



Results of the Illinois DCFS Rate Assessment Survey of Clinical Assessment Providers

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This survey aimed to gather valuable data regarding the implementation of clinical assessments for children and youth under the care of the Illinois Department of Children and Family Services (DCFS). This data collection aimed to inform rate structures and develop support services for clinical assessment providers. The survey focuses on gathering information about the clinical providers' experiences conducting clinical assessments, including the average time spent on each assessment. The survey also assessed factors that may influence the time required to complete clinical assessments and any recommended supports that could enhance the quality and efficiency of assessments for children and youth served by the Illinois DCFS. Additionally, survey respondents were invited to recommend support to enhance the quality and efficiency of clinical assessments for children and youth under the care of the Illinois DCFS. For additional information or questions about this survey, contact Dr. Heather Fox at hlfox2@illinois.edu.

Survey Development, Collection, and Analysis

The survey was developed based on a request of the Chief Psychologist, Dr. Erin Alexander, of the Division of Clinical and Child Services. Dr. Alexander provided subject matter expertise and expert review for the survey, and she facilitated a small pilot of the instrument with a group of consultants familiar with the clinical practice of the target population. See Appendix A for the survey instrument.

The survey was administered from May 10, 2023, to June 1, 2023. Survey data were collected through Qualtrics, an online survey platform. The population for this survey was all providers of clinical assessments for children and youth under the care of DCFS, henceforth referred to as clinical providers. The Division of Clinical and Child Services provided a list of 115 providers, their emails, and regional associations. Email invitations to participate in the survey were sent directly to all clinical providers, with additional reminder emails sent to those who had yet to participate approximately one week and two weeks after the initial invitation.

A total of 45 clinical providers participated in the survey. Seven of these responses were removed due to insufficient data, resulting in a survey sample of 38 clinical providers and a response rate of 33% (Table 1). Specifically, responses that did not provide their experience with the clinical assessments they used were removed from the sample.

An analysis of the sample by region shows that the sample did not reflect the regional distribution of clinical providers in the state. Table 1 shows the ratios of clinical providers by region. A chi-squared goodness of fit test was performed to determine whether the proportion of clinical providers was equal between the sample and population by region. The proportions differed significantly by region, $X^2(3, 115) = 28.56, p < .001$. Clinical providers in Cook County were unrepresented in the sample (0.7 times the anticipated rate). Southern and Central were overrepresented at 2.6 times and 1.7 times the anticipated rate.

Table 1***Survey Response Rate and Regional Analysis***

DCFS Region	Survey Invitations Sent		Surveys Completed		Response Rate	Ratio of Invitations Sent to Completed
	N	%	n	%	%	
Central	16	13.9	9	23.7	56.3	1.71
Cook	77	67.0	17	44.7	22.1	0.67
Northern	15	13.0	6	15.8	40.0	1.22
Southern	7	6.1	6	15.8	85.7	2.59
Total	115	100	38	100	33.0	-

Description of the Sample

The sample identified as predominately women (75%) and white (83%) (Table 2). White women comprised 64% of the sample, and white men comprised 19% of the sample. The sample included two men and four women who did not identify as white. These include one man and two women who identified as Black or African American, one man and one woman who identified as Latinx, and one woman who identified as American Indian or Alaska Native. There were no respondents who identified as a) Asian, South Asian, Southeast Asian, b) Middle Eastern, North African (MENA), c) Native Hawaiian or Other Pacific Islander, or d) Other.

Thirty-five respondents reported their highest level of education (Table 3). The majority of respondents (86%) reported obtaining a doctoral degree, and five individuals reported achieving a master's degree. Among the respondents, none reported a bachelor's degree as their highest level of education.

The survey respondents were asked, "How many years of experience do you have conducting clinical assessments (including, but not limited to, those completed for Illinois DCFS)?" More than half of the sample (63%) indicated they have over 15 years of experience, and a fifth (21%) indicated that they have between 5 to 9 years of experience (Table 4). The remaining 16% were split between less than five years of experience and 10 to 14 years of experience. Over three-quarters (77%) of the clinicians who complete parenting capacity assessments had 15-plus years of experience conducting clinical assessments. Only one of these respondents had under five years of experience. Most (65%) of the clinicians who complete psychological evaluations had 15-plus years of experience conducting clinical assessments. About one-fifth of these clinicians (19%) reported having between 5 and 9 years of experience. A slightly smaller proportion (57%) of those clinicians who complete neuropsychological evaluations had 15-plus years of experience, with just under a third (29%) having between 5 and 9 years of experience.

Table 2***Respondents' Race/Ethnicity and Gender***

Race/Ethnicity ¹	Men		Women		Total	
	Count	%	Count	%	Count	%
American Indian or Alaska Native	0	0	1	2.8	1	2.8
Black or African American	1	2.8	2	5.6	3	8.3
Hispanic, Latino, Latina, Latinx, or Spanish origin	1	2.8	1	2.8	2	5.6
White	7	19.4	23	63.8	30	83.3
Total	9	25.0	27	75.0	36	100

1. There were no respondents in the sample who identified as a) Asian, South Asian, Southeast Asian, b) Middle Eastern, North African (MENA), c) Native Hawaiian or other Pacific Islander, or d) other.

Table 3***Respondents' Education level***

Highest Education Level	Count	%
Bachelor's degree (for example, BA, BS)	0	0
Master's degree (for example, MA, MS, MEng, MSW, MBA)	5	14.3
Doctoral Degree (for example, EdD, PhD, PsyD)	30	85.7
Total	35	100

Table 4***Respondents' Years of Experience in Conducting Clinical Assessments at Illinois DCFS***

Years of Experience	All Respondents		Parenting Capacity Assessment		Psychological Evaluation		Neuropsychological Evaluation	
	Count	%	Count	%	Count	%	Count	%
Less than 5 years	3	7.9	1	7.7%	2	6.5%	1	14.3%
5 to 9 Years	8	21.1	2	15.4%	6	19.4%	2	28.6%
10 to 14 years	3	7.9	0	0.0%	3	9.7%	0	0.0%
Over 15 years	24	63.2	10	76.9%	20	64.5%	4	57.1%
Total	38	100	13	100.0%	31	100.0%	7	100.0%

Respondents were asked, "What language(s) do you provide clinical assessments for the Illinois Department of Children and Family Services?" and instructed to select all that apply (Table 5). They were provided with 13 language choices and the option to select and specify other languages. Only those languages where at least one clinician conducts clinical assessments were included in Table 5. The majority of respondents (31, 94%) reported conducting assessments in English, making it the most commonly used language for providing clinical assessments. Five

respondents indicated proficiency in Spanish, indicating that a significant portion of clinical assessments were conducted in this language. Two of the five who provide assessments in Spanish did not indicate that they provide assessments in English. One respondent indicated that they provided clinical assessment in all thirteen provided languages. This may reflect a practice of utilizing an interpreter for assessments that involve a client whose language is not English. One clinician indicated that they conduct assessments in four languages: English, Spanish, Russian, and Ukrainian.

Table 5
Languages for Providing Clinical Assessments for the Illinois Department of Children and Family Services (select all that apply, n = 33)

Languages	Count
English	31
Spanish	5
Russian	2
Arabic	1
Cantonese	1
Gujarati	1
Greek	1
Hindi	1
Italian	1
Mandarin	1
Polish	1
Tagalog	1
Urdu	1
Other (Ukrainian)	1

Clinical Assessment Types

Respondents were asked, “What types of assessments are you approved to complete for Illinois DCFS?” They were provided with three types of assessments a) parenting capacity assessments, b) psychological evaluation, and c) neuropsychological, and instructed to select all that apply. Among the respondents, 31 (81.6%) reported being approved to conduct Psychological Evaluations, 13 (34.2%) indicated being approved to conduct Parenting Capacity Assessments, and 7 (18.4%) reported being approved to conduct Neuropsychological Evaluations (Table 6). Also, 13 providers (34.2%) reported that they approved to complete two types of assessments. All of these were providers who conducted psychological and other evaluations. In total, 42% of the providers who provide psychological evaluations also provide either parenting capacity assessments (22.6%) or neuropsychological evaluations (19.6%).

Table 6

Crosstab of Types of Assessments Completed by Survey Respondents (n = 38)

Assessment Type	Parenting Capacity Assessment		Psychological Evaluation		Neuropsychological Evaluation		Total of Sample	
	Count	%	Count	%	Count	%	Count	%
Parenting Capacity Assessment	6	46.2	7	53.8	0	0	13	34.2
Psychological Evaluation	7	22.6	18	58.1	6	19.6	31	81.6
Neuropsychological Evaluation	0	0	6	85.7	1	14.3	7	18.4

We then asked respondents how long they had been conducting each type of clinical assessment for Illinois DCFS (Table 7). Among the respondents who conducted parenting capacity assessments ($n = 13$), five respondents (40%) had over 15 years of experience, and four (31%) had less than five years of experience. Among the respondents who conducted psychological evaluations ($n = 29$), 14 respondents (48%) had over 15 years of experience, with nine respondents (31%) having 5 to 9 years of experience. Among the respondents who conducted neuropsychological evaluations ($n = 6$), four respondents (67%) had less than five years of experience, and the remaining two (33%) had 15-plus years of experience.

Table 7**Respondents' Years of Experience Conducting Each Assessment Type for Illinois DCFS**

Years of Experience	Parenting Capacity Assessment		Psychological Evaluation		Neuropsychological Evaluation	
	Count	%	Count	%	Count	%
Less than 5 years	4	30.8	6	20.7	4	66.7
5 to 9 years	2	15.4	9	31.0	0	0
10 to 14 years	2	15.4	0	0	0	0
15+ years	5	39.5	14	48.3	2	33.3
Total	13	100	29	100	6	100

Clinical Assessment Tools

Respondents were asked, “What assessment tools are you trained to use for clinical assessments that you completed for DCFS?” They were provided with a listing of nine groupings (i.e., sets) of assessment tools, reflecting a total of 44 individually named assessment tools and other, of which they could specify. They were instructed to select all that apply. Among the 36 respondents who answered this question, the mean number of assessment tools for which the clinicians were trained was 18 (Table 8, $SD = 8.77$, range 1 - 43). However, there is a notable difference across the clinicians who do different assessment types.

Clinicians who conduct parenting capacity assessments indicated that they are trained to use between one and 23 assessments tools, for an average of 13 tools ($SD = 8.01$), as compared to clinicians who conduct psychological evaluations who indicated they are trained to use 7 – 43 assessment tools, with an average of 20 tools ($SD = 7.69$).

Not surprisingly, the seven clinicians who provide neuropsychological evaluations indicated being trained to use notably higher numbers of assessment tools. These clinicians indicated they are trained to use between 16 and 43 assessment tools, with an average of 27 tools ($SD = 8.86$). This is also reflected in the breadth of assessment toolsets utilized by clinicians who complete neuropsychological assessments. Nearly all of these clinicians utilized at least one tool in each of the nine assessment toolsets in this survey (Table 9). The exceptions were behavioral rating scales (86%) and language functioning tests (71%). Clinicians who completed psychological evaluations also utilized tools from most tool sets; however, less frequently than those completing neuropsychological assessments in most cases (the exception is behavioral rating scales, 90% versus 86%). Compared to clinicians completing neuropsychological assessments or psychological evaluations, a much smaller percentage of clinicians completing parenting capacity assessments utilized individual tools from every assessment tool set.

Table 8***Average Number of Assessment Tools Clinicians are Trained to Use for Clinical Assessments by Assessment Type***

Assessment Type	Count	Range	Mean	SD
Neuropsychological Evaluation	7	16 – 43	27.1	8.86
Psychological Evaluation	31	7 – 43	19.9	7.69
Parenting Capacity Assessment	11	1 – 23	12.9	8.01
Total	36	1 – 43	18.2	8.77

Table 9***Percent of Clinicians who Utilize at Least One Tool in Each Assessment Tool Set by Assessment Type***

Standardized Tests or Battery for...	Parent Capacity Assessment (n = 13)		Psychological Evaluation (n = 31)		Neuropsychological Evaluation (n = 7)	
	Count	%	Count	%	Count	%
Achievement	6	46.2%	30	96.8%	7	100.0%
Adaptive Functioning	8	61.5%	31	100.0%	7	100.0%
Behavioral Rating Scales	10	76.9%	28	90.3%	6	85.7%
Executive Functioning	5	38.5%	22	71.0%	7	100.0%
Intellectual and Cognitive Functioning	8	61.5%	31	100.0%	7	100.0%
Memory Functioning	7	53.8%	25	80.6%	7	100.0%
Language Functioning	1	7.7%	5	16.1%	5	71.4%
Neuropsychological Functioning	2	15.4%	15	48.4%	7	100.0%
Personality and Emotional Functioning	10	76.9%	31	100.0%	7	100.0%

Nearly all respondents (97%) indicated that they are trained to use assessment tools under the standardized tests for personality and emotional functioning (Table 10). Among this set of tools, the Minnesota Multiphasic Personality Inventory (92%), the Beck Depression Inventory (89%), and the Personality Assessment Inventory (81%) were common assessment tools for clinical providers to be trained to use. The assessment tools that were part of standardized tests for intellectual and cognitive functioning and standardized tests for adaptive functioning also were selected by more than 90% of participants. The Wechsler Adult Intelligence Scale (89%) and the Wechsler Intelligence for Children (WISC, 86%) were the two most commonly selected assessment tools under the standardized tests for intellectual and cognitive functioning. The Vineland Adaptive Behavior Scale (VABS, 78%) was the most commonly selected assessment tool under standardized tests for intellectual and cognitive functioning. Standardized tests for

achievement and standardized behavior rating scales were selected by 86% of the clinical providers in the survey, with the Wide Range Achievement Test (WRAT-5, 86%) and the Connors Assessments (75%) being the most common in each group, respectively. Three-quarters (75%) of respondents selected at least one assessment tool under Standardized tests for Memory Functioning, with the Wechsler Memory Scale (69%) being the most common tool in this set. Nearly 64% of clinical providers selected at least one assessment under Standardized tests for Executive Functioning, with the Trail Making Test (61%) being the most common tool in this set.

Nineteen respondents specified 93 other assessment tools they are trained to use for DCFS clinical assessments. Four respondents each specified the following assessments under other, Autism Diagnostic Observation Schedule, MCMI-V, and SRS-2. Three respondents each specified the following assessment: CAPS, Connors CPT, MACI-II, Rorschach Inkblot Test, SASSI-4, and Trauma Symptom Checklist for Children. See Appendix B for the complete list of assessment tools specified under other.

Less than half of the respondents utilized standardized battery for neuropsychological functioning (44%) and standardized tests for language functioning (17%). The NEPSY (a developmental neuropsychological assessment) was the most common neuropsychological functioning assessment tool used (36%), and the Boston Naming Test (17%) was the most common language functioning assessment tool.

Table 10

Assessment Tools used by Clinical Providers Are Trained to use for Clinical Assessments Completed for DCFS (Select all that apply, n = 36)

Assessment Tools	Count	%
Standardized Tests for Personality and Emotional Functioning	35	97.2
Minnesota Multiphasic Personality Inventory	33	91.7
Beck Depression Inventory	32	88.9
Personality Assessment Inventory	29	80.6
Rotter Incomplete Sentences Blank	21	58.3
Standardized Tests for Intellectual and Cognitive Functioning	33	91.7
Wechsler Adult Intelligence Scale	32	88.9
Wechsler Intelligence for Children (WISC)	31	86.1
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	22	61.1
Woodcock-Johnson Tests of Cognitive Abilities (WJ)	16	44.4
Stanford–Binet Intelligence Scale (SB)	13	36.1
Kaufman Assessment Battery for Children (KABC)	11	30.6
Differential Abilities Scale (DAS)	3	8.3
Standardized Tests for Adaptive Functioning	33	91.7
Vineland Adaptive Behavior Scale (VABS)	28	77.8
Adaptive Behavior Assessment System (ABAS)	25	69.4
Woodcock-Johnson Scales of Independent Behavior	7	19.4
Standardized Tests for Achievement	31	86.1

Wide Range Achievement Test, 5th Ed. (WRAT-5)	31	86.1
Wechsler Individual Achievement (WIAT)	23	63.9
Woodcock-Johnson Tests of Achievement (WJ)	16	44.4
Kaufman Test of Educational Achievement (KTEA)	14	38.9
Peabody Individual Achievement Test (PIAT-R)	9	25.0
Standardized Behavior Rating Scales	31	86.1
Connors instruments: Connors Rating Scales (CRS), Connors Adult AD/HD Rating Scales (CAARS)	27	75.0
Achenbach Scales, including Child Behavior Checklist (CBCL), Caregiver-Teacher Report Form (C-TRF), Teacher Report Form (TRF), Youth Self-Report (YSR), Adult Behavior Checklist (ABCL), Adult Self-Report (ASR)	22	61.1
Behavior Assessment System for Children (BASC-2)	21	58.3
ADHD Rating Scale-IV	10	27.8
Attention Deficit Disorders Evaluation Scale (ADDES)	9	25.0
ADD-H Comprehensive Teacher Rating Scale (ACTeRS)	5	13.9
Burk's Behavior Rating Scales (BBRS)	3	8.3
Behavior Rating Profile (BRP-2)	2	5.6
Social-Emotional Dimension Scale (SEDS-2)	2	5.6
Standardized Tests for Memory Functioning	27	75.0
Wechsler Memory Scale	25	69.4
California Verbal Learning Test	8	22.2
Benton Visual Retention Test	7	19.4
Rey Auditory Verbal Learning Test	6	16.7
Standardized Tests for Executive Functioning	23	63.9
Trail Making Test	22	61.1
Wisconsin Card Sort	14	38.9
Stroop Task	14	38.9
Other¹	19	52.8
Other	19	52.8
Standardized Battery for Neuropsychological Functioning	16	44.4
NEPSY	13	36.1
Repeatable Battery for the Assessment of Neuropsychological Status	7	19.4
Neuropsychological Assessment Battery	5	13.9
Luria-Nebraska Neuropsychological Battery	4	11.1
Standardized Tests for Language Functioning	6	16.7
Boston Naming Test	6	16.7
Comprehensive Aphasia Test	5	13.9
Boston Diagnostic Aphasia Examination	4	11.1

1. Respondents specified an additional 96 different assessment tools under other. Please see Appendix B for a complete list of assessment tools specified under other.

Experiences Conducting Different Assessment Types

This section of the survey used display logic to ask respondents about their experiences conducting each type of assessment they do for Illinois DCFS (parental capacity assessments, psychological evaluations, and neuropsychological evaluations) (see Table 5). Respondents were asked when they had completed the most recent assessment by assessment type (parenting capacity assessments, psychological evaluation, and neuropsychological evaluation, see Table 11). They were also asked, on average, how many of each assessment type they completed for Illinois DCFS in a month (Table 12). Finally, they were asked to estimate the total hours they spent on each assessment by type for both an average case and a complex case (Table 13). This includes reviewing documentation, collateral interviews, conducting the assessment, scoring and analysis, and report writing.

About two-thirds (69%) of the clinicians who complete parenting capacity assessments within the last two weeks, and they complete an average of one to two parenting capacity assessments monthly (67%). However, one respondent indicated that, on average, they complete an average of five or more parenting capacity assessments per month. Clinicians indicated that parenting capacity assessment on an average case takes 6 – 20 hours for a mean of 12.3 hours ($SD = 3.39$). Complex cases took longer, reflecting between 10 – 30 hours of work for a mean of 17.4 hours ($SD = 5.33$).

Just under half (45%) of the clinicians who complete psychological evaluations completed their most recent psychological evaluation more than six weeks before taking the survey. About a third (35%) of these clinicians had completed a psychological evaluation within the last two weeks. About two-thirds of these clinicians completed one to two monthly psychological evaluations. However, three clinicians indicated that they completed an average of five or more psychological evaluations monthly. Clinicians indicated that, for an average case, a psychological evaluation takes between 6 – 30 hours for a mean of 14.5 hours ($SD = 6.69$). Compared to average cases, complex cases took longer, specifically between 10 – 50 hours of work, for a mean of 21.2 hours ($SD = 10.98$).

Half (50%) of the clinicians who complete neuropsychological evaluations indicated their most recent neuropsychological evaluation within the last two weeks before completing the survey. Most (83%) of these clinicians reported completing an average of one to two neuropsychological evaluations monthly. However, one clinician indicated that they completed an average of five or more neuropsychological evaluations per month. Clinicians indicated that, for an average case, a neuropsychological assessment takes between 6 – 30 hours for a mean of 14.3 hours ($SD = 8.33$). Compared to average cases, complex cases took longer to complete, specifically between 6 – 40 hours of work for a mean of 19 hours ($SD = 11.01$).

Table 11*Most Recent Assessments Completed Clinicians by Type of Assessments*

Length of Time Since Last Assessment	Parenting Capacity Assessment		Psychological Evaluation		Neuropsychological Evaluation	
	Count	%	Count	%	Count	%
Within the last two weeks	9	69.2	10	34.5	3	50.0
2 to 4 weeks ago	2	15.4	2	6.9	1	16.7
5 to 6 weeks ago	2	15.4	4	13.8	1	16.7
More than 6 weeks	0	0	13	44.8	1	16.1
Total	13	100	29	100	6	100

Table 12*Average Number of the Assessments Completed Monthly by Assessment Type*

Average Number of Assessments per Month	Parenting Capacity Assessment		Psychological Evaluation		Neuropsychological Evaluation	
	Count	%	Count	%	Count	%
1 – 2 per month	8	66.7	16	64.0	5	83.3
3 – 4 per month	3	25.0	6	24.0	0	0
5+ per month	1	8.3	3	12.0	1	16.7
Total	12	100	25	100	6	100

Table 13*Estimated Number of Hours Spent on Each Assessment by Type of Assessment and Complexity of the Case*

Complexity of the Case	Parenting Capacity Assessment				Psychological Evaluation				Neuropsychological Evaluation			
	Count	Mean	SD	Range	Count	Mean	SD	Range	Count	Mean	SD	Range
An average case	12	12.3	3.39	6 - 20	30	14.5	6.69	6 - 30	6	14.3	8.33	6 - 30
A complex case	12	17.4	5.33	10 -30	29	21.2	10.98	10 -50	6	19.0	11.01	6 - 40

Factors in the Length of Time to Complete Assessments for Complex Cases

Respondents were asked what factors most affected the time it takes to complete each assessment type for complex cases (Table 14). The survey provided four factors and the option to specify other factors, and respondents were instructed to select the top two factors. Across the three assessment types, the top two factors expressed by 54% - 100% of respondents were: 1) writing the report is more time-consuming for complex cases, and 2) document review and preparation takes more time for complex cases. Four clinicians who completed parenting capacity assessments selected other and specified the following factors:

All of the above can come into play in more complex cases.

Communication and follow-through by POS agencies/case workers are major barriers to writing these reports.

I would like a simple answer. However, data for visitations, recent records, and or reports for services are often missing or outdated by more than a year, and previous diagnoses need to be well documented or are inadequate. Some of the more complex cases indicate clients who have, frankly, mixed personality diagnoses [styles] where they fluctuate in presentation and compliance and present with muddled symptoms. These clients, while intellectually astute, tend to require more information from collaterals and their attendant diagnoses. Because they are so well defended, they may take 4 hours or more just trying to obtain coherent information, and these (as well as some others) also often require research regarding the complex symptoms, evidenced-based treatment, and/or additional records.

Location of visits for observation (coordination)

Four clinicians who completed psychological evaluations selected other and specified the following factors:

Psychological evaluations for children and adolescents take longer due to the need to complete behavioral/ social-adaptive assessments.

All of the above can come into play in more complex cases.

Collateral interviews.

Some children and adolescents have substantial documentation/ records to review and synthesize. For example, I once had a child with agenesis of the corpus callosum,¹ and she had 1250 pages of medical documentation to comb through. Another adolescent with emerging schizophrenia had over 500 pages of psychiatric hospitalization records. A majority of our children present with

¹A failure to properly develop the white matter tract in the brain that connects the two brain hemispheres.

comorbid issues such as FASDs,² trauma, multiple neurodevelopmental disorders, and mood and anxiety disorders, all of which need detailed descriptions and recommendations.

One clinician who completes neuropsychological evaluations selected other and specified the following factor:

Similar issues as noted on the last page regarding documentation/record review, comorbid diagnoses, and more tests administered for neuropsychological evaluations.

Table 14

Factors that Most Effect Length of Time on Case for Complex Cases by Assessment Type

Factors Affecting Time on Case¹	Parenting Capacity Assessment (n = 13)		Psychological Evaluation (n = 30)		Neuropsychological Evaluation (n = 6)	
	Count	%	Count	%	Count	%
Writing the report is more time-consuming for complex cases.	12	92.3	22	73.3	6	100.0
Document review and preparation take more time for complex cases.	7	53.8	23	76.7	6	100.0
It takes more time to complete the assessment process/tools for complex cases.	5	38.5	15	50.0	2	33.3
Coordination with other professionals is more time-consuming for complex cases.	5	38.5	10	33.3	1	16.7
Other ²	4	30.8	4	13.3	1	16.7

1. Respondents were instructed to select up to two factors.
2. See the text for a complete listing of other factors specified by clinicians.

Intellectual and Developmental Disabilities (IDD) Evaluations or Autism Spectrum Disorder (ASD) Evaluations

All respondents were asked, "Do you complete either Intellectual and Developmental Disabilities Evaluation or Autism Spectrum Disorder Evaluations?" Out of the total 35 respondents, 15

² FASD is a diagnostic term for severe neuropsychological impairments associated with fetal alcohol spectrum disorders (FASD).

(42.9%) indicated that they do not complete IDD or ASD evaluations (Table 15). Just under half (46%) indicated that they completed both IDD and ASD evaluations. Four respondents (11%) indicated that they completed IDD evaluations but not ASD evaluations. None of the respondents indicated that they completed ASD but not IDD evaluations.

Table 15

Completion of Intellectual and Developmental Disabilities (IDD) and Autism Spectrum Disorder (ASD) Evaluations

	Count	%
Do not complete either IDD or ASD evaluations	15	42.9
Complete both IDD and ASD evaluation	16	45.7
Completes IDD evaluations only	4	11.4
Complete ASD evaluations only	0	0
Total	35	100

Clinicians were then asked how long they had completed IDD or ASD evaluations (Table 16). The largest proportion of both clinicians who completed IDD (44%) and ASD (39%) evaluations indicated that they had been conducting these evaluations for 15-plus years, followed by 5 – 9 years (IDD, 28%, and ASD, 31%).

Table 16

Years of Experience Conducting Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorder (ASD) Evaluations Type for Illinois DCFS

Years of Experience	IDD		ASD	
	Count	%	Count	%
Less than 5 years	3	16.7	3	23.1
5 to 9 years	5	27.8	4	30.8
10 to 14 years	2	11.1	1	7.7
15+ years	8	44.4	5	38.5
Total	18	100	13	100

Of the clinicians who completed IDD or ASD evaluations, equal proportions had completed an IDD (39%) or ASD (39%) evaluation between 2 to 4 weeks before the time of the survey (Table 17). About 39% of the clinicians who completed IDD evaluations indicated that their most recent IDD evaluation was more than six weeks before taking the survey. Less than a quarter (IDD 17%, ASD 23%) indicated that they had completed an IDD (17%) or ASD (23%) evaluation within the last two weeks. Three-quarters (73%) of clinicians who complete IDD evaluations indicated that they complete an average of 1 – 2 IDD evaluations monthly (Table 18). The next most common response for these clinicians was 3 – 4 per month (20%). Most (92%) of clinicians who conduct Autism Spectrum Disorder evaluations indicated that they completed 1 – 2 evaluations per month.

Table 17***Most Recent Intellectual and Developmental Disabilities (IDD) and Autism Spectrum Disorder (ASD) Evaluations Completed***

Length of Time Since Last Assessment	IDD		ASD	
	Count	%	Count	%
Within the last two weeks	3	16.7	3	23.1
2 to 4 weeks ago	7	38.9	5	38.5
5 to 6 weeks ago	1	5.6	2	15.4
More than 6 weeks ago	7	38.9	3	23.1
Total	18	100	13	100

Table 18***Average Number of Intellectual and Developmental Disabilities (IDD) and Autism Spectrum Disorder (ASD) Evaluations Completed***

Average Number of Evaluations per Month	IDD		ASD	
	Count	%	Count	%
1 – 2 per month	11	73.3	11	91.7
3 – 4 per month	3	20.0	0	0
5+ per months	1	6.7	1	8.3
Total	15	100	12	100

Clinicians indicated that IDD evaluation on an average case takes between 5 – 20 hours for a mean of 12.1 hours ($SD = 6.09$, Table 19). Compared to average cases, complex cases took longer, specifically between 8 – 40 hours of work, for a mean of 16.2 hours ($SD = 8.92$). Clinicians indicated that ASD evaluation on an average case takes between 7 – 25 hours for a mean of 14.2 hours ($SD = 6.34$). Compared to average cases, complex cases took longer, specifically between 10 – 40 hours of work, for a mean of 19.1 hours ($SD = 9.37$).

Table 19***Estimated Number of Hours Spent on Each Intellectual and Developmental Disabilities (IDD) and Autism Spectrum Disorder (ASD) Evaluation by Complexity of the Case***

Complexity of the Case	IDD				ASD			
	Count	Mean	SD	Range	Count	Mean	SD	Range
An average case	17	12.1	6.09	5 - 25	13	14.2	6.34	7 - 25
A complex case	16	16.2	8.92	8 - 40	12	19.1	9.37	10 - 40

Factors in the Length of Time to Complete Assessments for Complex Cases

Respondents were asked, “what factors most affect the length of time it takes (in total hours) to complete (IDD or ASD) for complex cases?” Clinicians completing IDD evaluations indicated that the top factor in extending the time involved in completing complex IDD evaluations is that writing the report is more time-consuming for complex cases (65%). Among IDD evaluations of complex cases, the second most frequent factor contributing to longer timeframe was the time it takes to document review and prepare for the evaluation (53%, Table 20). Similarly, the most prevalent factor that affected the time involved in a complex ASD evaluation was cited as the additional time necessary to write the report. The second most common factor extending the time spent on complex ASD evaluations is the additional time spent with the assessment process.

Table 20***Factors that Most Affect Length of Time on Case for Complex Cases by Evaluation Type***

Factors Affecting Time on Case	IDD (n = 17)		ASD (n = 13)	
	Count	%	Count	%
Writing the report is more time-consuming for complex cases	11	64.7	9	69.2
Document review and preparation take more time for complex cases.	9	52.9	6	46.2
It takes more time to complete the assessment process/tools for complex cases.	7	41.2	9	69.2
Coordination with other professionals is more time-consuming for complex cases.	8	47.1	4	30.8
Other ¹	2	11.8	2	15.4

1. Please see the text for a complete listing of other factors specified by clinicians.

Tools Included in the Typical Battery by Clinical Providers Conducting Autism Spectrum Disorder Evaluations

Respondents were asked, what is the typical battery of tests that you use to assess for and diagnose Autism Spectrum Disorder? They were instructed to select all that apply. The fourteen respondents who answered this question indicated they completed 5 – 14 assessment tools, averaging 8.7 tools ($SD = 2.79$). All of them included Standardized tests for Intellectual and Cognitive Functioning and Standardized tests for Adaptive Functioning as part of the typical battery of tests (Table 21). Among these tool sets, the most common assessment tools included were the Wechsler Adult Intelligence Scale (93%), the Wechsler Intelligence for Children (WISC, 93%), and the Adaptive Behavior Assessment System (ABAS, 71%). Four other tools were included in a typical battery of tests for more than half of this set of clinicians they were: a) the Behavior Assessment System for Children (BASC-2, 64%), b) the Connors instruments (57%), c) Vineland Adaptive Behavior Scale (VABS, 57%), and d) Wechsler Preschool and Primary Scale of Intelligence (WPPSI). Over half of the clinicians who complete ASD evaluations specified additional assessment tools that they include in the typical battery of tests for ASD; these are listed in Appendix B.

Table 21

Tools Included in the Typical Battery for by Clinical Providers Conducting Autism Spectrum Disorder (ASD) Evaluations (n = 14)

Assessment Tools	Count	%
Standardized Tests for Intellectual and Cognitive Functioning	14	100
Wechsler Adult Intelligence Scale	13	92.9
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	7	50.0
Wechsler Intelligence for Children (WISC)	13	92.9
Stanford–Binet Intelligence Scale (SB)	2	14.3
Standardized Tests for Adaptive Functioning	14	100
Woodcock-Johnson Scales of Independent Behavior	2	14.3
Vineland Adaptive Behavior Scale (VABS)	8	57.1
Adaptive Behavior Assessment System (ABAS)	10	71.4
Standardized Behavior Rating Scales	13	92.9
Achenbach Scales: Child Behavior Checklist (CBCL), Caregiver-Teacher Report Form (C-TRF), Teacher Report Form (TRF), Youth Self-Report (YSR), Adult Behavior Checklist (ABCL), Adult Self-Report (ASR)	3	21.4
Behavior Assessment System for Children (BASC-2)	9	64.3
Connors instruments: Connors Rating Scales (CRS), Connors Adult AD/HD Rating Scales (CAARS)	8	57.1
Attention Deficit Disorders Evaluation Scale (ADDES)	1	7.1
ADD-H Comprehensive Teacher Rating Scale (ACTeRS)	1	7.1
ADHD Rating Scale-IV	1	7.1
Standardized Tests for Personality and Emotional Functioning	9	64.3
Rotter Incomplete Sentences Blank	4	28.6

Beck Depression Inventory	1	7.1
Minnesota Multiphasic Personality Inventory	3	21.4
Personality Assessment Inventory	4	28.6
Standardized Tests for Achievement	8	57.1
Wechsler Individual Achievement Test (WIAT)	4	28.6
Kaufman Test of Educational Achievement (KTEA)	2	14.3
Woodcock-Johnson Tests of Achievement (WJ)	1	7.1
Wide Range Achievement Test, 5th Ed. (WRAT-5)	5	35.7
Other¹	8	57.1
Standardized Tests for Memory Functioning	4	28.6
California Verbal Learning Test	1	7.1
Wechsler Memory Scale	4	28.6
Standardized Battery for Neuropsychological Functioning	3	21.4
NEPSY	3	21.4
Standardized Tests for Executive Functioning	2	14.3
Wisconsin Card Sort	2	14.3
Trail Making Test	2	14.3

1. Respondents specified an additional 30 different assessment tools under other. Please see Appendix B for a complete listing of assessment tools specified as other.

Comments and Recommended Improvements for Billing and Rate Structure for Clinical Assessment Providers Serving Children and Families under Illinois DCFS

Respondents were asked, “Please share any comments or recommended improvements you have about the current billing or rate structure used to pay clinical assessment providers for children and families served by Illinois DCFS.” No clinicians from Southern region responded to this question. Twenty-two clinicians from Central, Cook, and Southern regions responded to this question by providing the following recommendations for improvements to the billing and rate structure:

Central Region Respondents Comments

- I feel it is fair, especially with the new increase.
- Compared to the hours spent in the evaluations, the rate structure is below what I receive from other sources. As cases often seem more complex, they take more time to read, test, interview, think, analyze, and write.
- If we were to give these tests in a private setting, it would be \$4,000. The costs of tests, time for staff to prepare, time for psychological to administer, analyze, and write the reports is much more than \$1,000. This is a service, of course, but more psychologists would be more willing to participate if the reimbursement is worth their time and effort. Lastly, if the bills were paid in a timely manner instead of months and months later, more psychologists would want to participate. The show rate is also terrible. Two of our licensed psychologists opted out after they experienced the pay and the time it took to get paid as well as not get paid when clients do not show since they are on commission.
- Increased rate of compensation would increase interest in taking these evaluations, as one of the bigger issues and more frequently occurring issues in no-shows, resulting in non-

billable provider hours. Compensation should account for the larger picture, which involves frequent occurrence of this issue, and should possibly meet or exceed managed care rates so providers/organizations are risking a hit on income to schedule these clients.

- It is impossible to know what payment is for what client, especially now for direct deposit. There needs to be a numbering system, so we know whose payment has yet to be processed. Court testimony should be paid at a higher rate. Most providers charge \$200-250 an hour for court testimony: less than \$100 is outrageous and probably deters people from becoming providers.
- It is recommended a flat rate of \$1600 per PCA and \$1800 for a Comprehensive Neuropsychological/Psychological/Psychiatric report be established for a max two children. \$75 for each additional child. Add-on for Home Based Assessment, Feedback Sessions, Miscellaneous Costs Associated with Psychological Testing, and Psychological Court Testimony be increased to \$100 per hour include mileage reimbursement based on Federal Mileage rates. The recommendation is made based on two factors: 1) Reduce the wage gap between mental health providers and standard living cost., 2) Provide comparable reimbursement rates with the Illinois Department of Human Services (IDHS).
- My organization bills DCFS through our contracts, and our processes differ from those for other providers. It can take a while to get paid. I am not sure that we know how to follow up on this for one of our contracts. I also wish that we could get paid for document review, which takes a lot of time given that many of our cases are complex. I regularly spend more time on the report than I can bill, as well, because I want it to be thorough and useful for our clients and their systems, and I feel that our standard rate for Post-Adopt evaluations (\$1,000) is low, particularly given how complex our Post-Adopt cases usually are.
- No improvements. The recent increase is appreciated.
- Rate needs to increase. These reports take time to be through and to write.
- The rates have improved somewhat but are still extremely low. Until the most recent increase, the rate was essentially the same as when I started doing these evaluations many years ago (early to mid-2000s, I believe).
- The reimbursement rate is very low considering the cost of materials and time for the assessment process. This is particularly evident when ASD or ADHD assessment is requested. Fair reimbursement would be \$1,300 with an additional \$200 for ASD or ADHD assessment. This may also increase the number of psychologists willing to provide testing.
- The rates have improved somewhat but are still extremely low. Until the most recent increase, the rate was essentially the same as when I started doing these evaluations many years ago (early to mid-2000s, I believe).
- We are paid much less than when we do, they same battery privately. Also, time till paid is sometimes a problem.

Cook Region Respondents Comments

- Given the amount of time some of our cases require, we are not always able to bill for all of the hours put into the cases.
- I believe that the pay scale for psychological evaluations is fair.

- I don't have any suggestions, but I find the administrative tasks associated with billing to be cumbersome.
- I have not had much experience.
- I'm pleased with the significant increase for those providing bilingual services: rates for assessments in English were improved but could be increased more (to 1,250 or 1,300).
- My organization bills DCFS through our contracts, and our processes are different than for other providers. It can take a while to get paid. I am not sure that we know how to follow up on this for one of our contracts. I also wish that we could get paid for document review, which takes a lot of times given that many of our cases are complex. I regularly spend more time on the report than I can bill, as well, because I want it to be thorough and useful for our clients and their systems, and I feel that our stand rate for Post-Adopt evaluations (\$1,000) is low, particularly given how complex our Post-Adopt cases usually are.
- No improvements are needed. The recent increase is appreciated.
- Rate needs to increase. These reports take time to be thorough and to write.
- The rate structure is very low for Psychological Evaluation. A more competitive rate would be \$1,200 per assessment.

Southern Region Respondents Comments

- I was approved and not paid. It is still unclear whether payment is coming. It is beyond frustrating, and I have spent hours working through the current system to become an approved provider. The rate is not worth my time and the effort I have applied to try and get payment for services. I want to help children and families. I am better able to do that in direct services than through this contract. It is sad.
- I recommend higher reimbursement for assessments because the rates are significantly below what we would get from insurance or our self-pay clients, even our self-pay clients who pay at the bottom of our sliding scale.
- The rate structure is very low for Psychological Evaluations. A more competitive rate would be \$1200 per assessment.
- The reimbursement rate is very low, considering the cost of materials and time for the assessment process. This is particularly evident when ASD or ADHD assessment is requested. Fair reimbursement would be \$1300, with an additional \$200.00 for ASD or ADHD.
- We are paid much less than when we do the same battery privately.
- It would be wonderful to have the option to be paid more for court appearances. Between court preparation, travel, waiting for court, and testifying, this can be extremely time-consuming. It would also be wonderful to be paid time and travel if it was necessary to travel for special circumstances for assessments.
- This is very specialized work. Unless sufficient time is spent critically reviewing the history, including reaching back to check for inaccuracy in current report, these evaluations are really not meeting the needs of our children and families.

Recommendations for Improving Communication, Coordination, Support, and Care for Children and Families Served by Illinois DCFS

Respondents were asked, “Please share any recommendations you have for communication, coordination, support, or changes that you feel are important to improve the quality and efficiency of care and support to children and families served by Illinois DCFS.” Sixteen clinicians from across regions responded to this question by providing the following recommendations for improvements to communication, coordination, support, and care for children served by Illinois DCFS:

Central Region Respondents Comments

- Getting collateral data completed is like pulling teeth, and caseworkers often get rude, especially people working in residential treatment. It needs to be understood that collateral sources are necessary for a more valid diagnosis.
- It is always helpful to talk with caseworkers, visit supervisors and caregivers to get updates on a client case. Most caseworkers are really helpful in completing adaptative assessments on children/clients. Being provided with updated reports on the client/case is always helpful (e.g., dispositional reports, court reports).
- One issue is the price of new tests. I have excellent communication with some caseworkers and consulting psychologists.
- There is a LOT of turnover in DCFS. This causes significant issues when trying to secure a collateral interview or securing surveys from case managers. I am also unsure at times of who to return the report to. Additionally, they are oftentimes so busy that they do not respond to or complete the surveys in a timely fashion. This delays the report. There are also occasions when caseworkers indicate that they do not have the information for the assessment (listed on the 417C) or don't know how to go about getting the information. They are asking that we secure it for them or provide a copy of the materials so that they can fill them out. They may need some training and guidance around this issue.
- We understand that the case workers have their hands full, but we need better communication between the case workers and their clients. When we test children, someone who knows the child must accompany the child. The interview will be more effective. The caseworkers must make sure that collaterals complete their part of the evaluation on time. Otherwise, the report would be delayed. We try to turn in the report in two weeks as required, but when collaterals do not do their part, the report may be incomplete or delayed. Caseworkers must follow up with their clients to make sure they show up to their appointment or help arrange their transportation. We block out four hours for DCFS testing, and when they don't show, it is too late for us to fill the time with another client who needs testing, so the four hours are wasted unbillable time. We spend many staff hours prepping for the tests. Staff confirms with client and caseworker at one month, then again at two weeks, then again the day before. We want them to show for their appointment. But too often, they do not show because there has not been coordination between client and caseworker. I hope this helps to improve coordination.

Cook Region Respondents Comments

- At times it can be difficult to get a hold of required records (e.g., birth records, previous genetic testing, medical records), but we are aware that for some cases, it is hard for

caseworkers to obtain this information. Sometimes the testing approval referral forms have referral questions that are difficult to answer if we do not have these records. Other referral questions ask for out-of-date tests to be administered or for tests that are not appropriate given the age of the child (e.g., asking for comprehensive objective and subjective personality assessments for a 5-year-old). Given that we have heavy caseloads, report turnaround time can be lengthy, and it can be frustrating that recommended services cannot be put in place until the report is received, even if we verbally tell the caseworker what services should be implemented. I would be happy to write a brief letter stating the child was evaluated, received diagnoses, and the services they require in the interim so they can get started. Some testing referrals that we receive are for children with severe language delays that clearly need speech and language therapy first. Their language impairment impedes their ability to demonstrate their true potential, which makes it difficult to complete a comprehensive evaluation and obtain reliable data on their cognitive functioning. For such cases, it may be better for us to consult with the caseworker and/or foster parents first and put speech and language intervention in place before completing a full psychological/neuropsychological evaluation.

- I am generally very content with the level of communication, coordination, and support for the assessments received.
- I love the regular provider meetings and hope that they continue. Referrals lasting only six months mean that some expire before their caseworker submits their paperwork, which creates a lot of work for our intake coordinator. We are also getting a lot of neuropsychological evaluation referrals that a clinical psychologist could competently complete, which makes it hard to schedule clients (rule out FASD, for example). I am not sure what to do when there are errors in the referral questions (which we have to type verbatim into the report) or when I get certain referral questions (“Perform a WISC-R” or questions that testing can’t answer, like “Based on testing, does this child have a history of prenatal substance exposure?”). With report writing, I would love to move to a more client-centered, rather than test-centered, format, integrating my findings by domain - presenting a summary, and putting tables in an appendix - but I’m not sure whether I’m allowed to do that. I would also love to know more about what happens after DCFS receives a report, and I was happy to get feedback on a report over the summer because it confirmed that I was on the right track.
- I would appreciate it if the consultants could have a unified way to select questions that the evaluator should answer. Recently I have been getting questions that seem like throwing everything against a wall to see what sticks. Very detailed questions that are repetitive or not specifically related to this client at this time. If someone has a significant trauma history, it is not usually beneficial to ask for detailed executive functioning tests. They are traumatized, and that impacts how they perform tasks. It is also sometimes asked for a "testing of the limits". Most of these clients have very challenging backgrounds and extensive trauma, and some are just hanging on. Exposing them to tests that are not needed can be upsetting to them and, IMO, unnecessary.
- If it is a return home goal the work and services need to focus on the bio parents and documentation regarding their follow through.
- My biggest concern is the amount of time it takes to receive payment after an invoice is submitted, owing in part to the long delays in communication to resolve any difficulties. For example, it has taken a long time to find out that sometimes corrections were needed

on my end and multiple requests for information about whether there were any difficulties often went unacknowledged or unanswered. In addition, I was unfamiliar with form CFS 417 as I did not receive it on the first few referrals, but when I realized it was needed to submit for billing and asked to receive it, some caseworkers and even a consulting psychologist were unfamiliar with it, which has caused several months delay in processing. Because there are different versions of the instructions about how to submit (emails, instruction sheets for Teams), I wonder if the most updated version could be accessible through the Teams app, as part of a resource section that would have up to date info about processes, forms, contact information (including email) for consulting psychologists, and even a provider list.

- Relative to the provision of Psychological Evaluations and the context of this survey, the system is well coordinated and responsive, both to me as a provider and to the agencies/caseworkers.
- Things are fine.
- To improve the communication, coordination and to support the quality and efficiency of care of children and families served by Illinois DCFS, it is recommended Mental Health agencies, including not-for-profit or private practitioners holding an LCPC, LCSW, Psy.D. or Ph.D., be awarded contracts to complete Parenting Capacity Assessments (PCA). These contracts should be assigned to the preferred provider based on region – Northern, Central, and Southern. The contracts should have a life span of three years, with an expected annual referral number and assigned performance metrics. The performance metrics should include a QI process, including turn time from referral to completion of the reports. Preferred providers should have access to the DCFS-SACWIS system to obtain reports, thereby limiting the communication challenges with POS/DCFS agencies. Lastly, PCA referrals should be made directly from the referring psychologist to the preferred PCA provider to improve communication and time of services. POS/DCFS agencies in charge of cases should be notified that a PCA has been approved, and the provider responsible for completing the report. This will eliminate delays in scheduling the PCA and communication challenges currently present.

Northern Region Respondents Comments

- It is very difficult to arrange appointments for testing due to transportation limitations for many clients and our location. It is also very difficult to obtain appropriate releases for information for children. I do not have suggestions for simplifying this process other than a point person that can arrange these various factors. The caseworkers change frequently or do not facilitate these processes other than to direct the clinician or the client to arrange appointments.

Southern Region Respondents Comments

- It seems like some of the caseworkers are not aware of the necessary paperwork for an assessment. Also, it seems like communication among the caseworker, the client, the client's family, and the neuropsychologist could be improved to reduce no-show appointments and late cancellations. We recently had a DCFS client show up at an unrelated location an hour and a half away from us to be assessed by us. We had to reschedule due to time and transportation issues because the client had the wrong address.

We have had other DCFS clients show up a couple of months early for an appointment because they were reportedly given the wrong day by their caseworker. Also, we often see clients get new caseworkers mid-assessment process, and it seems like they are not always made aware of the client's upcoming appointments.

Appendix A Clinical Provider Survey Instrument

The goal of this survey is to gather data on the implementation of clinical assessments for children and youth being served by the Illinois Department of Children and Family Services (DCFS) in order to inform rate structures and supportive services to clinical assessment providers. Please complete this short survey to help our clinical program leaders better advocate for clinical service providers. The survey asks about your experiences in conducting clinical assessments, the average time spent on each assessment, and factors affecting the amount of time to complete clinical assessments, as well as recommend supports to improve the quality and efficiency of clinical assessments of children and youth being served by Illinois DCFS. Thank you for contributing to this survey!

Part I. The following questions were asked of all the respondents

How many years of experience do you have conducting clinical assessments (including, but not limited to, those completed for Illinois DCFS)?

- Less than 5 years
- 5 to 9 years
- 10 to 14 years
- 15+ years

What county is your (primary) office located in?

(drop-down list of Illinois counties)

What types of assessments are you approved to complete for Illinois DCFS? (select all that apply)

- Parenting Capacity Assessments
- Psychological Evaluations
- Neuropsychological Evaluation

What assessment tools are you trained to use for clinical assessments that you completed for Illinois DCFS? (select all that apply)

Standardized Tests for Intellectual and Cognitive Functioning

- Wechsler Adult Intelligence Scale
- Wechsler Intelligence for Children (WISC)
- Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
- Woodcock-Johnson Tests of Cognitive Abilities (WJ)
- Stanford-Binet Intelligence Scale (SB)

- Kaufman Assessment Battery for Children (KABC)
- Differential Abilities Scale (DAS)

Standardized Tests for Adaptive Functioning

- Vineland Adaptive Behavior Scale (VABS)
- Adaptive Behavior Assessment System (ABAS)
- Woodcock-Johnson Scales of Independent Behavior

Standardized Tests for Achievement

- Wide Range Achievement Test, 5th Ed. (WRAT-5)
- Wechsler Individual Achievement (WIAT)
- Woodcock-Johnson Tests of Achievement (WJ)
- Kaufman Test of Educational Achievement (KTEA)
- Peabody Individual Achievement Test (PIAT-R)

Standardized Behavior Rating Scales

- Connors instruments: Connors Rating Scales (CRS), Connors
- Adult AD/HD Rating Scales (CAARS)
- Achenbach Scales, including Child Behavior Checklist (CBCL), Caregiver-Teacher Report Form (C-TRF), Teacher Report Form (TRF), Youth Self-Report (YSR), Adult Behavior Checklist (ABCL), Adult Self-Report (ASR)
- Behavior Assessment System for Children (BASC-2)
- ADHD Rating Scale-IV
- Attention Deficit Disorders Evaluation Scale (ADDES)
- ADD-H Comprehensive Teacher Rating Scale (ACTeRS)
- Burk's Behavior Rating Scales (BBRS)
- Behavior Rating Profile (BRP-2)
- Social-Emotional Dimension Scale (SEDS-2)

Standardized Tests for Personality and Emotional Functioning

- Minnesota Multiphasic Personality Inventory
- Beck Depression Inventory
- Personality Assessment Inventory
- Rotter Incomplete Sentences Blank

Standardized Tests for Memory Functioning

- Wechsler Memory Scale
- California Verbal Learning Test
- Benton Visual Retention Test
- Rey Auditory Verbal Learning Test

Standardized Tests for Language Functioning

- Boston Naming Test

- Comprehensive Aphasia Test
- Boston Diagnostic Aphasia Examination

Standardized Tests for Executive Functioning

- Trail Making Test
- Wisconsin Card Sort
- Stroop Task

Standardized Battery for Neuropsychological Functioning

- NEPSY
- Repeatable Battery for the Assessment of Neuropsychological Status
- Neuropsychological Assessment Battery
- Luria-Nebraska Neuropsychological Battery

Other (please specify) _____

Part II. The following questions were displayed in sets by assessment type (parenting capacity assessments, psychological evaluations, and neuropsychological evaluation) of the clinicians who indicated that they completed the specific type of assessment.

How long have you been completing (Parenting Capacity Assessments, Psychological Evaluations, and Neuropsychological Evaluations) for Illinois DCFS?

- Less than 5 years
- 5 to 9 years
- 10 to 14 years
- 15+ year

When did you complete your most recent (Parenting Capacity Assessments, Psychological Evaluations, and Neuropsychological Evaluations) for Illinois DCFS?

- Within the last two weeks
- 2 to 4 weeks ago
- 5 to 6 weeks ago
- More than 6 weeks ago

On average, how many (Parenting Capacity Assessments, Psychological Evaluations, and Neuropsychological Evaluations) for Illinois DCFS do you complete in a month?

- 1 – 2
- 3 – 4
- 5+

Please estimate how many hours you spend in total on each (Parenting Capacity Assessments, Psychological Evaluations, Neuropsychological Evaluations). Include time spent reviewing documentation, collateral interviews, conducting the assessment, and report writing for an average case and a complex case. (enter the number of hours each)

___ An average case

___ A complex case

What factors most affect the length of time it takes (in total hours) to complete (Parenting Capacity Assessments, Psychological Evaluations, and Neuropsychological Evaluations) for complex cases? (select up to two areas)

- Document review and preparation take more time for complex cases
- It takes more time to complete the assessment process/tools for complex cases
- Coordination with other professionals is more time-consuming for complex cases
- Writing the report is more time-consuming for complex cases
- Other (please specify) _____

Part III. The following question was asked of all respondents. The questions following were asked by evaluation type and were only asked of those clinicians who indicated that they conduct the type of evaluation.

Do you complete either Intellectual and Developmental Disabilities Evaluations or Autism Spectrum Disorder Evaluations? (select all that apply)

- No, I do not complete either Intellectual and Developmental Disabilities or Autism Spectrum Disorder evaluations
- Yes, I complete Intellectual and Developmental Disabilities evaluations
- Yes, I complete Autism Spectrum Disorder evaluations

When did you complete your most recent (Intellectual and Developmental Disabilities Evaluation, Autism Spectrum Disorder Evaluation) for Illinois DCFS?

- Within the last two weeks
- 2 to 4 weeks ago
- 5 to 6 weeks ago
- More than 6 weeks ago

On average, how many (Intellectual and Developmental Disabilities Evaluations, Autism Spectrum Disorder Evaluations) for Illinois DCFS do you complete in a month?

- 1 – 2
- 3 – 4
- 5+

Please estimate how many hours you spend in total on each (Intellectual and Developmental Disabilities Evaluation, Autism Spectrum Disorder Evaluation). Include time spent reviewing documentation, collateral interviews, conducting the assessment, and report writing for an average and complex case. (enter the number of hours each)

- ___ An average case
- ___ A complex case

What factors most affect the time it takes (in total hours) to complete (Intellectual and Developmental Disabilities Evaluation, Autism Spectrum Disorder Evaluation) for complex cases? (select up to two areas)

- Document review and preparation take more time for complex cases
- It takes more time to complete the assessment process/tools for complex cases
- Coordination with other professionals is more time-consuming for complex cases
- Writing the report is more time-consuming for complex cases
- Other (please specify) _____

What is in the typical battery of tests that you use to assess for and diagnose Autism Spectrum Disorder? (select all that apply)

Standardized tests for Intellectual and Cognitive Functioning

- Wechsler Adult Intelligence Scale
- Wechsler Intelligence for Children (WISC)
- Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
- Woodcock-Johnson Tests of Cognitive Abilities (WJ)
- Stanford–Binet Intelligence Scale (SB)

- Kaufman Assessment Battery for Children (KABC)
- Differential Abilities Scale (DAS)

Standardized tests for Adaptive Functioning

- Vineland Adaptive Behavior Scale (VABS)
- Adaptive Behavior Assessment System (ABAS)
- Woodcock-Johnson Scales of Independent Behavior

Standardized Tests for Achievement

- Wide Range Achievement Test, 5th Ed. (WRAT-5)
- Wechsler Individual Achievement (WIAT)
- Woodcock-Johnson Tests of Achievement (WJ)
- Kaufman Test of Educational Achievement (KTEA)
- Peabody Individual Achievement Test (PIAT-R)

Standardized Behavior Rating Scales

- Connors instruments: Connors Rating Scales (CRS), Connors
- Adult AD/HD Rating Scales (CAARS)
- Achenbach Scales, including Child Behavior Checklist (CBCL), Caregiver-Teacher Report Form (C-TRF), Teacher Report Form (TRF), Youth Self-Report (YSR), Adult Behavior Checklist (ABCL), Adult Self-Report (ASR)
- Behavior Assessment System for Children (BASC-2)
- ADHD Rating Scale-IV
- Attention Deficit Disorders Evaluation Scale (ADDES)
- ADD-H Comprehensive Teacher Rating Scale (ACTeRS)
- Burk's Behavior Rating Scales (BBRS)
- Behavior Rating Profile (BRP-2)
- Social-Emotional Dimension Scale (SEDS-2)

Standardized tests for Personality and Emotional Functioning

- Minnesota Multiphasic Personality Inventory
- Beck Depression Inventory
- Personality Assessment Inventory
- Rotter Incomplete Sentences Blank

Standardized tests for Memory Functioning

- Wechsler Memory Scale
- California Verbal Learning Test
- Benton Visual Retention Test
- Rey Auditory Verbal Learning Test

Standardized tests for Language Functioning

- Boston Naming Test

- Comprehensive Aphasia Test
- Boston Diagnostic Aphasia Examination

Standardized tests for Executive Functioning

- Trail Making Test
- Wisconsin Card Sort
- Stroop Task

Standardized Battery for Neuropsychological Functioning

- NEPSY
- Repeatable Battery for the Assessment of Neuropsychological Status
- Neuropsychological Assessment Battery
- Luria-Nebraska Neuropsychological Battery

Other (please specify) _____

Part IV. The following questions were asked of all the respondents

Please share any comments or recommended improvements you have about the current billing or rate structure used to pay clinical assessment providers for children and families served by Illinois DCFS.

Please share any recommendations you have for communication, coordination, support, or changes that you feel are important to improve the quality and efficiency of care and support to children and families served by Illinois DCFS.

What language(s) do you provide clinical assessments for the Illinois Department of Children and Family Services? (select all that apply)

- Arabic
- Cantonese
- English
- Gujarati
- Greek
- Hindi
- Italian
- Mandarin
- Polish
- Spanish
- Russian
- Tagalog
- Urdu
- Other (please specify) _____

What gender do you identify as? (select all that apply)

- Man
- Non-binary
- Transgender
- Woman
- I don't identify with a gender
- I prefer to self-identify (please specify) _____

How would you describe your race/ethnicity? (select all that apply)

- American Indian or Alaska Native
- Asian, South Asian, South East Asian
- Black or African American
- Hispanic, Latino, Latina, Latinx, or Spanish origin
- Middle Eastern, North African (MENA)
- Native Hawaiian or Other Pacific Islander
- White
- Other (specify) _____

What is the highest level of education that you have completed?

- Bachelor's degree (for example, BA, BS)
- Master's degree (for example, MA, MS, Meng, MSW, MBA)
- Doctoral Degree (for example, EdD, PhD, PsyD)

Appendix B Other Assessment Tools

Respondents were asked, "What assessment tools are you trained to use for clinical assessments that you completed for DCFS?" They were provided with a listing of nine sets of assessment tools, reflecting a total of 43 individually named assessment tools and other which they could specify. They were instructed to select all that apply (Table 9). Below is the list of the 93 assessment tools specified as other in response to this question.

Table 9 – Other tools used in Parenting Capacity Assessments, Psychological Evaluations, Neuropsychological Evaluations

AAPI	CARS2
AAPI-2	CAT
AI-A	CATA
ASRS	Child Abuse Potential Form
Autism Diagnostic Observation Schedule (4 respondents)	Child and Adolescent Memory Profile (2 respondents)
BASC3	Childhood Trauma Questionnaire (2 respondents)
Bateria IV Woodcock Munoz-translation of Woodcock-Johnson (Cognitive and Achievement)	Children's Memory Scale
Bayley-4	Children's PTSD Inventory
Bayley's Scales of Infant and Toddler Development	Clinical Evaluation of Language Fundamentals
Beck Anxiety Inventory (2 respondents)	Comprehensive Test of Nonverbal Intelligence
Beck Depression Inventory-2	Conners CPT (3 respondents)
Beck Hopelessness Scale (2 respondents)	CTOPP-2
Beck Resiliency Scales Children's Depression Inventory-2	Delis Kaplan Executive Function System (2 respondents)
Beck Youth Inventories for Children and Adolescents (2 respondents)	Denver II
Beck Youth Inventories-2	DES-II
Beery VMI (2 respondents)	Dissociation Evaluation Scale
Bender Gestalts	DKEFS
Behavior Rating Inventory of Executive Function	GARS (2 respondents)
BOSA	GARS-3
BRIEF	Gilliam Autism Rating Scale
BRIEF-2	HOME inventories
BRIEF-A	JSOAP-II
Brown Executive Function/Attention Scales	KCPT
CAPI	Leiter (2 respondents)
CAPs (3 respondents)	LS/CMI
	MACI-II (3 respondents)
	MC

MCMI-V (4 respondents)	SASSI-4 (3 respondents)
MIGDAS-2	Sentence Completion Series-Parenting
M-PACI	SRS-2 (4 respondents)
Offender Assessments	Stable/Acute 2007
PAI	Static-99R
Parenting Style Questionnaire	Symptom Checklist 90-R
Parenting Symptom Index	TAT (2)
PCRI (2 respondents)	Test of Memory and Learning
Preschool Language scales (2 respondents)	Thematic Apperception Test
PROFESOR	Toni
Projective Drawings	Trauma assessment tools
PSB	Trauma Symptom Checklist for Children (3 respondents)
PSI-4 (2 respondents)	Trauma Symptom Index (2 respondents)
Raven's Progressive Matrices	Trauma Symptom Inventory (2 respondents)
Resiliency Scale for Children	Multiscale Dissociation Inventory
Rey Complex Figure Test	TSCC
Reynolds Intellectual Assessment System	VP
Roberts Apperception Test (2 respondents)	Wide Range Assessment of Memory and Learning
Rorschach Inkblot Test (3 respondents)	WRAML-3
Rotter incomplete sentences	
SAI	
SAI-J	

Table 19 – Other used in Autism Spectrum Disorder

AAPI-2	GARS-3 (3 respondents)
ADES	MACI II
Autism Diagnostic Observation Schedule (5 respondents)	MIGDAS-2 (2 respondents)
Autism Quotient	MPACI
Autism Symptom Rating Scales	PCRI
Bayley-4	PPVT
BRIEF-2	Preschool Language Scales-5
BRIEF-A	PSI-4
Cambridge Emotion Quotient	Rey Complex Figure Test
CAP (2 respondents)	SASSI-4
Childhood Autism Rating Scale (CARS2-ST and CARS2-QPC)	SASSI-A3
Clinical Interview	Social Responsiveness Scale SRS2 (5 respondents)
DES	TSCC
D-KEFS (2 respondents)	
EVT	
Faces test	