregiver involvement in the child's education
- Ability to demonstrate effective parenting

- Offer a comprehensive assessment of parent/caregiver's ability actually to *use* what they know to address child's needs as they develop.
- Focus on parent/caregiver's capacity to *respond flexibly*, to cope with changing demands in parenting their child.
- If parent/caregiver has attended any form of parenting classes, is there any evidence that they benefitted?

Ability to Nurture Social and Emotional Competence of Children

- View of own strengths and weaknesses as a parent:
 - What aspect of parenting is most rewarding to the client?
 - What is most challenging?
- Ability to listen
 - Refers to parent/caregiver's ability to listen to communications both from and *about* the child, i.e., parent/caregiver's capacity to listen to the child and to absorb information other people offer about the child or their own functioning as a parent/caregiver.
 - Note whether parent/caregiver can focus on unwelcomed information as well as good news.
- Understanding of impact of own behavior on child
 - The parent/caregiver's degree of self-awareness of how own actions affect their child(ren)
 - Can range from understanding *and* showing ability to adjust own behavior to limit negative impact on child, through understanding but struggling to regulate own behavior, to showing little understanding or entrenched denial of any negative impact on child.
- Placing primacy on child's needs
 - Parent/caregiver can respond to child's needs even in times of personal stress or adversity
 - Able to put child's needs before own needs or urges
- Empathy with Child

- Is the parent/caregiver attuned and responsive to the child's emotional needs?
- Can the parent/caregiver understand and respond to the full range of emotional states, (e.g., joy, sorrow, anxiety, frustration) ?
- How well does the parent attend to the child's emotional needs?

Commitment to Permanency and Reunification (subheading)

- Participation in Visits
 - Refers both to attendance and involvement in activities/conversation with children.
 - Can range from consistent and active to no participation.
- Relationship with Permanency Worker
 - Parent/caregiver's level of responsiveness/cooperation with Permanency Worker
 - May range from actively staying in touch/responding to input, through inconsistent cooperation, to being uncooperative or actively hostile.
- Involvement in Treatment
 - Degree to which parent/caregiver actively engages in any recommended treatment programs.
 - Ranges from consistent/making progress, through sporadic involvement, to nonparticipation.
- Involvement in child's services/activities
 - Extent of parent/caregiver's participation in "shared parenting activities"
 - Can be actively involved, largely uninvolved, or some point between.
- Commitment to Reunification
 - Global assessment of parent/caregiver's motivation to do what is necessary to reunite with their child(ren)
 - Assess whether parent/caregiver is: undertaking or ready to take on whatever tasks are required to achieve reunification; committed to

reunification but occasionally fails to follow through; ambivalent; or seems uninterested in reunification

- **Impression (IA Screener only)**
 - If you can support it with objective, observable information you have gathered, offer an overall impression of the client's capacity to parent. Include areas of concern and mitigating strengths or protective factors.

V. Participant Assessment Information for (Insert name of Child)

Child Interview

- Child's age, ethnic background, physical appearance.
- Place of interview, who participated in interviews. Document any failed or cancelled previous attempts at interviewing. Cite specific reason for failure.
- Note any unusual communication needs (e.g., visually or hearing impaired, inability to read, language other than English spoken, etc.)
- Note any other factors that significantly impacted the interview, e.g., lack of privacy, client's emotional state at time of interview, etc.
- Describe how the child engages with the Assessment Team and how the interaction progressed over the course of the interview
- If the child expressed any central theme in your interview, summarize it here.

Child Personal History

- Date and country of birth. Include cultural background and/or countries of origin and immigration status as well as a language other than English spoken by the family
- Name of parents
- Number of siblings and age rank
- Parents' marital status and child's perception of parents' relationships.
- Child's perception of his/her family
- Child's perception of family structure and disciplinary practices in his/her home.
- History of loss, trauma, or other adverse experiences.

- Any history of multiple moves.
- If already mentioned, briefly summarize family history of domestic violence, physical or sexual abuse, sexual or physical abuse, substance use, mental illness, or developmental disability
- Family history of criminal activity or involvement with the legal system.

Educational

- Offer a narrative summary of child’s educational Well-being. Cover the following, in so far as possible:
 - Whether the child is currently in an educational program
 - If the child’s assigned grade is age appropriate—if not, why?
 - Are the child’s educational needs being met at this time?
 - Does the child face any obstacles to benefiting fully from schooling?
 - What resources and supports are available to the child?
 - Child’s academic performance, past and present.
 - Child’s record of school attendance.
 - Disciplinary status.
 - Child’s outlook on education and career goals.

Medical

(For Placement Cases Only)

- Comprehensive Health Examination:
- Date of Comprehensive Health Exam (CHE):
- Place where CHE occurred:
- Immunization Status: Current or Not Current
- Immunizations due:

Well Child Exam Status:

Date of Next Exam:

Name of Selected Primary Care Physician:

Special Health Care Needs (e.g. asthma, sickle cell, etc.)

Other: (List name or source of information, findings, recommendations and date)

- Medical History:
 - Summarize any significant illnesses, medical conditions, or hospitalizations in the child's life. Include information on pre-natal substance exposure, birth complications, time in NICU, etc.
- Current Treatment:
 - Provide name of child's current physician and date of last contact.
 - Note any medication child currently takes.
 - Identify any community resources the child is affiliated with for medical care.

Developmental Status:

- For PLACEMENT CASES WITHOUT IA SCREENER: Identify whether child (ages 0–3 years) received developmental screening (Note: This would occur through the DCFS Early Childhood Program or Child & Family Connections Program).
- If 0–3 developmental screening occurred, document date, place of screening.
- State whether the child's screening: a) shows age appropriate development; b) suggests possible delay in one or two domains; or c) raises significant concern, such as a serious delay in one area or moderate delay in multiple domains.
- Note if child has received developmental services or will be referred for further evaluation or other services.

For CASES WITH IA SCREENER:

- Screening Measure: Cite the tool used (Denver II, Ages and Stages, ESI-P/ ESI-K), the date of the screening, and the child's chronological age at the time of the screening. If the child is under 2 years of age, note any age adjustment for prematurity if applicable.
- Screening Conditions: Note any circumstances that may have affected the results. These could be individual, such as the child's ability to attend to tasks, follow

directions, and maintain eye contact, or they might be situational, such as a chaotic environment or intrusive third parties.

- Screening Results: Report significant findings from the screening tool you administered. Present your findings in the categories offered by the tool, e.g.:

Denver II (birth to 4 months):

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

ASQ (>4 months to 36 months):

Communication

Gross motor

Fine Motor

Problem Solving

Personal-Social

ESI-P and ESI-K (36 months to 72 months):

Offer a narrative of the results noting areas of strength or weakness (see ESI-R Examiner's Manual pp. 76–137 for examples).

- Impressions/Overview:
 - State whether the child's screening: a) shows age appropriate development; b) suggests possible delay in one or two domains; or c) raises significant concern, such as serious delay in one area or moderate delay in multiple domains.
 - Note if child has received developmental services or will be referred for further evaluation or other services.

Mental Health/Social and Emotional Functioning

For Cases Without a IA Screener:

- Mental Health History:

- If applicable, note type of treatment (e.g., psychiatric hospital, outpatient therapy, psychotropic medication, group therapy, etc.) and age at time of treatment. Include age at time of onset of complaints or symptoms (including behavioral symptoms), known precipitating factors, who recommended treatment and why, and course of treatment (e.g., completed successfully, left treatment because refused to go, etc.).
- If child was or is currently in mental health treatment, does the child show any visible benefit from treatment?

For CASES WITH IA SCREENER

- Screening Measure: Cite the tool used (ASQ-SE [ages 0 through 35 months], TSCYC [ages 3 through 8/12], TSCC [ages 8/12 through 16]).
- Screening Conditions: Note any circumstances that may have affected the results. These could be individual, such as the child's ability to attend to tasks, follow directions, and maintain eye contact, or they might be situational, such as a chaotic environment or intrusive third parties.
- Screening Results: Report significant findings from the screening tool you administered. Present your findings in the categories offered by the tool, e.g., for the TSCYC: Anxiety, Depression, Anger/Aggression, Post Traumatic Stress-Intrusion, etc.

For Children 0–3:

- Integrate findings from the ASQ-SE with your other sources of information. Comment on the following dimensions:
- Interpersonal Attachment: Has the child established a clear emotional bond with anyone? Does the child seek to be near them, turn to them when distressed, or react emotionally when separated?
- Coping/Emotional (feeling states and coping behavior): For example, for infants the use of comfort objects such as a caregiver or a pacifier, simple motor skills such as turning their body in a more comfortable position. For a junior toddler, how well can they state their needs, pointing, gesturing, using words? For a verbal toddler, comment on frustration tolerance and the ability to voice basic feelings and needs.
- Sensory Processing: Is the child over/under sensitive to any stimuli such as touch, sound, clothing, etc? (does the child seem to crave or avoid certain sensory experiences?)

- State Regulation: Does the child exhibit any unusual feeding, sleep, or elimination patterns? Is excess crying or inconsolability a concern?

For All Children:

- Traumatic Events/Stressors Child has Experienced
- Adjustment to Trauma
 - Integrate results of Trauma Checklist with interview and historical data.
- Other Psychological Issues Identified

Note in particular any behavior which could pose a danger to self or others

- Current Treatment:
 - Note whether child is involved in current mental health treatment.
 - Document if prescribed psychotropic medication currently.
 - Attitude toward Treatment:

For All Cases:

Social Functioning

- Interpersonal relationships:
 - Describe how the youth relates to siblings, peers, parents, and other adults. [33]
- FOR PARENTING TEENS (i.e., teen parent functions in the role of parent)
 - Describe how the youth relates to his/her offspring. [89]
 - Does the youth show a realistic understanding of the child's needs?
 - Has the youth been able to maintain a reliable presence in the child's life?
 - Is the youth able to put the child's needs above his/her own immediate needs and concerns?
- Problematic Behavior:
 - If not already covered above [61–67], note behavior that may be significantly disruptive or cause distress to others.
 - Pay particular attention to sexually reactive acting out.

- Does the youth's behavior interfere with participating in school or community activities?
- Is it strongly influenced by the youth's peer affiliations?
- Is it gang related?
- Legal history:
 - Has the youth been incarcerated or placed on probation?
 - If so, distinguish between status offenses and other delinquent behavior. Note, in particular, any sex offenses.
 - How did the youth respond to legal consequences?
- Substance Use:
 - Does the child have a history of substance use? Be specific.

For CASES WITH IA SCREENER

- Impressions:

Drawing on all the history available to you, together with your observations of and interview with the child, and any screening tool employed, characterize the child's emotional development. Note any serious concerns you have.

- If the child expressed any central theme in your interview, summarize it here.
- Note whether these concerns might render the child more vulnerable to maltreatment.
- Also comment on any symptoms that might jeopardize the youth's current placement or interfere with reunification.

Child's Strengths and Resiliency Factors

- Support System:
 - Is the child emotionally attached to anyone? If so, to whom? How is it expressed? How secure does the attachment appear to be?
 - Is the child's family a source of support?

- Does anyone in the child's life provide him/her with effective structure, supervision, and guidance?
- Is the child involved with community resources, or friends.
- Attitudes and Beliefs:
 - Does the child exhibit attitudes or beliefs that could promote well-being, such as optimism, goal-directed behavior, or a spiritual orientation. Does the child attend a place of worship?
- Temperament & Resiliency:
 - Identify traits the child exhibits associated with resiliency, e.g., easy going, has a high level of tolerance for frustration, is quick to recover from stress or problems, is out-going or gregarious.
- Competence and Coping Skills:
 - What are the child's interests and activities?
 - Has the child experienced success in any sphere of activity?
 - Does he/she show any particular talent or skill?
 - Does the child (if age appropriate) have any history of employment?
 - Has the child been able to cope successfully with stressful life events?
 - Does the child have a solid sense of self-esteem?
- Barriers to Protective Factors:
 - E.g., no transportation to after-school sports activity.

Parent Child Interaction

- Child's Behavior:

e.g., does the child:

 - Readily approach the parent?
 - Maintain proximity over the course of the visit?
 - Respond to parent's communication?

- Share information about life circumstances?
- Show any signs of avoidance or apprehension?
- Seek comfort/support/approval?
- Have an emotional response to parting?
- Parent's behavior:
e.g., does the parent:
 - Focus on the child?
 - Make physical contact?
 - Show interest in child's concerns/activity/news?
 - Understand child's communications accurately?
 - Offer comfort/support/approval?
 - Avoid burdening child with adult concerns or inappropriate topics?
 - Comfort child at parting?
- Parent/Child Interaction:
 - Is there an emotional exchange between parent and child?
 - Do they communicate actively?
 - How would you characterize the predominant emotion?
 - Warm, Hostile, Anxious, Ambivalent?
 - Is there adequate regulation, i.e., can the parent set reasonable limits and does the child respond?
 - Describe the give-and-take between parent and child.
 - Is it a synchronized dance, parallel play, or something in between?
- Attachment
 - Is there an emotional bond between the child and one or more parent/caregivers
 - Cite behavioral evidence, e.g.:
 - Pleasure in each other's company

- Child finds comfort in parent/caregiver's presence
- Modeling and mirroring, i.e., reflecting each other's feelings or actions
- Mutual distress at separation

Child's Adjustment to Placement

NOTE: For Placement cases only

- Household:
 - Describe child's placement, including other members of household, and note how long he/she has been there.
- Caregiver's Perception:
 - Report caregiver's perception of child and how caregiver sees child adjusting to home, school, and community.
- Child's Perception:
 - Report child's perception of home, school, and community and how child experiences his/her adjustment.
- Access to Family:
 - Has the child been able to maintain contact with family and/or other significant figures?
 - Has visitation been occurring?

Substitute Caregiver Interview

NOTE: For Placement cases only

Strengths and Areas of Concern for the Substitute Caregiver

Assess the substitute caregiver's ability to meet the child's or children's needs (medical, emotional, developmental, education, recreational) while in the home employing the following CANS dimensions:

- Supervision
- Knowledge of child's needs
- Involvement with care

- Refers to involvement or readiness to be involved in services directed toward enhancing child's well-being.
- Safety
- Collaboration with other parent/caregiver
 - Refers to substitute caregivers' relationship with parent/caregiver, whether they are prepared to work with the biological family in child rearing activities.
 - Can range from fully supportive of shared parenting, through mild reservations or difficulties, to minimal cooperation, even active efforts at undermining.
- Support for Permanency Plan Goal
 - Global rating of substitute caregivers' commitment to facilitating the identified permanency plan.
 - If goal is return home, includes degree of support for reunification.
- Inclusion of the child in the Foster Family
 - The degree to which the family members accept the foster child as an equal member of the family.
 - Ranges from full acceptance by all members, e.g., inclusion in all family events, to a clearly marginal status, e.g., child left behind from family trips, ignored or resented by some family members, milestones not celebrated, etc.
- *Note any caregiver expectations which appear unrealistic or counterproductive.*
- *Report any other specific concerns you have about the placement.*

Respite or Other Needs

Do you anticipate the need for respite and, if so, is there a readily available resource?

Is there any other service or resource that could significantly stabilize or enhance this child's placement?

VII. Recommendations

****NOTE:** Remember to include recommendations for issues needing further follow-up through interview, record gathering, or cross-corroboration. In making recommendations for child and families, remember to consider racial, ethnic, and cultural considerations.

A. Parent Recommendations

Summary: Briefly summarize the information you have gathered on each parent as it relates to safety, well-being, and permanency. Address how the parent fits into the case, their contribution to the reason for involvement, and what factors need to be resolved in order to exit safely.

Using the CANS as a reference, give your clinical impressions. Pay specific attention to the following factors:

- Current Safety Threats
- Underlying Conditions which may contribute to risk.
- Protective Factors, Strengths and Resources which mitigate risk and can serve as the foundation for a strength-based service plan.
- Guidance for engaging/working with the client
Advice on establishing a working alliance with this client.
Any caveats or pitfalls you can foresee.

Service Recommendations

Present recommendations in order of priority; focusing first on current safety threats. Keep in mind that (unless contraindicated) the goal is remain intact/reunite.

Draw a clear distinction between services that are services which are prerequisite to this goal vs. those which can be seen as supporting an intact family or enhancing well-being.

When a child is in placement, divide your recommendations into the following categories:

Services essential to a safe reunification:

Services supportive to a reunited family:

Child Recommendations

Summary: Succinctly characterize each child and his/her clinical presentation. Comment on any special needs or vulnerabilities the child presents. Offer any guidance/caveats which could prove helpful in working with the child.

Note any strengths that can be developed to promote resilience or off-set vulnerability.

Use the CANS as a cross check on your summary.

Service Recommendations

Present in order of significance to child's safety and well-being.

Substitute Caregiver Recommendations

NOTE: For Placement cases only:

Provide an assessment of caregiver's ability to meet child's needs, promote reunification and/or permanency, and readiness to participate in shared-parenting activities with the parents.

Service Recommendations

Make any recommendations necessary to

- a. stabilize placement
- b. address child's needs more appropriately
- c. promote permanency and reunification.

Visitation Recommendation

NOTE: For Placement cases only:

Identify parent/child needs or concerns that should be taken into account in planning visitations.

Offer general guidance on optimal conditions for visitation, such as frequency, duration, location, and parties present.

When appropriate, provide guidance on parent-child Supportive Visitations.

Note whether parent is willing to participate in shared activities with substitute caregiver (e.g., physician appointments, school functions, supportive visitations).

Prognosis

This section should flow naturally from your clinical summary.

Identify which path is most appropriate for the family at this time:

1. Remain Intact and/or Recommend immediate reunification— safety threats related to current DCFS involvement have been successfully addressed and resolved. Parent demonstrates at least minimally adequate standards of parenting.
2. Early Reunification with family— safety threats related to current DCFS involvement have been successfully resolved and parent is cooperative and believed able to reach permanency within five months.
3. Reunification within 5–12 months.
4. Concurrent Planning
5. Expedited Termination.

Support your prognosis by citing information or behavioral observations reported in your assessment.

Comment on parents' ability/willingness to cooperate with services directed toward permanency outcome. Again, substantiate your opinion by summarizing data gathered in your assessment.

About Chapin Hall

Established in 1985, Chapin Hall is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities.

Chapin Hall's areas of research include child maltreatment prevention, child welfare systems and foster care, youth justice, schools and their connections with social services and community organizations, early childhood initiatives, community change initiatives, workforce development, out-of-school time initiatives, economic supports for families, and child well-being indicators.

