The Improvement of Child Protective Services with Structured Decision Making

The CRC Model

Children's Research Center

A Division of the National Council on Crime and Delinquency

"CPS units have been plagued by long-standing systemic weaknesses in day-to-day operations, including difficulty in maintaining a skilled workforce; consistently following key policies and procedures designed to protect children; developing useful case data and recordkeeping systems, such as automated case management; and establishing good working relationships with the courts."

Complex Challenges Require New Strategies,
United States General Accounting Office, July 1997

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PREFACE

The Children's Research Center (CRC) was established to help federal, state and local child welfare agencies reduce child abuse and neglect by developing case management systems and conducting research which improves service delivery to children and families. The Center is a division of the National Council on Crime and Delinquency (NCCD), which was established in 1907 to perform a similar role for private and public agencies serving delinquent children. NCCD, which employs staff at offices in San Francisco, California, and Madison, Wisconsin, is one of the oldest nonprofit research and advocacy agencies in the United States. During the last two decades, the agency has conducted research, evaluated programs and developed case management systems for more than 50 state or federal agencies. In 1986, after successful completion of a risk assessment model for Alaska's delinquent population, that state's Social Services agency asked NCCD to work with Child Protective Services (CPS) staff to devise a system that would provide the same level of structure for CPS. This initial project began NCCD's expansion of structured decision making (SDM) principles and practices to the child protection field.

The success of the Alaska CPS project led to similar efforts in the early 1990's in Michigan, Oklahoma, Rhode Island, and Wisconsin. During the past five years, NCCD's work in child welfare has increased dramatically. Indiana, Georgia, and New Mexico have all designed and implemented structured decision making models. So too has one of Australia's six states (South Australia). California, Minnesota and Ohio begin implementation in 1999. Colorado will implement some aspects of the system in 1999 as well. With each new project, we have honed our understanding of the needs of child welfare agencies and what is required to successfully implement major organizational change. In addition, we have assembled a substantial research database and developed systems for monitoring service delivery, improving efficiency, and measuring the effectiveness of child welfare policies, programs, and services.

Improving child protection systems has been a formal part of NCCD's mission since 1993, when our Board of Directors authorized the creation of a special division called the Children's Research Center (CRC). Many abused and neglected children later become involved in delinquent and criminal behavior, ending up in substance abuse programs, training schools, jails, and prisons throughout the nation. To stem the cycle of crime and violence in the United States, organizations like NCCD must focus on improving services to families and children. The CRC mission is to continue research and evaluation efforts in child welfare and to assist agencies to improve their service delivery systems. Meeting the needs of at-risk children and families will create a better, safer society for all Americans.

This document outlines CRC's approach to risk assessment and structured decision making in child welfare. Examples of research results, decision support systems, and data we have compiled are shown throughout this booklet to illustrate the value of the SDM model. We believe you will find the materials informative and thought provoking. For additional information, please contact the Children's Research Center.

Janice Ereth, Ph.D., Director, Children's Research Center

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The number of abuse and neglect allegations nationwide has risen dramatically over the last two decades. Most child welfare agencies have been hard pressed to respond effectively, as the new demands have outpaced available resources. The results have included lawsuits in more than 30 states, media exposes resulting from child deaths, increased concerns over worker and agency liability, and a continuous search for new strategies and resources to address the burgeoning problem.

The need for additional resources is obvious, but that is not the only issue. The increasing pressures have highlighted a problem that has long plagued human services agencies in general, and child welfare agencies in particular: the need for more efficient, consistent and valid decision making. Child protection workers are asked to make extremely difficult decisions, yet in many agencies, workers have widely different levels of training and experience. Consequently, decisions regarding case openings, child removal and reunification, and other service-related issues have long been criticized as inappropriate, inconsistent, or both. In fact, research has clearly demonstrated that decisions regarding the safety of children vary significantly from worker to worker, even among those considered to be child welfare experts (Rossi, et.al., 1996). As pressure to make critical decisions affecting children and families rises, so does the potential for error. Inappropriate decisions can be costly, leading to an overuse of out-of-home placements, or tragic, resulting in the injury or death of a child.

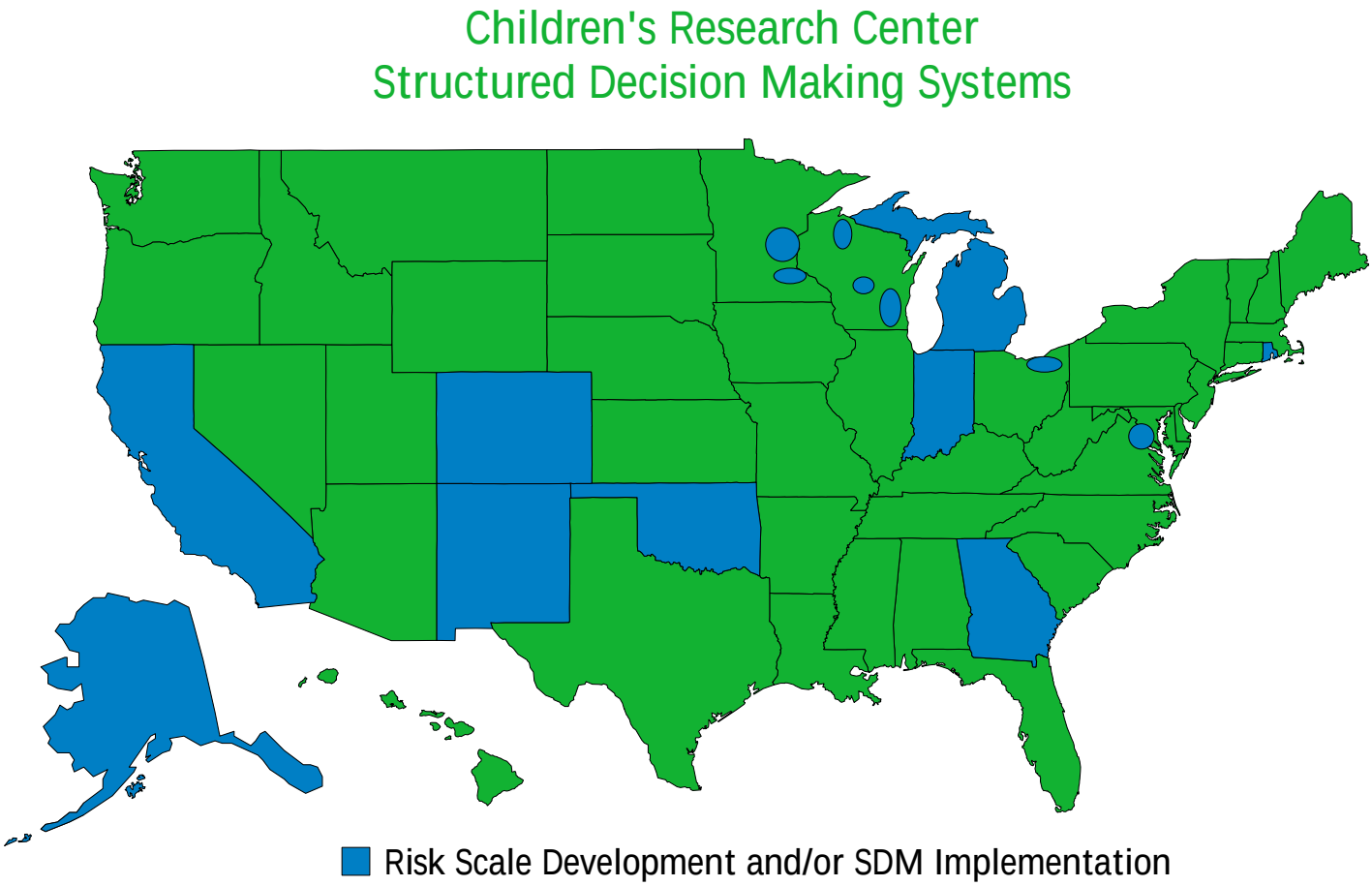
Inconsistent and inappropriate decisions are the heart of the problem facing America's child welfare agencies.

The problems of increasing referrals, limited resources, and liability concerns are inextricably linked with decision making issues. Agencies overwhelmed by heavy workloads need to be able to consistently and accurately determine *which* cases should be investigated, *which* children need to be removed, and *which* families require the most intensive services. Clearly, new methods are required to help agencies and

workers make decisions as efficiently and effectively as possible. Tools are needed that help workers make accurate and reliable assessments of immediate safety issues and longer-term risk. Decision making strategies are needed that help focus limited resources on those families at higher levels of risk. These decision tools must be embedded in case management systems that incorporate clearly defined service standards, mechanisms for frequent reassessments, methods for measuring workload, and mechanisms for ensuring accountability and quality controls.

How child welfare decisions get made and how agency resources are utilized are the key issues addressed in the CRC structured decision making model. While the model does not purport to be a "cure-all" for the current crisis in child welfare, that crisis cannot be overcome until the issues surrounding child welfare decision making are confronted. We believe the model described in this document - when properly implemented - will result in a significant step forward for child welfare services. This model is based on work completed or underway in fourteen states, ranging from California to Rhode Island.

Figure 1



Note: SDM has also been implemented in South Australia.

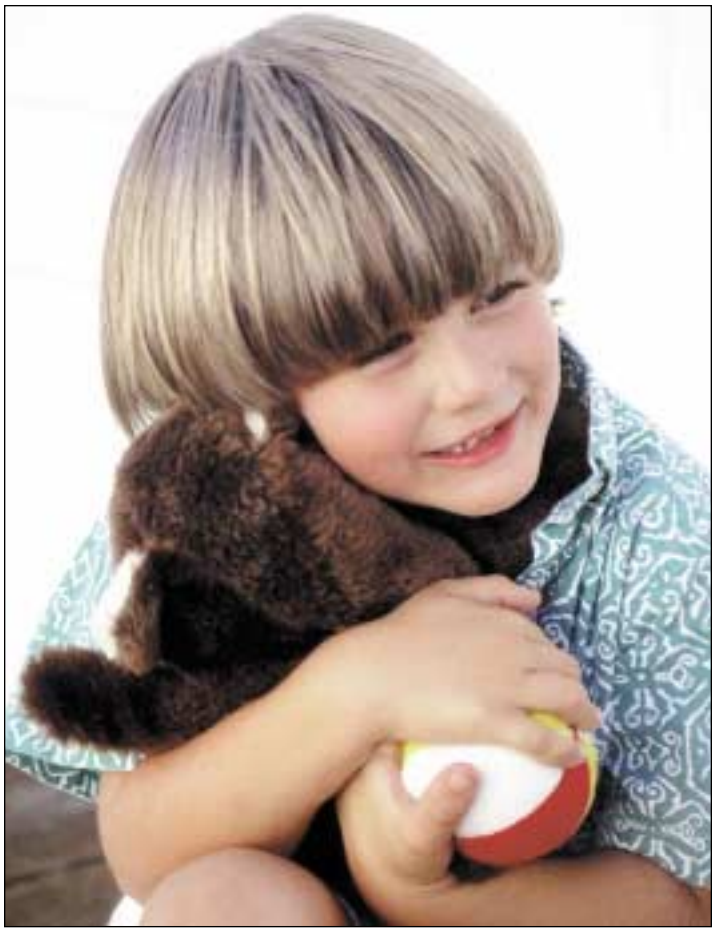
Principles

The structured decision making model described in this document is based on four primary principles. ***First, decisions can be significantly improved when structured appropriately: that is, specific criteria must be considered for every case by every worker through highly structured assessment procedures.*** Failure to clearly define decision making criteria and identify how workers are to apply these criteria results in inconsistencies and, sometimes, inappropriate case actions.

The second principle stipulates that priorities given cases must correspond directly to the results of the assessment process. Expectations of staff must be clearly defined and practice standards must be readily measurable. The assessment process has little meaning unless results lead directly to an indicated decision. And those decisions should be structured so that the highest agency priority is given to the most serious and/or highest risk cases. Moreover, if prioritization is to be translated into practice, there must be clearly identified - and implemented - differential service standards associated with each type of case. Service standards, differentiated by level of risk, provide a level of accountability that is often missing in human service organizations.

The priority assigned to cases must correspond directly to the results of a clear, concise and carefully structured assessment process.

The third principle is that virtually everything an agency does - from providing services to an individual case to budgeting for treatment resources - is a response to the assessment process. For example, risk and needs assessments should be directly linked to service plans. In the aggregate, assessment data also will help indicate the range and extent of service resources needed in a community. Similarly,



assessment and case classification results are tied directly to agency service standards, which in turn drive staff workload and budgeting issues.

Fourth, a single, rigidly defined model cannot meet the needs of every agency. All state and county child welfare agencies are not organized to deliver services in the same way and do not always share similar service mandates. As a result, the CRC approach to system development is a collaborative one in which agencies are engaged in a joint development effort. Each system is built upon a set of principles and components which are then adapted to local practices and mandates, incorporating a great deal of input from local managers and staff. The result is a site-specific system which is "owned" by the agency and builds upon its strengths as a service organization.

Figure 2

OBJECTIVES OF THE STRUCTURED DECISION MAKING MODEL

- To introduce structure to critical decision points in the child welfare system.
- To increase the consistency and validity of decision making.
- To target resources to families most at risk.
- To improve the effectiveness of Child Protective Services.

System Components

The SDM model has several basic components. At the heart of the system is a series of tools used to assess families and structure the agency response to them. The following tools are used at multiple decision points, ranging from intake to reunification:

- a *response priority* decision system to guide how quickly investigative staff should respond to a referral alleging child abuse/neglect;
- a *safety assessment* to determine the threat of **immediate** harm and identify steps needed to protect children;
- a research-based *risk assessment* to estimate the likelihood of future abuse/neglect;
- standardized assessments of *family and child strengths and needs* to guide service planning; and
- periodic *reassessments* of safety, risk, and needs to determine the need for changes in service levels and/or changes in permanency planning.

A second basic component is the use of service levels (e.g., low, medium, high) with minimum standards for each level. The service levels and associated standards are designed to ensure that staff time and attention is concentrated on those families at the highest levels of risk and need.

Finally, the model also includes two management-related components:

- A workload measurement and accounting system for determining the number of child welfare staff needed to meet the workload demand, and for distributing workload equitably among staff.
- A management information component that uses aggregate family assessment data, agency response/decision data and workload data to assist managers in planning, monitoring, budgeting and evaluation.

Figure 3

SUMMARY OF STRUCTURED DECISION MAKING SYSTEM COMPONENTS

COMPONENT	WHEN USED	PURPOSE/DECISIONS	METHOD OF DEVELOPMENT
1. Response Priority	At time of referral	Accept referral or not, how quickly to respond	Policy/consensus
2. Safety Assessment	At onset of investigation; prior to any removal and when considering return	Identify immediate threat of harm and potential protecting interventions/removal	Policy/consensus/research
3. Risk Assessment	By completion of investigation	Assess long-term likelihood of re-abuse or re-neglect, open or close decision, level of service	Research - risk study
4. Family Strengths and Needs Assessment	By completion of investigation (typically for opened cases)	Assess family strengths/needs, help determine level of service, drive case plan	Policy/consensus
5. Child Strengths and Needs Assessment	By completion of investigation (typically for those entering out-of-home care)	Assess child's strengths/needs, drive child's service plan	Policy/consensus
6. Classification and Service Standards	At completion of risk/needs	Differentiate levels of service for opened cases	Policy
7. Risk/Needs Reassessment	Every 3-6 months	Measure progress, adjust service level, amend case plan, case closure	Research/policy
8. Reunification Assessment	When considering return from foster care	Reassess risk, safety, compliance with case plan and visitation	Research/policy
9. Workload Management	Ongoing	Assess number of staff needed, workload allocation, case assignments	Research - workload study
10. Management Information	Ongoing	Monitor quality assurance, planning, evaluation, budgeting	Aggregate data: assessment results; service referrals; workload; outcomes

The Structured Decision Making Tools

The SDM system brings structure and consistency to each decision point in the child welfare system through the use of assessment tools that are objective, comprehensive, and easy to use. The structured assessments ensure that each family is systematically evaluated and that critical case characteristics are not overlooked. They are in a straightforward, simple format that is seldom more than one or two pages in length. This allows critical case information to be documented in a short time. The relative ease of application is particularly critical for agencies where staff turnover is high, there are large numbers of inexperienced staff, and/or workload is threatening to overwhelm staff.

The model uses different tools for each decision point because there are different issues that need to be addressed at each stage of the case. The issues associated with determining response priority for example, are quite different from those required to assess the nature of services needed for an open case. No single instrument can successfully capture or organize the disparate issues that must be considered at each distinct point of case processing.

The assessment tools are *not* intended to make case decisions for direct service workers. Staff still need to exercise professional judgement. But the various tools help *structure* decisions by bringing objective information to bear on these critical questions:

- Are factors present that indicate the child may be in immediate danger if left in the home during the investigation?
- What is the likelihood that abuse or neglect will recur in this family in the near future?
- What specific family issues need to be addressed in order to reduce risk?
- What relative priority for agency service resources should this family receive?
- Can the child be returned home?

The model uses different criteria at each decision point to address the issues at each stage of the case.

Staff in states that have implemented the SDM model generally believe that the assessment tools help them focus on critical issues, and provide a basis for explaining and justifying their decisions. In short, staff view the assessment tools as mechanisms which help them work with families more effectively.

Responding to Allegations of Abuse/Neglect

The initial call alleging abuse or neglect typically requires staff to answer two questions: 1) is this an allegation of abuse or neglect?; and, if so, 2) how quickly do we need to initiate the investigation? These "front door" questions have major implications for child safety and for agency workload. Yet, all too often agency policy about what should or should not be investigated is vaguely defined or not clearly understood by staff. Even when it is clear that the allegation is abuse/neglect related, the criteria for determining the urgency of the case and the speed of the agency's response often varies by the unit, the supervisor, and/or the intake worker involved.

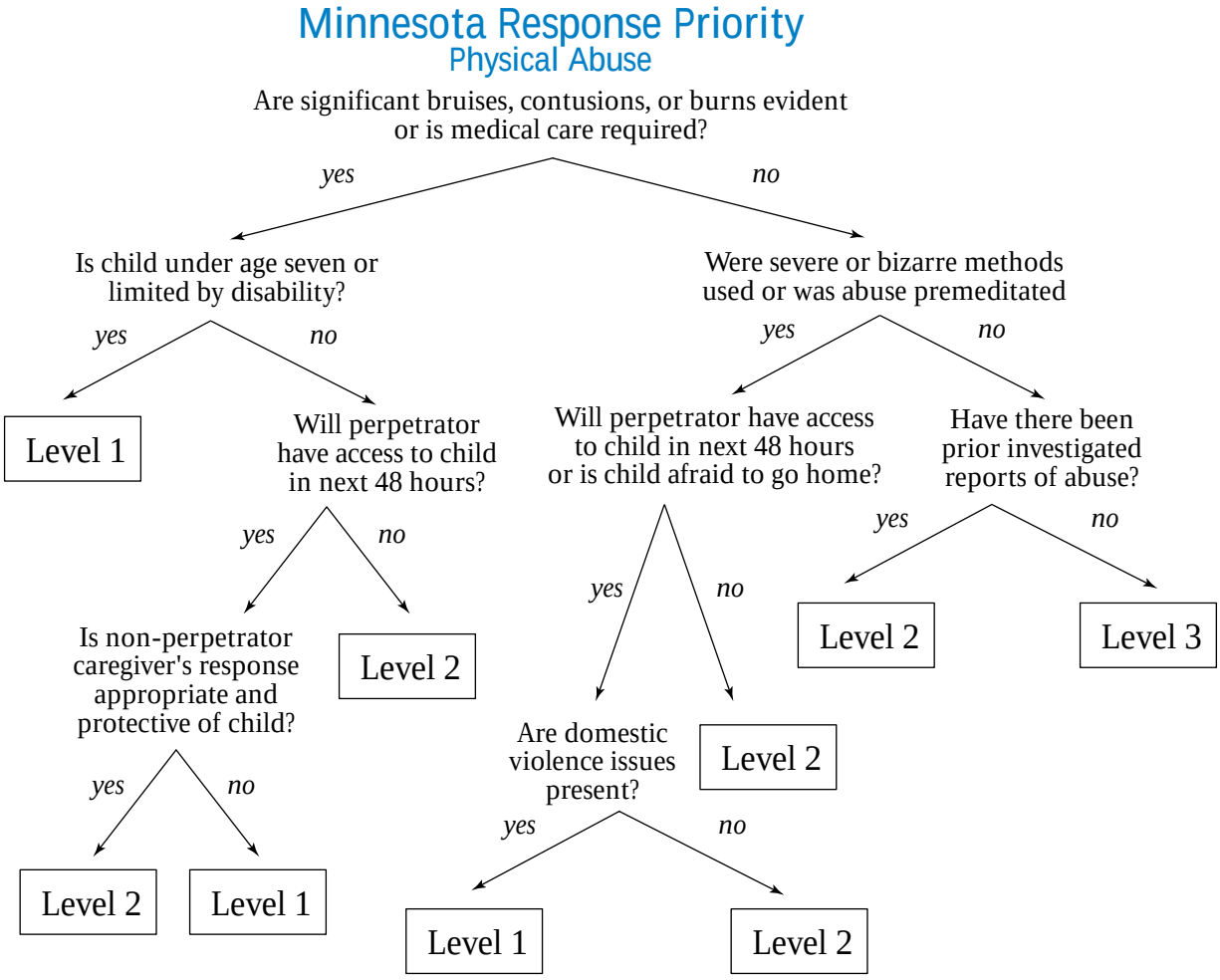
The CRC SDM system clearly identifies factors that determine how quickly staff should respond to new child abuse/neglect referrals. This results in greater consistency among workers and also permits administrators to

easily convey to key decision makers and the general public how the agency deals with abuse and neglect referrals.

An example of a response priority decision system is shown in Figure 4. This "decision tree" approach incorporates and prioritizes critical factors and leads staff to a decision about the speed of the response. (The figure shows the criteria for responding to allegations of abuse. Separate decision trees are used for other types of allegations.)

The questions of whether and how quickly to respond to an allegation have major implications for child safety and agency liability.

Figure 4



Level 1 requires a face-to-face response within 24 hours.
Level 2 requires a face-to-face response within 3 working days.
Level 3 requires a face-to-face response within 5 working days.

Assessing the Threat of Imminent Harm

Perhaps the most critical decision facing child welfare workers is whether to leave an abused or neglected child in the home while services to reduce risk of harm are put into place. It is a difficult decision, with major implications for the safety of children, their long-term psychological development, family functioning, worker liability, and the professional image of the agency. Yet, as documented in a major national study of child welfare decision making (Rossi, et.al., 1996), there is no consistent agreement among child welfare workers and experts about the conditions that warrant removal from the home. Sadly, one of the key study findings was that "a family's chances of having a child taken into custody varies widely according to the person who is assigned to investigate that case" (Rossi, et. al., 1996).

To address this concern, the SDM model incorporates a safety assessment protocol (see Figure 5) that is adapted from a model originally developed in New York (Salovitz, 1993). The purpose of the tool is:

- to help workers assess whether and to what extent any children are in immediate danger of serious physical harm;
- to determine what interventions should be initiated or maintained to provide appropriate protection; and
- if sufficient protection cannot be provided, to establish criteria for emergency removal.

At the onset of an investigation, staff must be able to assess child safety concerns, and develop and implement appropriate safety plans. The safety assessment facilitates these tasks by requiring workers to: 1) focus attention on a set of 10-12 specified, and clearly defined, conditions that potentially represent a threat to child safety; and 2) identify the interventions needed to control and remediate any unsafe

condition(s). Children are considered to be "unsafe" when *any* safety factor is present *and* the only intervention considered sufficient to protect them is removal. The safety assessment is also completed when considering a return home for any children who had previously been removed.

The safety assessment helps workers focus attention on a set of 10-12 specified, and clearly defined, conditions that potentially represent a threat to child safety.

The CRC model makes a clear distinction between "safety" issues and "risk" issues. **Safety** refers to **imminent** danger to the child and the steps required to provide immediate, short-term protection. **Risk**, on the other hand, represents the likelihood that the caretaker will re-abuse or re-neglect the child in the **future**. The concept and practice of risk assessment is described in the following section.

Figure 5

GEORGIA DEPARTMENT OF HUMAN RESOURCES
SAFETY ASSESSMENT AND PLAN

7/2/97

Case Name: _____ **County #:** _____ **Case #:** _____
Last First MI

Case Manager: _____ **Case Manager ID#:** _____ **Date:** ____/____/____

Safety Assessment
Directions: The following list of factors are behaviors or conditions that may be associated with a child being in danger of serious harm. Identify the presence or absence of each factor by placing an "X" in either the "yes" or "no" column if factor applies to any child in the household.

	Yes	No	
1.	____	____	Caretaker's behavior toward child is violent or out-of-control.
2.	____	____	Caretaker describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.
3.	____	____	Caretaker caused serious physical harm to the child or has made a plausible threat to cause serious physical harm.
4.	____	____	Explanation for the injury is unconvincing and/or inconsistent.
5.	____	____	The family refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.
6.	____	____	Caretaker has not, or cannot, or will not provide supervision necessary to protect child from potentially serious harm.
7.	____	____	Caretaker is unwilling, or is unable, to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care.
8.	____	____	Caretaker has previously maltreated a child and the severity of the maltreatment, or the care giver's response to the previous incident(s), suggests that child safety may be an immediate concern.
9.	____	____	Child is fearful of caretaker(s), other family members, or other people living in or having access to the home.
10.	____	____	Child's physical living conditions are hazardous and immediately threatening.
11.	____	____	Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
12.	____	____	Caretaker's current drug or alcohol use seriously affects his/her ability to currently supervise, protect, or care for the child.
13.	____	____	Other (specify): _____

Safety Plan/REASONABLE EFFORTS CHECKLIST
For each condition identified consider the resources available in the family and the community that might help to keep the child safe. Check each response taken to protect the child and explain below. Describe all safety interventions taken or immediately planned by you or anyone else, and explain how each intervention protects (or protected) each child.

_____ 1. Use of family resources, neighbors, or other individuals in the community as safety resources.
_____ 2. Use community agencies or services as safety resources.
_____ 3. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
_____ 4. Have the non-maltreating care giver move to a safe environment with the child.
_____ 5. Have the care giver(s) place the child outside the home (formal voluntary placement).
_____ 6. Other: _____
_____ 7. Legal action must be taken to place the child(ren) outside the home.

Safety Decision
Directions: Identify your safety decision by checking the appropriate box below. Check one box only. This decision should be based on the assessment of all safety factors and any other information known about this case. **"Safe" should be checked only if no safety factors were identified above.**

A. Unsafe: _____ Without a controlling intervention(s), one or more children will likely be in immediate danger of serious harm.
_____ Number of children removed from the home (any removal from the home).

B. Conditionally Safe: _____ Controlling safety interventions have been taken since the referral was received, and those interventions have resolved the Unsafe situation for the present time.

C. Safe: _____ There are no children likely to be in immediate danger of serious harm.

Assessing Future Risk

The family risk assessment scales are research-based tools which estimate the likelihood that a family will again become involved in an abuse or neglect incident. They are the result of research that examines the relationship between family characteristics and child welfare case outcomes. The risk scales, which incorporate a range of family characteristics (e.g., number of prior referrals, children's ages, caretaker substance abuse), have all demonstrated a strong correlation with subsequent child abuse/neglect referrals. One very important research finding is that a single instrument should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate risk scales are used to assess the future probability of abuse or neglect. Figure 6 shows the empirically-based abuse and neglect risk assessment tools recently developed for the State of California.

CRC risk assessment instruments have demonstrated their ability to classify families into risk groups that have high, medium or low probabilities of continuing to abuse or neglect their children.

Because these tools are products of research on the actual experience of families previously reported to the agency, it is possible to assess risk with a reasonably high degree of accuracy. Recent research has indicated that risk instruments are transferrable among jurisdictions (Baird, Wagner, Healy, and Johnson, 1999). However, when research is done using cases from the local jurisdiction the agency has added confidence that the risk instrument reflects local conditions and the local child welfare population.

The risk assessment concept is simple. The scales are used to classify families into risk groups that have high, medium or low probabilities of continuing to abuse or neglect their children. For instance, in many of the CRC risk assessment studies, it often has been possible at the completion of the investigation to identify "high risk" families that have a 50% or higher probability of again abusing or neglecting their children. It has also been possible to identify "low risk" families where the chances of subsequent maltreatment were only 5% or lower.

The differences between these groups are substantial. High risk families are far more likely than low risk families to re-abuse their children. The research has shown that high risk families have significantly higher rates of subsequent referrals and investigations, more subsequent substantiations, and are more often involved in serious abuse or neglect incidents resulting in medical care and/or hospitalization. Armed with this critical information, agencies are well-positioned to make decisions about how resources should be differentially allocated across clients.

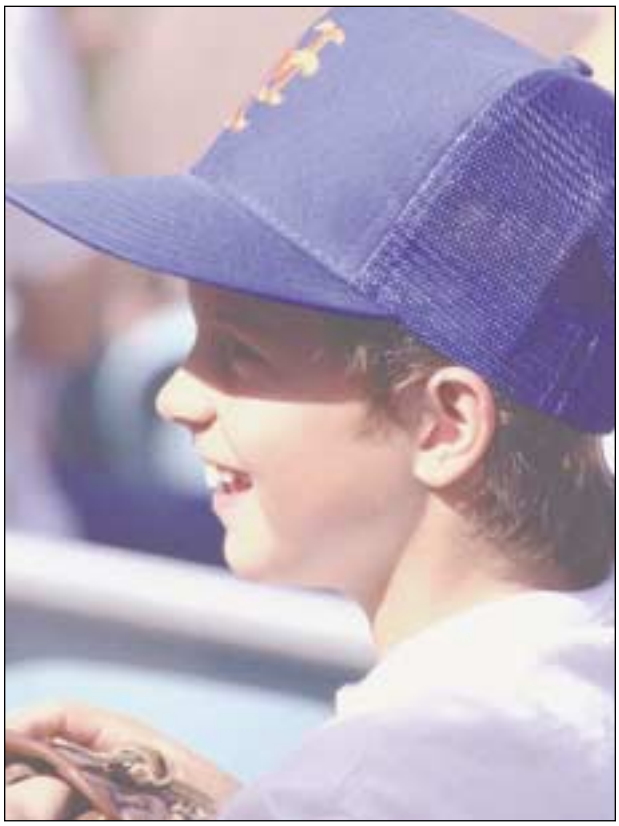


Figure 6

CALIFORNIA
FAMILY RISK ASSESSMENT

c: 10/98

Case Name: _____ **Case #:** _____ **Date:** ____/____/____

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

NEGLECT **Score**

N1. Current Complaint is for Neglect
- a. No 0
- b. Yes . . . . 1 _____

N2. Prior Investigations (assign highest score that applies)
- a. None 0
- b. One or more, abuse only 1
- c. One or two for neglect 2
- d. Three or more for neglect . . . . 3 _____

N3. Household has Previously Received CPS (voluntary/court-ordered)
- a. No 0
- b. Yes . . . . 1 _____

N4. Number of Children Involved in the CA/N Incident
- a. One, two, or three 0
- b. Four or more . . . . 1 _____

N5. Age of Youngest Child in the Home
- a. Two or older 0
- b. Under two . . . . 1 _____

N6. Primary Caretaker Provides Physical Care Inconsistent with Child Needs
- a. No 0
- b. Yes . . . . 1 _____

N7. Primary Caretaker has a Past or Current Mental Health Problem
- a. No 0
- b. Yes . . . . 1 _____

N8. Primary Caretaker has Historic or Current Alcohol or Drug Problem (Check applicable items and add for score)
- a. Not applicable 0
- b. ____ Alcohol (current or historic) 1
- c. ____ Drug (current or historic) . . . . 1 _____

N9. Characteristics of Children in Household (Check applicable items and add for score)
- a. Not applicable 0
- b. ____ Medically fragile/failure to thrive 1
- c. ____ Developmental or physical disability 1
- d. ____ Positive toxicology screen at birth . . . . 1 _____

N10. Housing (check applicable items and add for score)
- a. Not applicable 0
- b. ____ Current housing is physically unsafe 1
- c. ____ Homeless at time of investigation . . . . 2 _____

TOTAL NEGLECT RISK SCORE ____

ABUSE **Score**

A1. Current Complaint is for Abuse
- a. No 0
- b. Yes . . . . 1 _____

A2. Number of Prior Abuse Investigations (number: _____)
- a. None 0
- b. One 1
- c. Two or more . . . . 2 _____

A3. Household has Previously Received CPS (voluntary/court-ordered)
- a. No 0
- b. Yes . . . . 1 _____

A4. Prior Injury to a Child Resulting from CA/N
- a. No 0
- b. Yes . . . . 1 _____

A5. Primary Caretaker's Assessment of Incident (check applicable items & add for score)
- a. Not applicable 0
- b. ____ Blames child 1
- c. ____ Justifies maltreatment of a child . . . . 2 _____

A6. Domestic Violence in the Household in the Past Year
- a. No 0
- b. Yes . . . . 2 _____

A7. Primary Caretaker Characteristics (check applicable items and add for score)
- a. Not applicable 0
- b. ____ Provides insufficient emotional/psychological support . 1
- c. ____ Employs excessive/inappropriate discipline 1
- d. ____ Domineering parent . . . . 1 _____

A8. Primary Caretaker has a History of Abuse or Neglect as a Child
- a. No 0
- b. Yes . . . . 1 _____

A9. Secondary Caretaker has Historic or Current Alcohol or Drug Problem
- a. No 0
- b. Yes, alcohol and/or drug (check all applicable) . . . . 1 _____
  ____ Alcohol ____ Drug

A10. Characteristics of Children in Household (check appropriate items and add for score)
- a. Not applicable 0
- b. ____ Delinquency history 1
- c. ____ Developmental disability 1
- d. ____ Mental health/behavioral problem . . . . 1 _____

TOTAL ABUSE RISK SCORE ____

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
_____ 0 - 1	_____ 0 - 1	_____ Low
_____ 2 - 4	_____ 2 - 4	_____ Moderate
_____ 5 - 8	_____ 5 - 7	_____ High
_____ 9 +	_____ 8 +	_____ Very High

POLICY OVERRIDES. Circle yes if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.

Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
Yes No 2. Non-accidental injury to a child under age two.
Yes No 3. Severe non-accidental injury.
Yes No 4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If yes, circle override risk level, and indicate reason. Risk level may be overridden one level higher.

Yes No 5. If yes, override risk level (circle one): Low Moderate High Very High

Discretionary override reason: _____

FINAL RISK LEVEL (circle final level assigned): Low Moderate High Very High

Risk Classification and Re-Referral Rates

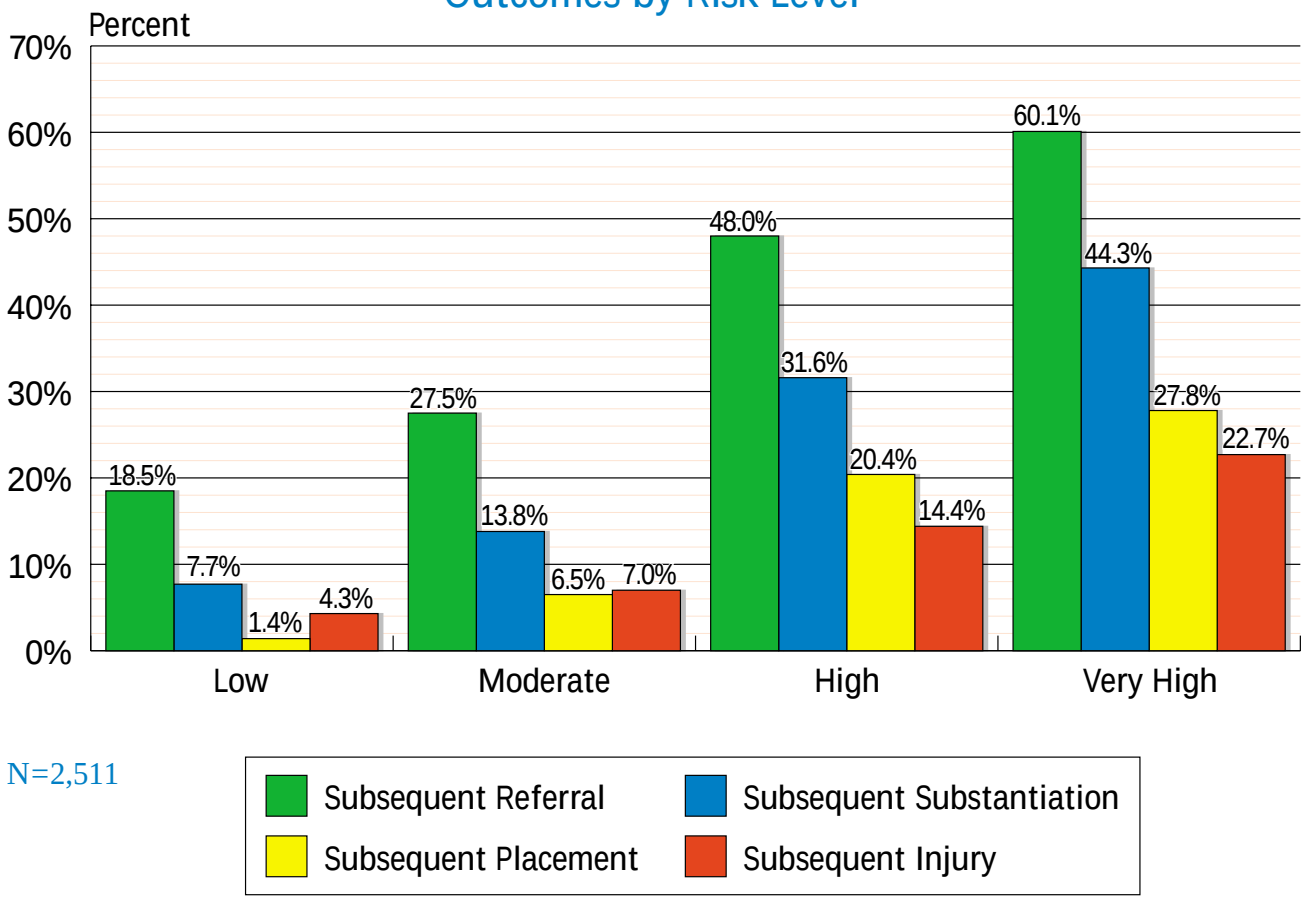
Figure 7 illustrates results from a recent CRC study (California, 1998). A random sample of 2,511 families referred to child welfare from seven California counties was included in the research. As the figure demonstrates, there is a strong relationship between risk levels and all outcome measures.

For example, the data show that among families classified as low risk, just 18.5% had a subsequent referral for abuse or neglect during the 24-month follow-up period. In contrast, among families classified as very high risk, the re-referral rate was 60%, more than three times the rate found for low risk cases.

Importantly, in all CRC studies to date, the risk systems developed also promote equity in decision making. Because equity is a major principle of the development process, the proportion of African Americans, Whites and Hispanics assigned to each risk level is virtually identical in all jurisdictions. These results suggest that well-structured assessment tools and decision making systems can help overcome some of the racial disparities resulting from traditional practices.

Figure 7

California Risk Assessment Outcomes by Risk Level



N=2,511

Results of other risk studies are presented in Appendix A.

In many child welfare agencies, inexperienced workers, minimal training, and high turnover all but guarantee that clinical judgments of risk will vary widely among workers. Line staff often fail to identify high risk families during abuse/neglect investigations and therefore do not engage them in services (Johnson and L'Esperance, 1984). CRC research shows that in some agencies using traditional assessment methods, many (in some instances, most) high risk cases are *not* opened for services while many low risk families are carried on caseloads for years. The result is that agencies are losing the opportunity to prevent abuse in the families who are most at risk. By using actuarial risk assessment, child welfare agencies can directly address this issue and significantly improve the initial case service decisions made by individual workers.

Risk assessment can help line staff make better decisions. Research has consistently demonstrated that simple actuarial tools can assess risk more accurately than even a well-trained clinical staff person (Meehl 1954; Dawes, Faust, and Meehl 1989).

Assessment of Family Needs and Strengths

Another important feature of the CRC structured decision making system is the family strengths and needs assessment. A companion piece to the risk assessment, it is used to systematically identify critical family issues and resources and help plan effective service interventions. The strengths and needs assessment instrument shown on the following page was designed - using a consensus approach - in collaboration with staff from counties in Wisconsin. This and similar tools serve several purposes:

The strengths/needs assessment is used to systematically identify family issues. It provides a foundation for the service plan.

- It ensures that all workers consistently consider each family's strengths and weaknesses in an objective format when assessing need for services.
- It provides an important case planning reference for workers and first line supervisors which eliminates long, disorganized case narratives and reduces paperwork.
- It provides a basis for monitoring whether appropriate service referrals are made.
- The initial needs assessment, when followed by periodic reassessments, permits case workers and supervisors to easily assess change in family functioning and thus monitor the impact of services on the case.
- It provides management with aggregated information on the issues client families face. These profiles can then be used to develop resources to meet client needs.

Some jurisdictions have also developed a child-focused strengths and needs assessment tool for use with children who may be placed out of the home. An example is shown in Appendix B.

Reassessment of Risk and Needs

The initial assessments of risk and service needs are followed by routine *reassessments*, which are conducted at established intervals (generally every 90 days) as long as the case is open. Case reassessment ensures that any changes in risk or family service needs will be considered in later stages of the service delivery process, and that case decisions will be made accordingly. Case progress will determine if a lower or higher service level is needed, or if the case can be closed. In most agencies, the risk and needs assessment/reassessment instruments have become formal case planning documents and thus reduce the need for long case narratives and other paperwork. The time saved is available to actually serve families.

Periodic reassessment also provides for ongoing monitoring of important case outcomes such as: 1) new abuse or neglect incidents; 2) out-of-home placement status of children in the family; 3) changes in each family's service utilization pattern; and 4) changes in the severity of previously identified needs. In short, the reassessment of each family at fixed intervals provides direct service workers and their supervisors with an efficient mechanism for collecting and evaluating information necessary to effectively manage their cases.

Figure 8

WISCONSIN URBAN CAUCUS FAMILY STRENGTHS AND NEEDS ASSESSMENT

Case Name: _____ **Date:** ____/____/____

Case Number: _____ **Referral Date:** ____/____/____ **Initial** **Reassess #:** 1 2 3 4 5 ___

				Scored	Caregiver Scored (P,S,B,or O)
1.	Substance Abuse:	a.	No evidence of problem. . . . 0		
		b.	Abuse creates some problems in family OR caregiver in treatment. . . . 3		
		c.	Serious abuse problem. . . . 5	_____	_____
2.	Emotional Stability:	a.	No evidence or symptoms of emotional instability or psychiatric disorder. . . . 0		
		b.	Moderate problems that interfere with functioning. . . . 3		
		c.	Problems that severely limit functioning. . . . 5	_____	_____
3.	Family Violence:	a.	No threatening or assaultive behavior among family members. . . . 0		
		b.	Isolated incidents of past assaultive behavior. . . . 2		
		c.	Current pattern of intimidation, isolation, threats of harm, or verbal abuse. . . . 4		
		d.	Repeated assaultive behavior OR any incident resulted in injury. . . . 5	_____	_____
4.	Intellectual Ability:	a.	No evidence of limitations in intellectual functioning. . . . 0		
		b.	Somewhat limited intellectual functioning. . . . 2		
		c.	Intellectual ability severely limits ability to function. . . . 3	_____	_____
5.	Health:	a.	No known health problems that affect functioning. . . . 0		
		b.	Moderate disability/illness; impairs ability to care for child(ren). . . . 2		
		c.	Serious disability/illness; severely limits ability to care for children. . . . 3	_____	_____
6.	Caregiver Victimization:	a.	No evidence of problem. . . . 0		
		b.	Caregiver(s) has been victimized. (Check and add for score)		
			____ Caregiver(s) neglected as child(ren). . . . 1		
			____ Caregiver(s) has been a victim of sexual abuse. . . . 1		
			____ Caregiver(s) has been a victim of physical abuse. . . . 1	_____	_____
7.	Parenting Skills:	a.	No known/minimal deficits in parenting skills. . . . 0		
		b.	Needs improvement in parenting skills. . . . 3		
		c.	Repeated displays of abusive, neglectful, or destructive parenting patterns. . . . 5	_____	_____
8.	Environmental:	a.	Family has adequate housing, clothing, and nutrition. . . . 0		
		b.	Physical environment presents potential hazards to health or safety. . . . 2		
		c.	Conditions exist in household that have caused illness or injury. . . . 3		
		d.	Family is homeless. . . . 4	_____	_____
9.	Support Systems:	a.	Family has available, and uses, external support system(s). . . . 0		
		b.	Resources limited or have some negative impact or caregiver reluctant to use. . . . 2		
		c.	Caregiver unable to access internal or external resources (skill deficits). . . . 3		
		d.	Resources unavailable or have major negative impact. . . . 4	_____	_____
10.	Financial:	a.	Family income sufficient to meet needs and is adequately managed. . . . 0		
		b.	Income limited, but is adequately managed. . . . 1		
		c.	Income insufficient or not well-managed; unable to meet basic needs/responsibilities. . . . 2		
		d.	Family is in financial crisis - little or no income. . . . 3	_____	_____
11.	Education/ Literacy:	a.	Basic education and functional literacy skills. . . . 0		
		b.	Caregiver marginally educated or literate; creates some problems. . . . 1		
		c.	Functionally illiterate; creates major problems. . . . 2	_____	_____
12.	Problem Recognition:	a.	No problem observed or problem(s) acknowledged, wants assistance. . . . 0		
		b.	Problem(s) acknowledged, does not want assistance. . . . 2		
		c.	Problem(s) denied; uncooperative; resists assistance or intervention. . . . 4	_____	_____
13.	Family Interaction:	a.	Developmental roles/interactions appropriate. . . . 0		
		b.	Moderate communication or behavior problems and/or some inappropriate role functions. . . . 2		
		c.	Serious family dysfunction in communication or behavior patterns, personal boundaries, attachment and roles. . . . 4	_____	_____
14.	Child(ren) Characteristics:	a.	No known emotional, behavioral, intellectual, or physical problems. . . . 0		
		b.	Minor problems, but little impact on functioning. . . . 1		
		c.	Problems in one or more areas that sometimes limit functioning. . . . 2		
		d.	One child has severe/chronic problems that result in serious dysfunction. . . . 3		
		e.	Children have severe/chronic problems that result in serious dysfunction. . . . 4	_____	

Child(ren) Problem Areas (check all that apply):

___ substance abuse ___ health/handicap ___ emotional stability ___ exceptional education needs
___ school behavior/truancy ___ support system ___ intellectual ability ___ life/social skills
___ peers ___ sex abuse issues ___ assaultiveness ___ status offending ___ delinquent behavior

TOTAL SCORE _____

The primary needs of the family are:

1. _____ _____
2. _____ _____
3. _____ _____

NEEDS LEVEL:

Low	0 - 10
Medium	11 - 20
High	21 - 54

Establishing Service Standards for Cases at Each Risk Level

Not all families involved in child abuse or neglect incidents require the same level of child welfare services. Yet in terms of case assignment and resource allocation, many child welfare agencies treat each case the same. Hence, services are sometimes provided to families who will not benefit from them, while other higher risk families do not receive the resources needed to adequately protect children.

Risk assessment provides an objective framework for making service decisions. The ability to more accurately assess risk allows agencies to target service resources more efficiently. A primary mechanism for targeting resources is the use of differential service standards, whereby the mandated frequency of contact between the worker and the family is tied to the family's level of risk. Low risk families need not receive the same amount of agency resources (i.e., case worker time) as high risk families because they are much less likely to again maltreat their children. When differential worker contact standards based on risk are established by an agency, it becomes possible to make existing service resources reach farther and produce better results. Figure 9 shows how the Michigan Family Service Agency has defined and differentiated service standards by case type. Similar standards have been implemented in many other agencies.

Linking service standards to risk assures that resources are targeted to families most likely to again abuse or neglect their children.

Figure 9

MICHIGAN CPS SERVICE STANDARDS

Service Level	Minimum Standards
Low	1 face-to-face contact by the CPS worker with client per month, plus 1 collateral contact per month by the worker on behalf of the client
Moderate	2 face-to-face contacts by the CPS worker with client per month, plus 2 collateral contacts per month by the worker on behalf of the client
High	3 face-to-face contacts by the CPS worker with client per month, plus 3 collateral contacts per month by the worker on behalf of the client
Intensive	4 face-to-face contacts by the CPS worker with client per month, plus 4 collateral contacts per month by the worker on behalf of the client

Structured Decision Making for Children in Out-of-Home Care

CRC has applied the principles of standardized assessment and structured decision making to families with children in foster care. The intent of the foster care component is to ensure that state and federal policies regarding reunification, permanency planning for children, and termination of parental rights are effectively translated into practice. To this end, the model establishes presumptive guidelines for children in care based on: 1) risk of future maltreatment; 2) the safety of the home environment; and 3) demonstrated parental interest and involvement in the lives of their children. It is a "best practice" guide that will facilitate implementation of the new federal legislation while leading to more consistent and appropriate decision making. While every agency will need to modify this component of the model to include its own assessment instruments, policies, and terminology, the overall logic of the system is universally applicable. The system presumes the following:

- When families reduce risk to an acceptable level and maintain appropriate visitation with their children, the child should be returned home *if* the home is judged to be safe.
- When risk remains high *or* the home remains unsafe *or* parents fail to meet their visitation responsibilities for a specified period time (in concert with federal guidelines and agency policy), it is presumed that the goal will be changed from return home to another plan for permanency.

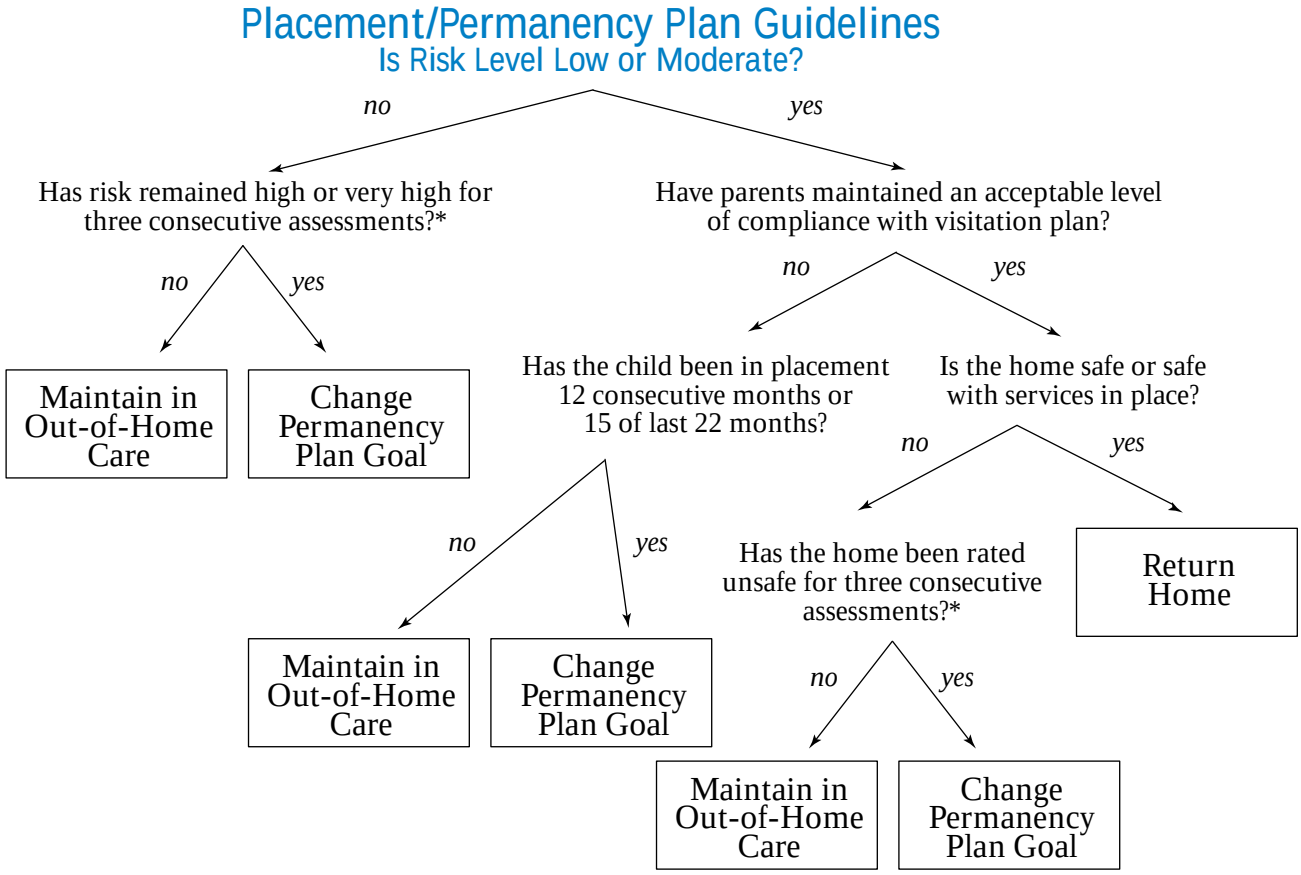
In the foster care model, the *initial* risk level is established using the research-based risk assessment instrument. The risk *reassessment* assumes that risk is reduced if the family has made significant progress toward treatment goals. The reassessment scoring system generally precludes consideration of reunification if there had been *any new substantiation* of maltreatment of *any* child in the household since the previous assessment.

The reunification model consists of four *assessment* components:

- a structured risk reassessment;
- a structured evaluation of parental compliance with visitation schedules;
- a reunification safety assessment; and,
- structured guidelines for changing the permanency planning goal.

As shown in Figure 10, the results of the structured assessments (Risk, Visitation Compliance, Safety) are jointly considered to guide decisions regarding return to the home or changes in the permanency plan. This is presented as an *example*. In practice, CRC staff work with each agency to develop a protocol that incorporates criteria reflective of key local policies and regulations.

Figure 10



*Agency policy would determine the number of assessments conducted before a change in the permanency plan is indicated.

THE MANAGEMENT COMPONENTS OF THE SDM MODEL

In addition to providing greater consistency in decision making and more efficient use of resources, the SDM model includes two components designed specifically to facilitate management and administration of the child welfare agency. These components - workload measurement and management information reports - build upon and help maximize the utility of the structured decision making aspects of the model.

Workload Measurement

Workload measurement is based on the assumption that simple caseload counts do not adequately capture the *amount of time* - and therefore the number of staff - needed to fulfill the child welfare agency's mandates. Moreover, given the delineation of distinct case types and differential service standards in the SDM model, caseload counts are an ineffective measure for determining how workload should be distributed across work units or individual staff.

Workload measurement translates "caseload" into time requirements and ultimately, staffing needs. To establish a workload system, a simple case-based time study is conducted to determine the *amount of time actually needed by staff to meet service standards* for various types of cases. This information is used to calculate the agency's total "workload demand," which can then be compared to the current "supply" of

available staff. Knowing the monthly time requirement for each case type, and the total workload demand, allows the agency to:

- provide a rational, empirical basis for budget and staffing requests to external funding sources;
- develop an internal system for equalizing workload across staff or work units; and
- estimate the impact of new service responsibilities or budget restrictions on agency service delivery.

Since the agency is able to specify its case-related service standards, and identify the number of staff required to serve cases

Workload measurement translates "caseload" into time requirements and ultimately, staffing needs.

according to those standards, a workload-based budget in essence becomes a contract for services. Funding bodies will know exactly what level of service will be provided based on the level of staff resources allocated. The effect of budget reductions on client service will be readily apparent, as will the effect of enhanced resources.

Figure 11 provides an example of a workload-based budget.

Figure 11

DETERMINATION OF WORKLOAD DEMAND AND STAFF NEEDED

(Example)

Case Type	Number of Cases Per Month	Time Required Per Case, Per Month to Meet Standards	Time Required Per Month by Case Type
Abuse/Neglect Intakes	700	1.0 hrs	700 hrs
Investigations	350	6.5 hrs	2,275 hrs
Ongoing Cases			
Low	100	3.3 hrs	330 hrs
Medium	250	4.2 hrs	1,050 hrs
High	150	6.6 hrs	990 hrs
Foster Care Cases	100	9.0 hrs	900 hrs
TOTAL WORKLOAD DEMAND			6,245 hrs/month
WORKER TIME AVAILABLE PER MONTH [1]			120.6 hrs
TOTAL NUMBER OF STAFF NEEDED [2]			51.8

1. Time available to handle cases. Reflects reductions from salaried hours due to vacation, sick days, training and administrative tasks.
2. Calculated by dividing workload demand by time available per worker.

Management Information Reports: Data for Planning, Monitoring and Evaluation

An important feature of the CRC model is that it can provide management with information to routinely monitor and evaluate programs, assess the impact of policy, identify service needs and determine which programs and intervention strategies provide the best results for various types of cases. A basic premise underlying CRC's approach to management information is that the information needed to make good decisions at the individual case level (e.g., structured assessments of risk and service needs) is the same information needed - in aggregate form - by agency supervisors, analysts and administrators.

As shown in Figure 12, aggregated risk information can, for example, document changes in the nature of the client population. This (example) graph reveals substantial increases over a five-year period in the proportion of substantiated cases identified as high and very high risk. This information clearly demonstrates new challenges facing the agency and documents changes in workload. Similarly, Figure 13 shows how managers can use needs and service referral data to monitor the extent to which clients are receiving services for identified problems, and the effectiveness of those services upon subsequent substantiations.

Figure 12

Changes in Initial Risk Levels 1993 - 1998

(Example)

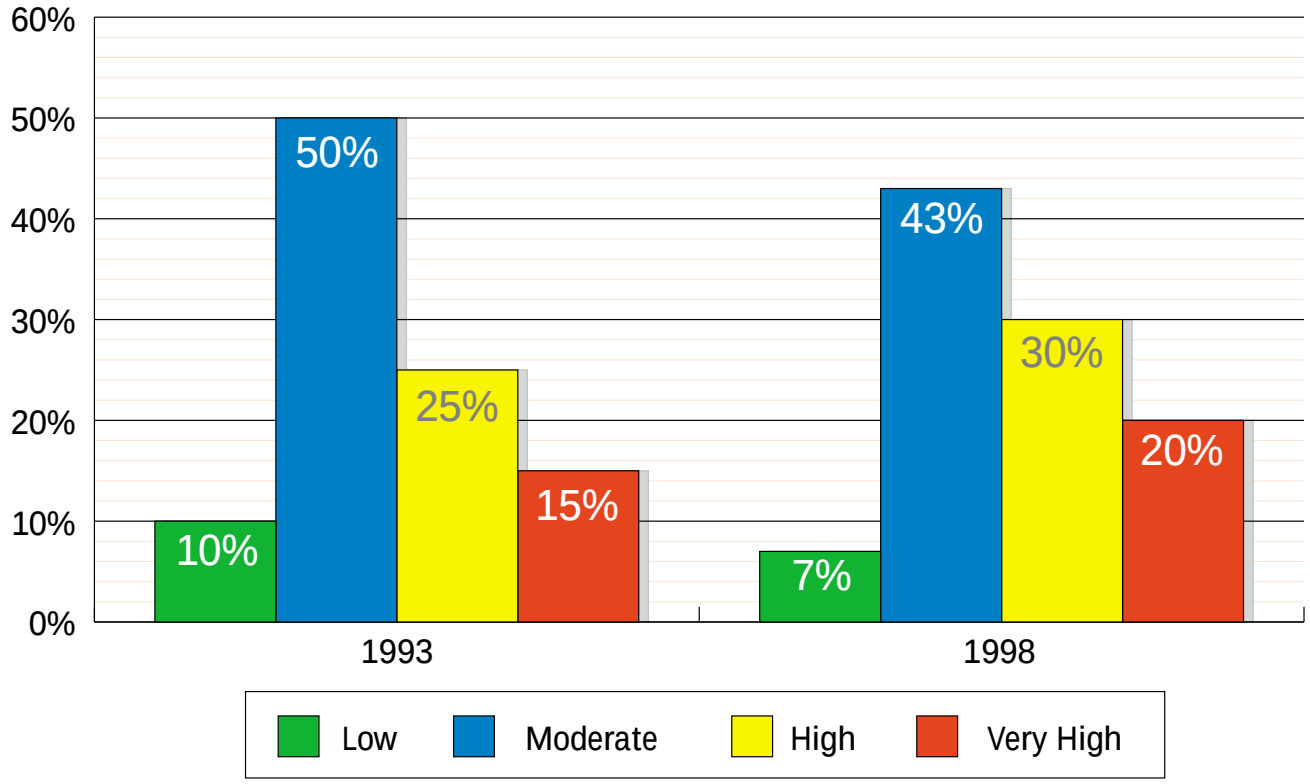
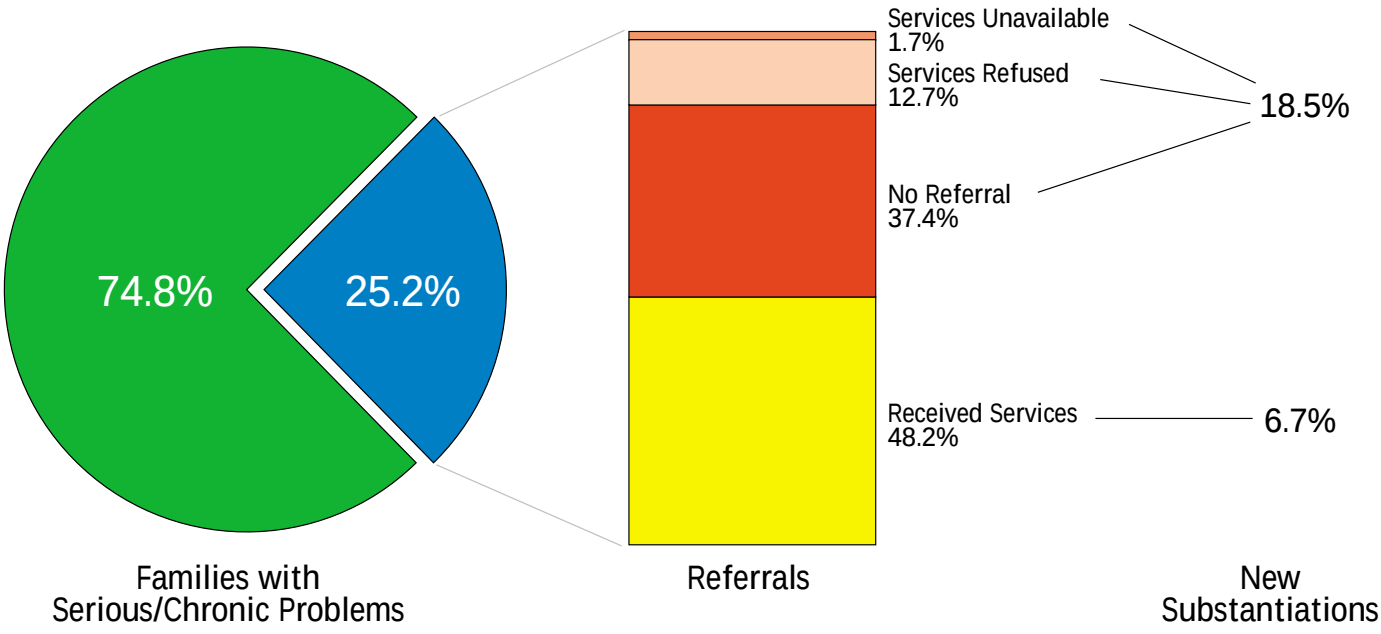


Figure 13

Substance Abuse Rehabilitation Needs, Referrals, and Outcomes



Source: Michigan Family Independence Agency

SDM management information can also be used to increase the agency's *evaluation* capabilities. The organization can establish clearly defined outcome objectives for policies and programs and use the aggregate data generated by the CRC model to determine the extent to which those objectives were realized. A consortium of counties in Wisconsin, for example, using data routinely generated by the CRC system, were able to: 1) revalidate their risk assessment instrument, and 2) demonstrate that providing intensive services to high and very high risk cases **significantly** reduced subsequent referrals for abuse and neglect. These data have profound implications for future funding and resource allocation.

The data generated by the SDM system can be used to evaluate child welfare policies and programs.

In sum, the CRC approach: 1) provides the ability to critically evaluate programs essential for improving services to families and children, and 2) directly enhances an agency's evaluation capacity by providing quality data on client characteristics, system processing and case outcomes.

The SDM model incorporates laudable goals. The components of the model make conceptual and intuitive sense, and they are informed by extensive research. But a key question remains: does the SDM model work? That is:

- are case decisions in fact more *consistent* across staff?
- does SDM help staff make *better* decisions?
- does the model actually have an *impact* in terms of reducing the incidence of subsequent abuse and neglect?

The results of two evaluations that addressed these questions are presented below.

The OCAN Study

A variety of risk assessment tools have been developed and adopted by child welfare agencies. Until recently however, these risk models, whether consensus- or empirically-based, had not been rigorously evaluated. To remedy this, the Office of Child Abuse and Neglect (OCAN) selected the Children's Research Center (overseen by an independent Advisory Board of national experts) to conduct a comparative evaluation of the reliability and validity of three different risk models (Baird, Wagner, Healy and Johnson, 1999). These included two consensus models - the Washington Risk Assessment Matrix and the California Family Assessment Factor Analysis (a derivative of the Illinois CANTS model) - as well as the empirically-based Michigan Family Risk Assessment.

The reliability of the empirically-based Michigan model was significantly greater than the consensus models tested in a national study.

Risk Assessment Reliability

The first phase of the study assessed the reliability of the three risk models by measuring the extent to which *different* workers assigned the *same* risk level to the *same* family. The study methodology involved a total of 80 randomly selected cases which were assessed by four case readers who had been trained in the Washington scale, four others who had been trained to use the California instrument and four others who had been trained in the Michigan model.[1] Both simple comparisons of the percentage of cases on which raters agreed and a statistical measure of reliability, Cohen's Kappa, demonstrated that the reliability of the Michigan system was significantly higher than the level of reliability attained by the "expert" or "consensus-based" approaches to risk assessment.

[1] The study took place in four different sites to ensure broad geographic and ethnic representation - Alameda County (Oakland), CA; Dade County (Miami), FL; Jackson County (Kansas City), MO; and four counties in Michigan (Macomb, Muskegon, Ottowa and Wayne). The 80 sample cases consisted of 20 selected from each site. There were three people in each site - each trained on a different risk instrument - who completed the risk assessments. Each site team scored the 20 cases from its site and the cases from each of the other sites.

Risk Assessment Validity

The second phase of the OCAN study evaluated the validity of the California, Michigan and Washington risk assessment systems. "Validity" refers to the extent to which an instrument in fact measures what it purports to measure. In the child welfare risk context, the fundamental evaluation questions for assessing the validity of risk instruments are as follows:

- Does a higher risk classification indicate a greater probability of re-referral for abuse or neglect?
- Are there substantial differences in re-referral rates *between* risk classifications? Ideally, "high" risk cases should have a re-referral rate that is three to four times greater than the cases classified as "low" risk.

A significantly higher level of reliability was found for the Michigan system than either of the two consensus-based approaches. In 85% of all cases, at least three of the four raters agreed on the risk level assigned to a case. Reliability of the consensus based instruments, however, was well below what is considered adequate. When the Washington or California systems were used to rate risk, substantial differences among the raters were noted. For both systems, at least three of the four raters agreed on a risk level in only about 50% of all cases assessed. A statistical test used to measure reliability (Cohen's Kappa) indicated the Michigan scale was reliable, while the Washington and California scales were not.

To assess the validity of the three risk instruments, CRC compared results from a cohort of 1,400 cases investigated for abuse and neglect allegations in the Fall of 1995. Following the investigations, each family was tracked for 18 months. Figure 14 presents the **mean** number of investigations per case at each risk level. Clearly, the Michigan system did a superior job identifying families with low, moderate and high proclivities for maltreating children.

Figure 14

Mean Number of New Investigations and Substantiations Reported During an 18-Month Follow-Up Period by Risk Level

	California		Michigan		Washington	
	Investigations	Substantiations	Investigations	Substantiations	Investigations	Substantiations
Low	.525	.22	.246	.09	.386	.18
Moderate	.658	.28	.541	.21	.665	.27
High	.585	.22	.872	.43	.636	.28
Base Rate	**.580**	**.24**	**.586**	**.25**	**.596**	**.25**

Note: Base rates for each system vary slightly because the number of cases for which each risk assessment was completed ranges from 929 for Michigan to 876 for California.

Evaluation of the Michigan Structured Decision Making System

Between 1989 and 1992, CRC and Michigan child welfare staff worked together to design an SDM system for CPS cases (Baird, Wagner, Caskey and Neuenfeldt, 1995). The system consisted of risk and needs assessment instruments, case planning and reassessment tools, as well as differentiated service standards. System implementation began in 13 pilot counties during 1992.

Did the implementation of this risk-based structured decision making system have an impact on child welfare outcomes? Michigan's phased implementation schedule presented an opportunity to formally evaluate the *impact* of SDM by comparing outcomes in the 13 SDM counties with those in a matched sample of 11 counties that were still operating under the traditional system. The evaluation sample consisted of all cases with substantiated abuse or neglect between September 1992 and October 1993. The SDM and comparison study samples each totalled approximately 900 families. Outcome measures included new referrals, investigations and substantiations occurring during a 12-month follow-up period.

There were several important findings regarding differences in decision making and case processing that occurred in the SDM and comparison counties. The process evaluation findings included:

High risk families in the SDM counties were significantly more likely to become involved in parenting skills training, substance abuse treatment, family counseling and mental health services.

Case Closing Decisions

- The SDM counties were significantly more likely to close *low and moderate risk cases* following substantiation, while the non-SDM counties closed more *high and intensive risk cases*. Moreover, cases that were closed without services in the SDM counties had significantly lower re-referral rates than closed cases in the comparison group. This indicates that the use of risk assessment led to improved screening in the SDM counties.

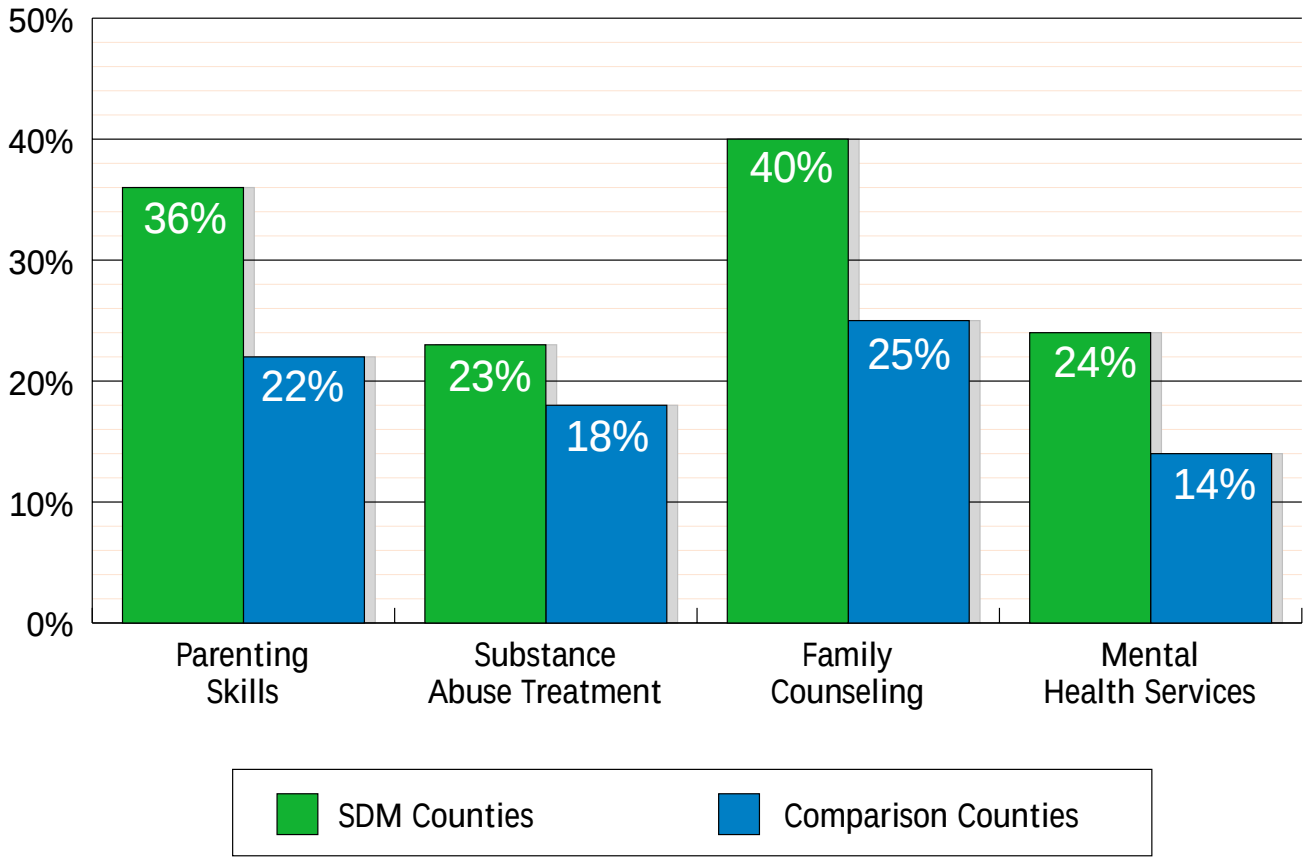
Changes in Service Provision

- Program participation in the SDM counties occurred at significantly higher levels than in the comparison counties. This was particularly true for high and intensive risk families. For example, high risk families in the SDM counties were more likely than the high risk non-SDM cases to become involved in parenting skills training, substance abuse treatment, family counseling and mental health services (see Figure 15).

Figure 15

Michigan SDM Evaluation Results

Percent of High Risk CPS Cases that Received Specific Services



Outcomes

The evaluation also examined whether changes such as those noted above resulted in a better overall system of child protection. *The principle question is whether implementation of the SDM system translated into lower rates of maltreatment in Michigan.* Figure 16 compares overall results for cases from SDM with comparison counties. **For each outcome measure, families in the SDM counties had better outcomes than other families**. The greatest difference was found in rates of new substantiations, where SDM families had a rate that was 50% lower than that observed for the comparison group (6.2% vs. 13.2%).

A separate analysis of outcomes by risk group also showed positive results for the Michigan SDM system. For example, *high risk* CPS cases handled in the SDM counties had fewer new referrals, fewer subsequent child injuries, lower rates of subsequent placement in foster care and, like the overall sample, were only half as likely as comparison families to have a subsequent substantiation.

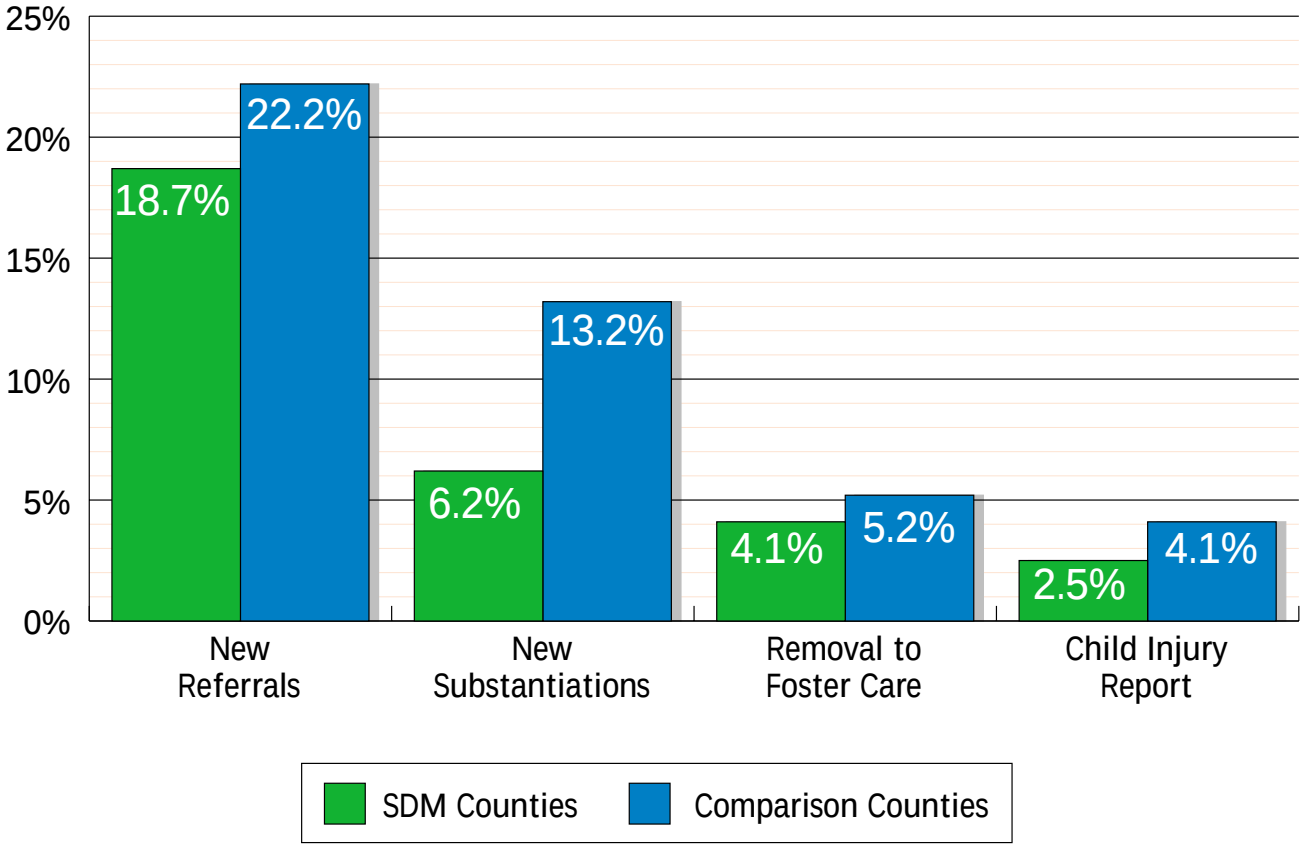
SDM families had a subsequent substantiation rate that was 50% lower than that found in the comparison group.

In summary, the results of this carefully controlled evaluation showed that SDM not only resulted in important changes in decision making and service provision for child welfare cases but, as anticipated, it ultimately had a positive impact on the protection of Michigan's children.

Figure 16

Michigan SDM Evaluation Results

Outcomes for CPS Cases
12-Month Follow-Up



CONCLUSION

The future of child welfare services in the U.S. depends on the ability of CPS agencies to effectively deal with growing caseloads, increased public scrutiny, and static or diminishing resources. The number of abuse and neglect complaints has ***tripled*** since 1980. ***Clearly, new methods are needed to deal with this crisis.*** Agencies cannot ignore technologies which significantly improve decision making and help target resources to children and families most at risk For example, the use of empirically-based risk assessment is not a question of replacing professional judgment with statistical inference. It is simply a matter of using the best information available to protect our children from harm. And as demonstrated through the recent OCAN evaluation, the research-based risk tools used by CRC are clearly superior to other models in terms of both their reliability and their validity.

Risk assessment is only one component of the CRC system. The CRC model is comprehensive, using structured decision making at all key decision points from intake to reunification. Moreover, it allows the ***best information*** to be used at every organizational level. It *links* assessments to service plans, and agency standards to workload and budgeting. It provides data to workers for case decision making and data to managers for planning and program evaluation. Finally, as demonstrated by the OCAN and Michigan evaluation research, the CRC model represents a practical and efficient means for improving the plight of America's child protective service systems.

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APPENDIX A

MICHIGAN ASSESSMENT FOR SUBSTANTIATED CASES
FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

3/1/95

PS Case Name _____ PS Case # _____
Load # _____ Date ___/___/___

Neglect

N1. Current Complaint is for Neglect
- a. No . . . 0
- b. Yes . . . 1 ____

N2. Number of Prior Assigned Complaints
- a. None . . . 0
- b. One . . . 1
- c. Two or more . . . 2 ____

N3. Number of Children in the Home
- a. Two or fewer . . . 0
- b. Three or more . . . 1 ____

N4. Number of Adults in Home at Time of Complaint
- a. Two or more . . . 0
- b. One/none . . . 1 ____

N5. Age of Primary Caretaker
- a. 30 or older . . . 0
- b. 29 or younger . . . 1 ____

N6. Characteristics of Primary Caretaker **(check & add for score)**
- a. Not applicable . . . 0
- b. ___ Lacks parenting skills . . . 1
- c. ___ Lacks self-esteem . . . 1
- d. ___ Apathetic or hopeless . . . 1 ____

N7. Primary Caretaker Involved in Harmful Relationships
- a. No . . . 0
- b. Yes, but not a victim of domestic violence . . . 1
- c. Yes, as a victim of domestic violence . . . 2 ____

N8. Primary Caretaker Has a Current Substance Abuse Problem
- a. No . . . 0
- b. Alcohol **only** . . . 1
- c. Other drug(s) (with or without alcohol) . . . 3 ____

N9. Household is Experiencing Severe Financial Difficulty
- a. No . . . 0
- b. Yes . . . 1 ____

N10. Primary Caretaker's Motivation to Improve Parenting Skills
- a. Motivated and realistic . . . 0
- b. Unmotivated . . . 1
- c. Motivated but unrealistic . . . 2 ____

N11. Caretaker(s) Response to Investigation
- a. Viewed situation as seriously as investigator and cooperated satisfactorily . . . 0
- b. Viewed situation less seriously than investigator . . . 1
- c. Failed to cooperate satisfactorily . . . 2
- d. Both b and c . . . 3 ____

TOTAL NEGLECT RISK SCORE ____

Abuse

A1. Current Complaint is for Abuse
- a. No . . . 0
- b. Yes . . . 1 ____

A2. Prior Assigned Abuse Complaints
- a. None . . . 0
- b. Abuse complaint(s) . . . 1
- c. Sexual abuse complaint(s) . . . 2
- d. Both b and c . . . 3 ____

A3. Prior CPS Service History
- a. No . . . 0
- b. Yes . . . 1 ____

A4. Number of Children in the Home
- a. One . . . 0
- b. Two or more . . . 1 ____

A5. Caretaker(s) Abused as Child(ren)
- a. No . . . 0
- b. Yes . . . 1 ____

A6. Secondary Caretaker has a Current Substance Abuse Problem
- a. No, or no secondary caretaker . . . 0
- b. Yes **(check all that apply)**
  - ____ Alcohol abuse problem
  - ____ Drug abuse problem . . . 1 ____

A7. Primary or Secondary Caretaker Employs Excessive and/or Inappropriate Discipline
- a. No . . . 0
- b. Yes . . . 2 ____

A8. Caretaker(s) has a History of Domestic Violence
- a. No . . . 0
- b. Yes . . . 1 ____

A9. Caretaker(s) is a Domineering Parent
- a. No . . . 0
- b. Yes . . . 1 ____

A10. Child in the Home has a Developmental Disability **or** History of Delinquency
- a. No . . . 0
- b. Yes **(check all that apply)**
  - ___ Developmental disability including emotionally impaired
  - ___ History of delinquency . . . 1 ____

A11. Secondary Caretaker Motivated to Improve Parenting Skills
- a. Yes, or no secondary caretaker in home . . . 0
- b. No . . . 2 ____

A12. Primary Caretaker Views Incident Less Seriously than Agency
- a. No . . . 0
- b. Yes . . . 1 ____

TOTAL ABUSE RISK SCORE ____

RISK LEVEL

Assign the family's risk level based on the highest score on either scale, using the following chart:

Neglect Score	Abuse Score	Risk Level
__ 0 - 4	__ 0 - 2	__ Low
__ 5 - 7	__ 3 - 5	__ Moderate
__ 8 - 12	__ 6 - 9	__ High
__ 13 - 20	__ 10 - 16	__ Intensive

OVERRIDES

Policy: Override to Intensive. Check appropriate reason.
- __ 1. Sexual Abuse cases where the perpetrator is likely to have access to the child victim.
- __ 2. Cases with non-accidental physical injury to an infant.
- __ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
- __ 4. Death (previous or current) of a sibling as a result of abuse or neglect.

Discretionary: __ 5. Reason _____

OVERRIDE RISK LEVEL _____ Low _____ Moderate _____ High _____ Intensive

Supervisor's Review/Approval of Discretionary Override _____ Date ___/___/___

Note: In practice, comprehensive definitions accompany each item.

RHODE ISLAND

FAMILY CLASSIFICATION FOR RISK OF ABUSE

Score

A1. Did the current investigation indicate abuse?
- a. No 0
- b. Yes . . . . . +1 _____

A2. How many early warnings were received for this household prior to the current incident?
- a. None . . . . . -1
- b. One 0
- c. Two or more . . . . . +1 _____

A3. How many unfounded investigations of this household were conducted prior to the current incident?
- a. None 0
- b. One . . . . . +1
- c. Two or more . . . . . +3 _____

A4. Has any prior investigation of this household indicated sexual abuse?
- a. No 0
- b. Yes, prior sexual abuse . . . . . +2 _____

A5. How many children were indicated for abuse or neglect in this incident?
- a. One child 0
- b. Two children . . . . . +1
- c. Three or more children . . . . . +2 _____

A6. Age of the youngest child indicated for abuse or neglect in this incident?
- a. Age 16 or older . . . . . -2
- b. Age 15 or younger . . . . . 0 _____

A7. Age of the primary adult caretaker?
- a. 36 years or older . . . . . -1
- b. Age 35 or younger . . . . . 0 _____

A8. Is there evidence that either caretaker has an alcohol or drug problem?*
- a. No 0
- b. Yes . . . . . +1 _____

A9. Does the family appear to receive little or no external support from family, friends, or community resources?*
- a. Some support 0
- b. Little or no support . . . . . +1 _____

A10. Does this appear to be a stable family?*
- a. No 0
- b. Yes . . . . . -1 _____

A11. Does any child in the family have a CYCIS contact record or CYCIS service history?
- a. No . . . . . -1
- b. Yes, CYCIS contact 0
- c. Yes, CYCIS service history . . . . . +1 _____

* See Appendix definition

TOTAL ABUSE SCORE _____

RHODE ISLAND

FAMILY CLASSIFICATION FOR RISK OF NEGLECT

Score

N1. Did the current investigation indicate neglect?
- a. No 0
- b. Yes . . . . . +1 _____

N2. Was the type of neglect indicated at this investigation inadequate food, clothing, medical care or failure to thrive (CANTS allegations 43, 45, 46, 48)?
- a. No 0
- b. Yes . . . . . +1 _____

N3. How many early warnings were received for this household prior to this incident?
- a. None 0
- b. One . . . . . +1
- c. Two or more . . . . . +2 _____

N4. How many unfounded investigations of this household were conducted prior to the current incident?
- a. None . . . . . -1
- b. One 0
- c. Two or more . . . . . +1 _____

N5. Was neglect or sexual abuse indicated at any prior investigation of this household? (check and add for score)
- a. ___ Neglect . . . . . +1
- b. ___ Sexual Abuse . . . . . +2
- c. ___ None of the above . . . . . 0 _____

N6. How many children were indicated for abuse or neglect in this incident?
- a. One or two children 0
- b. Three or more children . . . . . +1 _____

N7. Age of the oldest child indicated for abuse or neglect in this incident?
- a. Age 11 or older . . . . . -1
- b. 6 - 10 years old 0
- c. Less than 6 years old . . . . . +2 _____

N8. Was the primary adult caretaker a perpetrator in this incident?
- a. No 0
- b. Yes . . . . . +1 _____

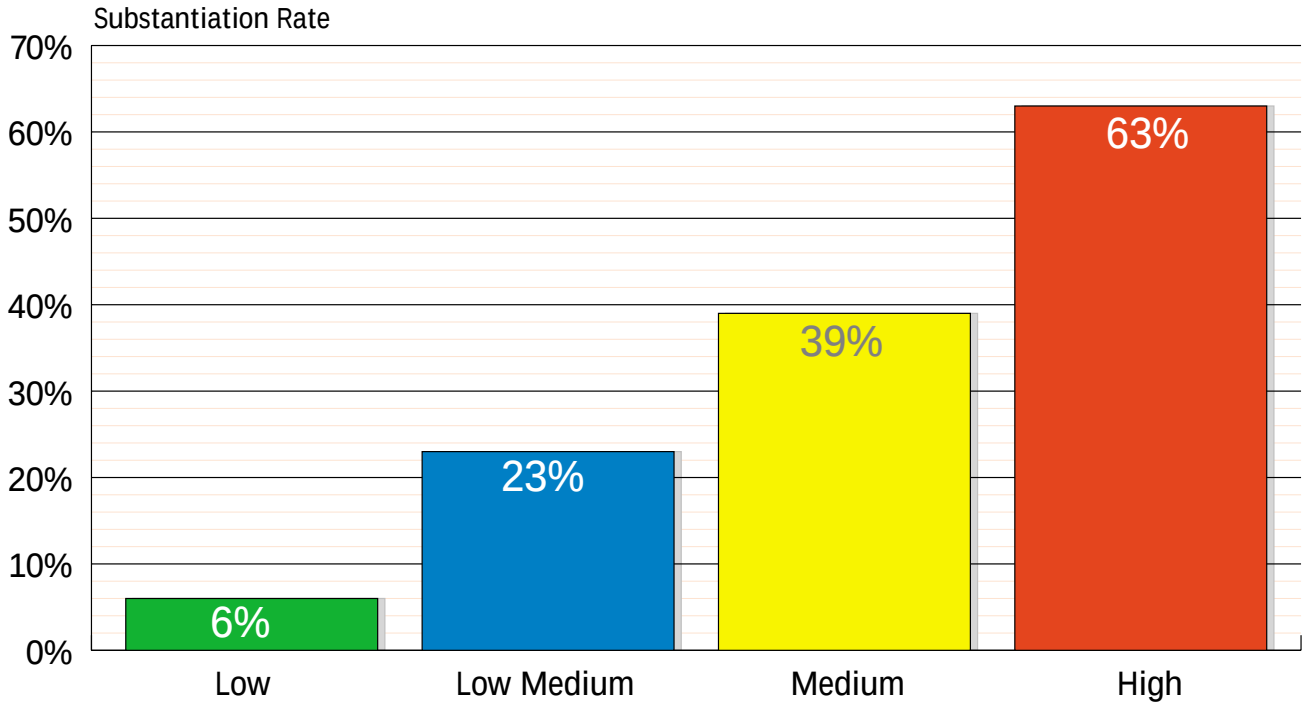
N9. Does this appear to be a stable family?*
- a. No 0
- b. Yes . . . . . -1 _____

N10. Does any child in this family have a CYCIS contact record or a CYCIS service history?
- a. None 0
- b. Yes, CYCIS contact . . . . . +1
- c. Yes, CYCIS service history . . . . . +2 _____

* See Appendix definition

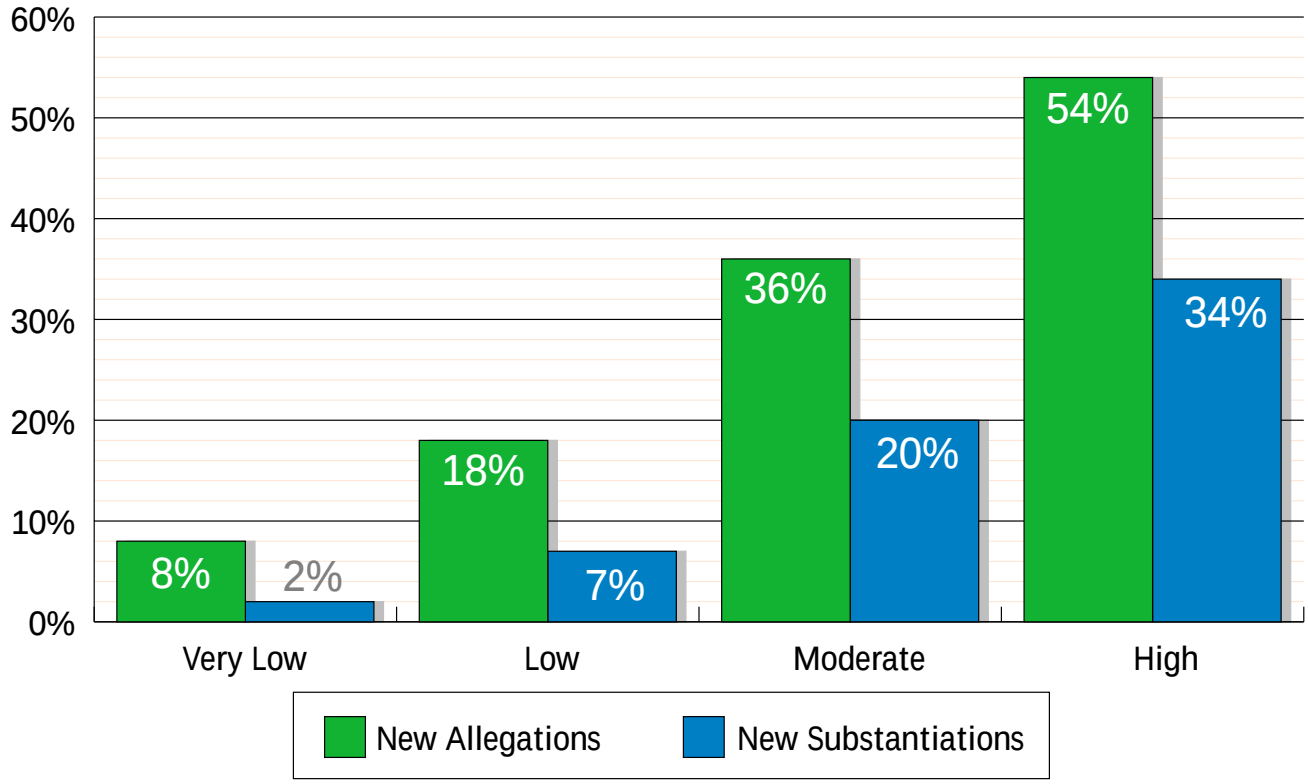
TOTAL NEGLECT SCORE _____

Rhode Island
Substantiation Rates by Risk Levels



Note: Validation study conducted on 956 cases in 1994.

New Mexico Risk Assessment Study*
Outcomes by Risk Level Assigned



*Includes substantiated and unsubstantiated cases.

APPENDIX B

CALIFORNIA
FAMILY STRENGTHS AND NEEDS ASSESSMENT
(For Caretakers and Children)

c: 10/98

Case Name: _____ **Case Number:** _____

Date of Referral: ___/___/___ **Date of Assessment:** ___/___/___ **Initial** or **Reassess #:** 1 2 3 4 5 ___

County: _____ **Worker:** _____

1. Child Name: _____ **Case #:** _____ **4. Child Name:** _____ **Case #:** _____

2. Child Name: _____ **Case #:** _____ **5. Child Name:** _____ **Case #:** _____

3. Child Name: _____ **Case #:** _____ **6. Child Name:** _____ **Case #:** _____

The following items should be considered for each family/household member. Worker should base score on their assessment for each item, taking into account family's perspective, child's perspective where appropriate, worker observations, collateral contacts, and available records. Refer to accompanying definitions to determine the most appropriate response. Enter the score for each item.

B. CHILD - Rate each child according to the current level of functioning.

		Child 1 Score	Child 2 Score	Child 3 Score	Child 4 Score	Child 5 Score	Child 6 Score
CSN1.	**Emotional/Behavioral**						
	a. Strong emotional adjustment ..... +3						
	b. Adequate emotional adjustment 0						
	c. Limited emotional adjustment ..... -3						
	d. Severely limited emotional adjustment ..... -5	____	____	____	____	____	____
CSN2.	**Family Relationships**						
	a. Nurturing/supportive relationships ..... +3						
	b. Adequate relationships 0						
	c. Strained relationships ..... -3						
	d. Harmful relationships ..... -5	____	____	____	____	____	____
CSN3.	**Medical/Physical**						
	a. Preventive health care is practiced ..... +2						
	b. Medical needs met 0						
	c. Medical needs impair functioning ..... -2						
	d. Medical needs severely impair functioning ..... -4	____	____	____	____	____	____
CSN4.	**Child Development**						
	a. Advanced development ..... +2						
	b. Age-appropriate development 0						
	c. Limited development ..... -2						
	d. Severely limited development ..... -4	____	____	____	____	____	____
CSN5.	**Cultural/Community Identity**						
	a. Strong cultural/community identity ..... +1						
	b. Adequate cultural/community identity 0						
	c. Limited cultural/community identity ..... -1						
	d. Disconnected from cultural/community identity ..... -3	____	____	____	____	____	____
CSN6.	**Substance Abuse**						
	a. No substance use ..... +1						
	b. Experimentation/use 0						
	c. Alcohol or other drug use ..... -1						
	d. Chronic alcohol or other drug use ..... -3	____	____	____	____	____	____
CSN7.	**Education**						
	Does child have a specialized educational plan? ____ No ____ Yes, describe: _____						
	a. Outstanding academic achievement ..... +1						
	b. Satisfactory academic achievement 0						
	c. Academic difficulty ..... -1						
	d. Severe academic difficulty ..... -3	____	____	____	____	____	____
CSN8.	**Peer/Adult Social Relationships**						
	a. Strong social relationships ..... +1						
	b. Adequate social relationships 0						
	c. Limited social relationships ..... -1						
	d. Poor social relationships ..... -2	____	____	____	____	____	____
CSN9.	**Delinquent Behavior**						
	(Delinquent behavior includes any action which, if committed by an adult, would constitute a crime.)						
	a. Preventive activities ..... +1						
	b. No delinquent behavior 0						
	c Occasional delinquent behavior ..... -1						
	d. Significant delinquent behavior ..... -2	____	____	____	____	____	____

"In the last 50 years or so, the question of whether a statistical or clinical approach is superior has been the subject of extensive empirical investigation; statistical vs. clinical methods of predicting important human outcomes have been compared with each other, in what might be described as a 'contest.' The results have been uniform. Even fairly simple statistical models outperform clinical judgment. The superiority of statistical prediction holds in diverse areas, ranging from diagnosing heart attacks and predicting who will survive them, to forecasting who will succeed in careers, stay out of jail on parole, or be dismissed from police forces.

..... objections (to using statistical models) ignore the data from well over 100 studies, almost all of which show the superiority of prediction based on statistics rather than on experts' intuition. For example, undergraduate records and test scores alone predict performance in graduate school better than do the ratings of admissions committees. ***The objections to using statistics also ignore the ethical mandate that, for important social purposes such as protecting children, decisions should be made in the best way possible. If relevant statistical information exists, use it. If it doesn't exist, collect it.***" (emphasis added)

- Robin Dawes, Professor
Carnegie Mellon University

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