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Caseworker and Clinician Perspectives on Clinical Integration in Child and Family Team Meetings

Select Findings from the Evaluation of Clinical Integration in Child and Family Team Meetings

Overview of the Clinical Integration Child and Family Team Meeting Pilot Project (CI-CFTM)

CI-CFTM was an ambitious pilot project of the Immersion Sites, the Integrated Assessment team, DCFS Clinical, and the Juvenile Protective Association (JPA) evaluation team aimed at improving the clinical response to youth in lower levels of care who had significant histories of trauma and emotional and behavioral problems soon after youth entered care. Integration of skilled DCFS Clinical staff into early Child and Family Team Meetings (CFTMs) focused on providing more clinical support to caseworkers, youth, parents, and foster parents with the hope of preventing or reducing subsequent behavior problems and placement disruptions. The pilot aimed to infuse earlier clinical support for 4 to 17-year-old youth in lower levels of care (i.e., with relatives, fictive kin, or traditional foster parents) with complex trauma and high level of emotional/behavioral needs by involving DCFS clinical in early CFTMs. It was hoped that the increased attention to these cases would result in a high percentage of youth and families receiving CFTMs and the accompanying clinical consultation. The CI-CFTM was implemented in four counties across the state between July and December 2021.

Eligible cases were referred to CI-CFTM by the Integrated Assessment team at Northern Illinois University. Twenty-eight youth between the ages of 4-17 were included in the CI-CFTM pilot sample and had at least one CFTM during the pilot's trial period. There are a few challenges that the pilot highlighted. First, it took an average of 105 days after case opening for cases to be referred to CI-CFTM, making it impossible for DCFS Clinical to intervene as early as would have been ideal—when service plans were being developed. Second, workers and supervisors noted the lack of experienced workers, turnover, vacancies and high caseloads led to not scheduling CFTMs. And lastly, the rates of CFTM completion were no higher when the caseworker was a trained CFTM facilitator. JPA conducted a comprehensive evaluation of the CI-CFTM Pilot. It is important to note that despite high levels of commitment, CI-CFTMS were implemented in only 46% of eligible cases. As part of the evaluation caseworkers and clinical staff shared their perspectives on the pilot through case level surveys. In total, caseworkers on 11 of the 28 child cases and clinical staff on 16 of the 28 child cases completed surveys. In total 21 cases had a survey completed by either a caseworker or a clinical staff. This brief includes selected findings from the evaluation of clinical integration in child and family team meetings with a focus on the survey data.

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Caseworker Perspectives

In most cases the caseworkers rated the overall CFTM process as helpful (90%). In 55% of the cases the caseworkers reported mixed or neutral feelings regarding the satisfaction with the clinical support provided, where in 36% of the cases the caseworkers reported that they were somewhat or very satisfied with the clinical support. Across most of the cases the caseworkers found that clinical staff were helpful in supporting them in identifying services, supports, and facilitating connecting children with the services they needed.

Caseworkers found clinical staff helpful in identifying and helping to connect youth to services related to physical abuse, intimate partner violence, behavioral problems at school, psychotropic medication issues, and the lack of opportunities for fun and recreation. Caseworkers identified a wide range of barriers to service engagement. Waiting lists for services was the only barrier listed in a majority of cases. Other common barriers were a lack of services in the area and a lack of adequate transportation. Caseworkers rated clinical staff most helpful in the following areas a) demonstrating how youth's developmental needs and opportunities relate to functioning, b) describing youth's clinical needs, c) answering caseworkers questions, d) working collaboratively with caseworker to prepare CFTMs and e) identifying services matching youth's needs. Select comments from caseworkers reflecting the benefits and challenges to clinical integration into CFTMs are provided in Table 1.

Table 1. Selected Comments from Caseworker Survey

Benefits	Challenges
• *Provided extra support to the recommended services from the Integrated Assessment and was able to explain, brainstorming as to how to address the barriers, addressed task from prior meetings to make sure it was followed through.* • *They suggested services that I was not aware of.* • *Clinical helped the foster parents think outside of the box when it came to behaviors the youth were exhibiting.* • *It was nice to have extra support and a clinical perspective.* • *Having someone from the clinical staff explain mental health and services to not only the parents but also the caseworker.*	• *Action plans are cumbersome and should be completed by clinical staff.* • *Workers are new and have not completed CFTM training and don't know what to do.* • *DCFS clinical could have been more helpful when the case first opened and prior to the Integrated Assessment being completed.* • *DCFS clinical should know more about the case and know whether or the family has a history of involvement. If DCFS clinical knew of more involvement in the past it would provide more options to assist the family based on the past and present case.* • *The biggest barrier is a long waiting list and having foster parents take youth to services. This is not something that could be resolved by DCFS clinician.*

DCFS Clinical Staff Perspectives

Overall, most DCFS clinical staff thought the consultation they provided was "somewhat" or "very" helpful for 13 out of 17 items related to clinical helpfulness during CFTMs. DCFS clinical staff reported that almost all caseworkers and foster parents were very receptive to their input. These findings were somewhat surprising (and promising) given concerns about how stressed caseworkers are and the common view in the field that foster parents are often not receptive to input. Biological mothers were rated as somewhat to very receptive in most cases. While most supervisors were very receptive, 25% were seen as not receptive. Fathers and youth were only infrequently rated, suggesting lower participation in CFTMs. Select comments from DCFS clinical staff reflecting the benefits and challenges to clinical integration into CFTMs are provided in Table 2.

In interviews, the clinical staff highlighted that while they felt that this process was important there are underlying challenges to expanding the pilot. One key challenge is staffing. Placement teams are understaffed and overwhelmed due to severe resource constraints. This includes managing high caseloads, a lack of availability of all types of placements, and reduced availability of community-based services. This results in caseworkers who are focused on crisis management tasks (i.e. finding emergency placements) and regulatory tasks (i.e. reporting) and who may perceive clinical recommendations as an increased work burden. Also, as a result of understaffing, caseworkers may also not have the time or resources necessary to learn the psychoeducation related to their cases (e.g., the effects of trauma or clinical needs of youth). Limited staffing also results in delays in completing assessments and scheduling CI-CFTMs. Finally, high turnover means that new staff are often not sufficiently trained on key tasks such as effective strategies for making referrals.

Table 2. Selected Comments from DCFS Clinical Staff Survey

Benefits	Challenges
• *Education on trauma triggers, importance of continuing therapy and having community supports within the communities.* • *The agency caseworker needed additional support regarding what service referrals to make, understanding trauma responses, the referral process for community services, education on what community services are available, etc.* • *The clinical coordinator was able to share some trauma education to the relative foster parents and provide additional training opportunities and resources.* • *CFTM's helped with communication, service referrals, identifying service options in the community, and providing relationship building between the biological parents and foster parents.* • *The CFTMs were helpful: with team members being able to communicate with each other; accountability to ensure referrals were completed; problem solve barriers as they came up; discuss available service options and what issues services could address; provide opportunities for extra-curricular activities for the youth.*	• *Service referrals need to be made as soon as possible from case opening to address trauma history and help keep placements stable.* • *Three follow up staffings is a lot. It was hard to get everyone together monthly for four months straight.* • *One team never scheduled the staffing after several follow up attempts and the intervention of the Clinical Manager to explain the process. All three (caseworkers) were unclear about why their case was referred and had some difficulty understanding what they needed to do.* • *I think this project needs better clarification with the field. Moreover, when the Integrated Assessment provides wonderful recommendations, it is not clear to the field what more is needed.* • *The first CFTM was not scheduled until approximately three months after case opening and service referrals had not been made for the identified youth for the pilot.*

Conclusion

CI-CFTM was a good example of positive coordination and communication across DCFS departments and partners. Both the IA team and DCFS Clinical mangers and staff, who were brought into the project after its initial formulation, were strongly and actively supportive of the project and its implementation, despite their own staffing challenges. Both caseworkers and clinical staff found the consultation helpful for a) preparing for the CFTM, b) providing psychoeducation to participants on the clinical needs of the youth, c) engaging participants in services or supports, d) service matching and referral linkage, e) promoting therapeutic responses to the youth, and f) addressing individualized needs in the case.

When CFTMs actually occurred, both caseworkers and DCFS Clinical usually found the consultation and the CFTM to be somewhat to very helpful in preparing for the CFTM, providing psychoeducation to participants about the clinical needs of youth, engaging participants in services or supporting services, service matching and referral linkage, promoting therapeutic responses to youth, and addressing individualized needs in the case. Interestingly, and somewhat unexpectedly, DCFS Clinical staff reported that almost all caseworkers and foster parents were very receptive to their input. This highlighted both the skill of the Clinical team and the need caseworkers and foster parents have for support. Both caseworkers and DCFS Clinical frequently identified school behavior issues, psychotropic medication issues, and the need for recreation and fun. Given these common concerns, and a wonderful interest in supporting strengths-based services and supports, it may be helpful for DCFS Clinical and others to develop appealing psychoeducational material, case studies, and resource guides that help supervisors and frontline caseworkers support youth and foster parents more effectively in these areas.

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