Differential Response in Missouri after Five Years

Final Report

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Chapter One

Introduction

This is a report of research conducted by the Institute of Applied Research (IAR) for the Missouri Division of Family Services (DFS). Three separate but related research studies were completed by IAR during 2002 and 2003. The first was a follow-up study of the evaluation of the Family Assessment and Response Demonstration conducted from 1995 through early 1998. The demonstration and the resulting system will be referred to throughout this report as FA. Further information was collected on the families that were studied during the evaluation to determine whether the outcomes observed five to seven years ago continued to be present. The second study was a consideration of certain processes and characteristics of the FA system after it was adopted statewide and to the present time. The third study concerned the implementation of several child and family assessment tools designed to assist hotline workers and local investigators and family assessment workers in their decisions about families reported to DFS for child abuse and neglect. These are referred to as Structure Decision Making (SDM) tools. Certain SDM tools had been implemented and were in the process of being implemented in local DFS offices throughout the state while this study was conducted.

1. Follow-Up of the Family Assessment and Response System

The Missouri State Legislature mandated the Family Assessment and Response Demonstration through Senate Bill 595 in 1994. The bill required that the Department of Social Services test a new, more flexible response to reports of child abuse and neglect (CA/N). In demonstration areas, hotline reports were screened into two categories: investigation and family assessment. Certain kinds of incidents were specifically defined in state law to require an investigation because of their relative severity and potential to involve criminal violations. CA/N investigations in Missouri in which there is found probable cause that abuse or neglect occurred are said to be "substantiated," and in these cases perpetrators' names are entered into the state's Central CA/N Registry. This approach will be referred to as traditional investigation (TI) in this report.

Other less severe incidents could be screened for family assessment. The FA response was meant to be non-accusatory and supportive, offering needed services as soon as possible without the trauma, stigma, or delay of the investigative process, and to involve the family in a collaborative response to problems and needs. A central feature, however, was an assessment of child safety and when safety problems were found, development of a child safety plan. Unlike traditional investigations, however, family assessments were neither substantiated nor unsubstantiated. Instead there were primarily two conclusions: services needed or services not needed.

An important element of the new approach involved establishing stronger ties to resources within the community able to assist children and families. This was a particularly important goal because the demonstration was essentially cost-neutral. Thus, while the family assessment approach served to focus attention on a broader set of underlying conditions and problems CA/N families were experiencing, no additional funds were made available within the child protection system to address the problems that were identified.

The demonstration took place in 14 small and medium-sized counties across Missouri and in certain zip codes in St. Louis County and the City of St. Louis.

Research Design. The evaluation of the FA Demonstration employed a quasi-experimental design, in which outcomes for families and offices in the demonstration area as a whole were compared to outcomes in a comparison area. The comparison area was composed of 14 small and medium-sized counties across the state and selected zip code areas in St. Louis City and County. The entire comparison area closely matched the demonstration area in population and DFS caseload characteristics.

Cases that entered in the demonstration and comparison areas on or after July 1, 1995 were included in the evaluation. Data from the DFS client information system were available on all cases. In addition, baseline data were provided for the two previous years. A variety of other data collection methods were also used, including family surveys and interviews, worker/administrator surveys and interviews, surveys of community providers and stakeholders, and case reviews and case-specific surveys of workers on samples of demonstration and comparison families.

The major outcomes of the demonstration measured through the evaluation included the following:

- The percentage of reported incidents in which some action was taken increased.
- Child safety was not compromised, and in certain types of cases was improved.
- In cases where child safety was threatened, children were made safer sooner.
- Recurrence of CA/N reports decreased.
- Removal of children from homes neither increased nor decreased.
- Needed services were delivered more quickly.
- There was greater utilization of community resources.
- Cooperation of families improved.
- Families were more satisfied and felt more involved in decision-making.
- Workers judged the family assessment approach to be more effective.
- Community representatives preferred the family assessment approach.
- There was evidence that investigations were enhanced.

These were generally positive results. However, as is emphasized again in the present report, the impact of the demonstration was mitigated by large caseloads and limited resources. The decision by the state to make the FA demonstration essentially cost neutral limited its effects.[1]

[1] Those who want to read more about the original demonstration and evaluation will find the extended digest of the final research report on the web at: http://www.iarstl.org/papers/MoFamAssess.pdf

The Present Follow-Up Research. Chapter Two in this report is based primarily on data from the DFS client information system, although data collected from sample cases in the original evaluation are also utilized. The original data extractions continued from July 1993 through November 1997. For the present study, these files were updated through November 2002. Information was available on all families studied in the original evaluation for the seven-year period from July 1993 through November 2002. Using this information, analyses were conducted in four areas:

1. An analysis was conducted of family risk of future CA/N (the probability that families would be re-reported) based on information available through the DFS system.

2. Using measures of family risk as control variables, comparisons were made of differences in CA/N recurrence over a five-year period for each family.

3. A comparative study was carried out of child removal and placement during the same five-year follow-up period.

4. A study of chronic CA/N families was begun by defining and identifying chronic child abuse and neglect, analyzing the characteristics of chronic CA/N families, and determining whether the FA approach had had any effects in such cases.

2. The Statewide FA System

Based on the generally positive results of the FA Demonstration, the Missouri State Legislature in 1998 made the FA model permanent and extended it statewide. Counties were gradually added to the system during the following 18 months. By the end of 1999, the system was implemented in all Missouri Counties.

Two methods were used to study the current FA system. A statewide survey of DFS Children's Services workers and administrators was conducted. The survey queried staff about the implementation and operation of the FA approach and sought their attitudes and opinions about its effectiveness and value as an approach to families.

The second method involved analyses of statewide DFS client information system data for the period from 1995 through 2002. The data set provided information on counties before and after the statewide FA implementation.

Two sets of analyses are reported in Chapters Three and Four. These are, respectively:

5. An analysis of the results of a statewide survey of DFS Children's Services staff concerning the implementation, operation and effectiveness of the family assessment approach.

6. An analysis of statewide data on screening of cases for family assessment or traditional investigations and changes in DFS responses to families after implementation of the family assessment and response system.

3. Preliminary Evaluation of the Structured Decision Making Tools

The state of Missouri is in the process of adopting versions of the Structured Decision Making (SDM) tools that are now being used in several other states. Two of the proposed instruments are considered here: 1) the Safety Assessment tool and 2) the Family Risk Assessment tool. These instruments are utilized at the local office level by investigators and/or family assessment workers. The safety tool is designed to assist the worker in determining whether children are safe, conditionally safe, or unsafe, and when they are determined to be less than safe, to determine responses that will enhance safety. The family risk tool leads the workers to examine a number of factors that are known to be related to recurrence of child abuse and neglect and to develop a categorical rating of the overall risk of future abuse and neglect.

Two approaches were taken to analyzing the safety tools. These are reported in Chapter Five:

7. An analysis is conducted of a survey of investigators and family assessment workers who had begun to used the SDM tools to determine their attitudes toward the new tools and their assessment of strengths and problems associated with their use.

8. A case-specific study was conducted that asked workers to provide additional safety- and risk-related information and ratings of one CA/N report for which they were responsible. These responses were then compared to scoring of the safety and risk tools.

Chapter Two

A Follow-Up of Family Assessment Demonstration Families

In this chapter the findings of an analysis of data on the original families studied in the Family Assessment (FA) Demonstration are described. Long-term outcomes in child abuse and neglect (CA/N) recurrence and removal and placement are considered. In addition, chronic child abuse and neglect is defined and examined for these same families.

Families Selected for the FA Evaluation

This part of the original evaluation involved a quasi-experimental design. As described in the Introduction, comparison areas were selected to match the counties and zip code areas where the new approach was being tried. All families *with an opportunity to be served* by DFS were selected in the demonstration and comparison area over a period of 24 months (July 1995 through June 1997). In the comparison areas these included families with substantiated investigations and families with unsubstantiated investigations but with preventive services needed. In demonstration areas, families in these two categories were selected along with those a third category that originated under the new approach: family assessment, services needed (Figure 2.1). A total of 7,711 families in the original study were tracked in this follow-up study.

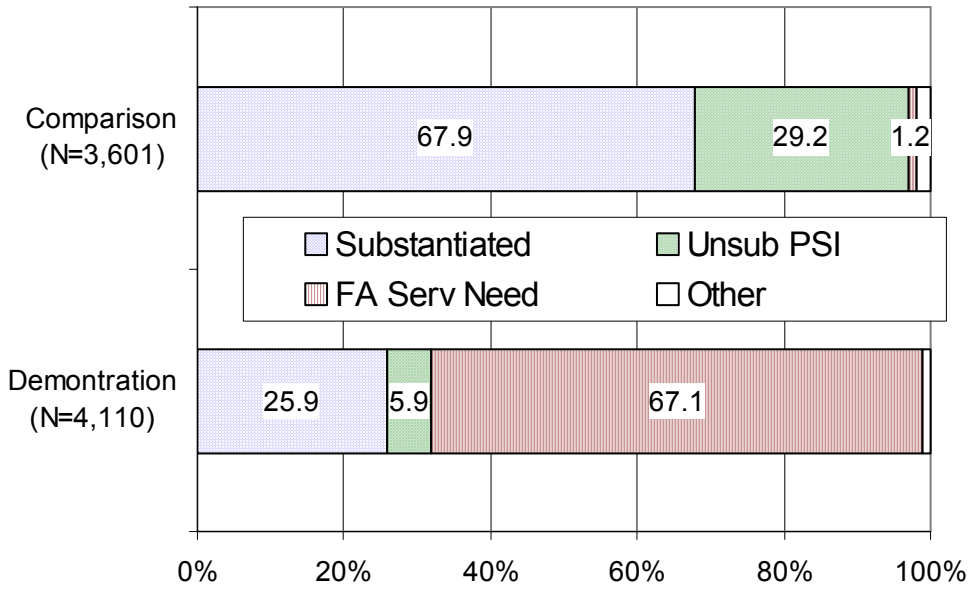


Figure 2.1. Conclusions of Initial CA/N Incidents of Study Families

Over two-thirds of the study families in the demonstration areas fell into the new category of cases. The assumption was that under the old system most or all of these families

would have received a traditional investigation (TI). The original evaluation demonstrated that these two groups of families were highly similar on various demographic and case criteria.

On the other hand, one of the findings of the original evaluation was that the introduction of the family assessment approach tended to shift the agency in the direction of preventive services. Families with certain types of reports that would probably have been unsubstantiated investigations under the traditional approach were given the designation "services needed," after a family assessment. These tended to be the less severe cases, and as was demonstrated through more intensive analysis of sample cases, greater numbers of families were served in which no immediate child safety problems could be found. This is illustrated in the Figure 2.2. Fewer educational neglect cases were considered but more failure to supply basic needs, less severe physical abuse, and parent-child conflict cases were considered under the demonstration.

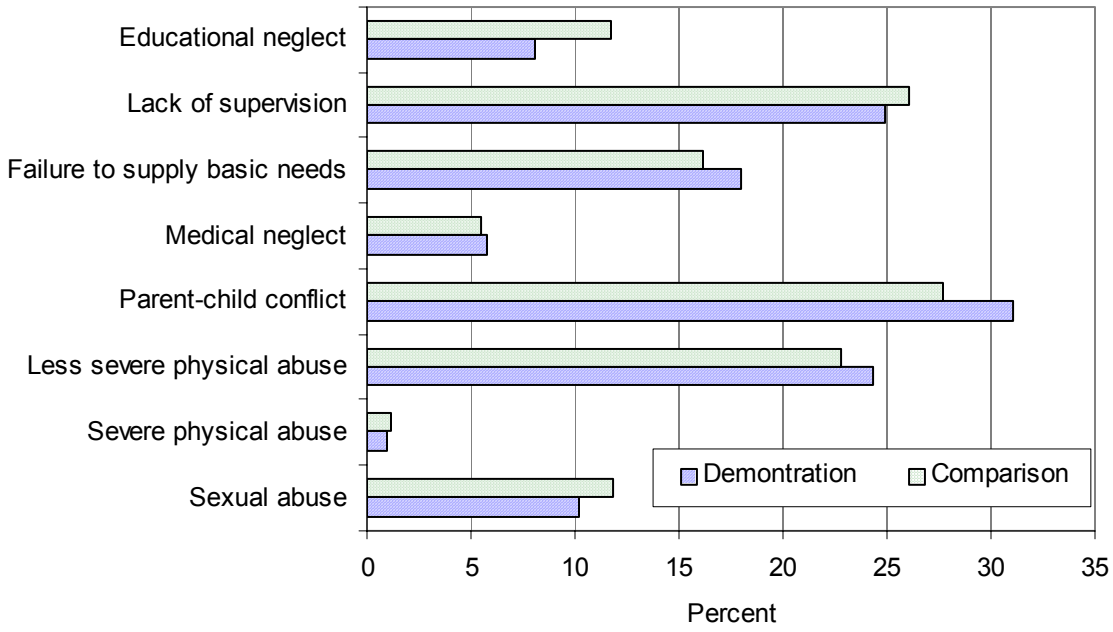


Figure 2.2. Types of Reported CA/N among Study Families in Demonstration and Comparison Areas

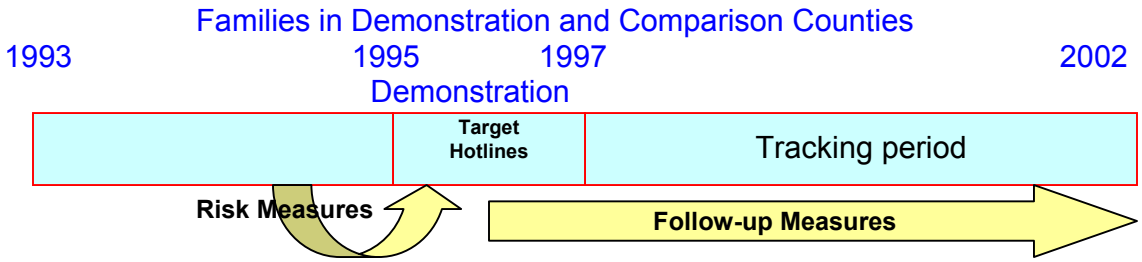
In the present analysis these differences are taken into account. In addition, a broader consideration is also given to "risk" factors, that is, to characteristics of families that are known to be related to the emergence of new child abuse and neglect.

Risk of Child Abuse and Neglect Recurrence

In reference to families that have been in contact with the child protection agency (DFS) at least one time, "risk" refers to the *probability of CA/N (reporting) recurrence*, that is, to the likelihood a family will be reported again for child abuse and neglect. DFS is currently introducing a Structured Decision Making (SDM) Family Risk Assessment instrument intended to screen families in precisely this way. The SDM tools will be considered in Chapter Five. Local office workers are completing this instrument during their initial home visits with families. Another approach is to determine whether certain variables

present in DFS systems when a CA/N incident report (hotline) is received can be used for this purpose.

Data were available for all study families for two years prior to the initiating (target) incident. This included all CA/N reports as well as Family-Centered Services, Alternative Care, and payment records for families. The target hotlines occurred throughout the period for selecting families (7/95 through 6/97). Whenever a new investigation or family assessment was conducted that ended with one of the three types of conclusions defined above, the family entered the study. Families were then tracked in the state data system. In the same way that two years of before-data were available for each family, five years of after-data or tracking data were available. This is shown in the following diagram.



Certain characteristics of families are associated with CA/N recurrence, are shown in Table 2.1. CA/N recurrence refers to the number of new hotlines during the five-year tracking period for each family. These ranged from 0 to 35 new hotline reports. The average was 2.4 per family. Each of the variables shown in the table were significantly associated with CA/N recurrence. For example, as the number of children increased (from 1 to 5) the average number of new hotlines during the tracking period increased from 2.04 to 3.93. The only exception in this set is families with one or more teenage children at the time of the target incident, which had a *lower* probability of new hotlines.

Table 2.1. Measures of CA/N Risk

Risk Measure		Average (mean) Hotlines during Follow-up Period
Number of children named the target hotline:	1	2.04
	2	2.74
	3	3.42
	4	3.78
	5	3.93
Any child in family less than one year old	No	2.27
	Yes	3.06
Any child in family one to two years old	No	2.27
	Yes	3.06
Any child in family three to five years old	No	2.23
	Yes	2.91
Any child in family six to ten years old	No	2.07
	Yes	3.01
Any child in family eleven to twelve years old	No	2.32
	Yes	3.19
Any child over 12 in family	No	2.73
	Yes	1.84
Paramour (non-parent) present in family	No	2.35
	Yes	2.71

Table 2.1. Measures of CA/N Risk

Risk Measure		Average (mean) Hotlines during Follow-up Period
Mother-only family	No	2.27
	Yes	2.58
Previous Family-Centered Services Case	No	1.99
	Yes	3.65
Previous Child Removed	No	2.29
	Yes	3.71
Previous Financial Expenditure through DFS	None	2.26
	$0-999	2.53
	>$1,000	3.30
Number of previous CA/N Hotline reports	None	1.59
	1	2.56
	2 to 5	3.95
	6 or more	6.80

The number of hotlines during the before period (the last measure in Table 2.1) was the strongest and most consistent predictor of hotline recurrence. However, each of the 13 variables in the list is only a moderate predictor of CA/N recurrence. Predictability may be strengthened slightly by combining them, although some high-risk families will never be seen in the system again (false positives) and many low risk families will in fact return (false negatives).

The variables were weighted (based on their inter-correlation) and summed. For purposes of clarity they were then divided into four categories based on quartiles within summed risk scores: low, moderate, high and very-high risk. One of the problems in conducting the original analysis of FA was uncertainty about differences between demonstration and comparison families, not only in regard to types of CA/N incidents but the more general levels of risk (Figure 2.3). As is evident in the figure, the risk levels of the two groups were quite similar. By developing a single measure, risk can now be considered in the analysis. Essentially, this means that demonstration families at a given risk level can be compared to comparison families at the same level.

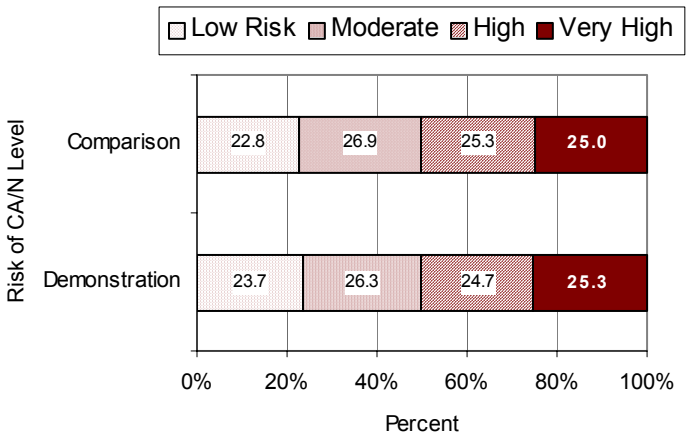


Figure 2.3. Risk of Future CA/N Levels among Demonstration and Comparison Families

CA/N Recurrence after Five Years

A central question of the original evaluation was whether families under the new FA approach would come into contact with DFS more or less frequently in the future. Figure 2.4 shows this in the most general way by asking were more hotlines received during the follow-up period for demonstration or comparison families? The graph illustrates at least two

things. First, the rate of new hotlines found in the original evaluation continued to be lower for demonstration families after five years. The line of means for demonstration families is lower in the graph than the line for comparison families. The differences are not large but are statistically significant (p = .048). Second, the lines for *both* demonstration and comparison families rise sharply from low risk on the left to very high risk on the right. This shows that the factors underlying the risk scores of families were more important explainers of recurrence than the differences produced by FA.

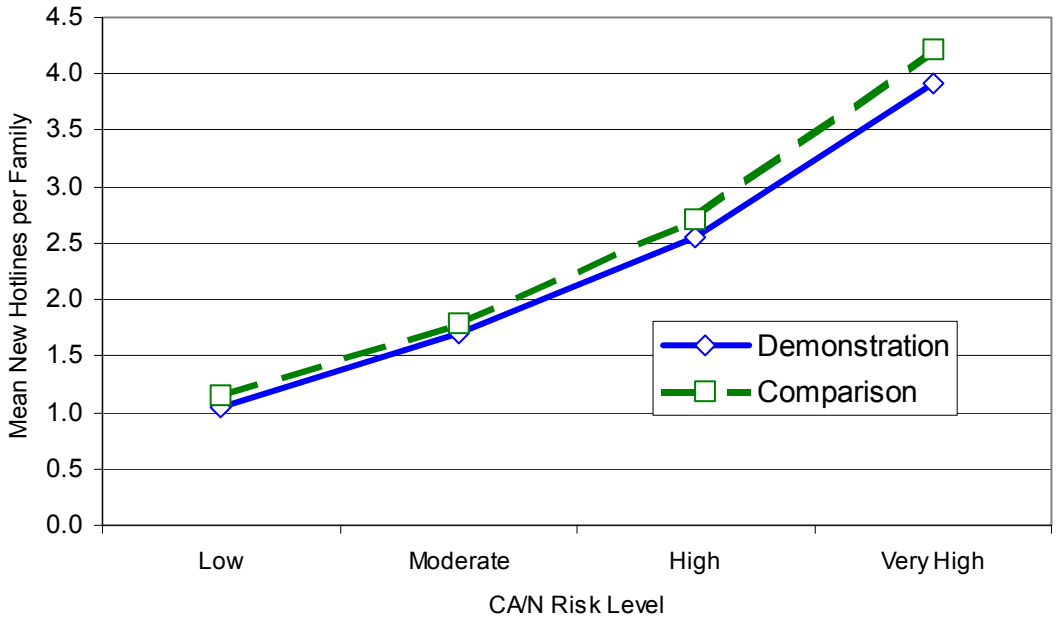


Figure 2.4. CA/N Hotline Recurrence for Demonstration and Comparison Families after 5 Years

This can be understood by comparing means. The mean rate of recurrence for very high-risk comparison families (square on the upper right of the graph) was 4.22 compared to 3.92 for demonstration families (the diamond on the upper right). The difference was .3 hotlines per family (4.22 – 3.92 = .3). By contrast, the overall mean for low-risk families (combining demonstration and comparison) was 1.10 hotlines per family and the overall mean for high-risk families was 4.07. The difference in this case was 2.97 (4.07 – 1.10 = 2.97). Essentially this compares the largest *gap* (.3) between the demonstration and comparison lines with the *rise* (2.97) of both lines combined.

The effects of risk, then, dwarf those of the FA demonstration. However, they do not make them disappear, and this fact increases the likelihood that the differences are the result of differences produced by the FA demonstration compared to the traditional system. The gap between the lines—which is consistent across each of the four risk levels—suggests that *risk of new CA/N reports was reduced for some families who experienced the FA approach.* A major difference between these two groups of families is that over two-thirds of the demonstration families were approached through a family assessment rather than an investigation (see Figure 2.1). This in turn meant that many demonstration families experienced a different service approach than comparison families.

The particular kinds of new CA/N that were most reduced were also identified.

- Demonstration families of all types had fewer new episodes of less severe physical Abuse (primarily bruises, welts and red marks).
- Demonstration families had fewer new episodes of lack of supervision and proper parenting.
- Demonstration families had fewer new episodes of educational neglect.

Considering the *type of target report coupled with types of subsequent reports* on these families during the baseline period, it was the second of these three categories that stood out in the analysis. Demonstration families that had a history of one past incident of lack of supervision or had a target incident of lack of supervision tended to have less future reports of lack of supervision than similar comparison families. In addition, these families as a group had lower rates of new reports overall. This analysis rules out families that had a history of *chronic* lack of supervision of children.

Types of Families Assisted under the FA Approach

The last finding suggests that particular types of families were helped in the long-term by the FA approach. What differences in the approach and services to families might have produced these effects?

In the 1995 to 1998 FA evaluation, a number of differences were discovered. Under the new family-friendly approach, families were more satisfied and felt that they were more involved in decision-making. The analysis revealed an increase in the delivery of basic necessities to families, including food, clothing, assistance with housing, medical care and the like. The time between the initial incident and the delivery of first services to families was reduced in demonstration areas.

This suggests that families in need of immediate, short-term, and family-friendly assistance with basic necessities were most likely to benefit from the FA approach. If helped, a small (but statistically significant) proportion of these kinds of families would experience no recurrence of child abuse and neglect reports. The evaluation showed that a shift occurred in the attention of the agency toward cases of this kind—during the demonstration period. *Half of the demonstration families (50.4 percent) who were never seen again by the agency were families for whom no FCS case was opened and over eight out of ten of these (81.1 percent) were family assessment-services needed cases.* This corresponds with responses of DFS staff concerning the types of cases with which FA is likely to be most effective (see Chapter Three). This is the positive side of the family assessment approach. The approach should be promoted rather than discouraged.

Families not assisted under the FA Approach

The positive effects of the demonstration were modest at the time of the evaluation and, judging from the analysis above, continue to be modest. This was noted in the original FA evaluation report (also noted at the conclusion of the following chapter) where we said that the positive effects of FA were *"mitigated by caseload size and limited resources, that is, restrictions in the time workers were able to devote to individual families and the amount and kind of assistance workers were able to provide families and children."*

Because the new approach was cost-neutral (involved no new funding from the Missouri Legislature) workers were encouraged to refer families to community agencies whenever possible rather than to open formal service cases. This indeed occurred. The linkage of families to community agencies was significantly higher in demonstration areas. Simultaneously, the proportion of families for which FCS cases were opened in which services funded by DFS might have been offered was significantly reduced in demonstration areas.

Under these limitations, some families with more fundamental and long-term needs may have been provided fewer services under the new approach. Many families that formerly would have received a substantiated investigation and FCS case opening under the traditional system instead received a family assessment, minimal direct assistance from an assessment worker and referral to a community agency. Some portion of these families may have needed more than was provided. The key focus here *should not be* on the investigation and substantiation. The evaluation found much evidence that the safety assessment and planning (properly conducted) during family assessments could protect children as effectively as traditional investigations. *Rather, the key focus is that case openings occurred more often for such families under the traditional system.* FCS case opening has two consequences: 1) services funded directly by DFS are possible (although only a minority of FCS families traditionally received funded services) and 2) DFS workers are in contact with families for a longer period.

The patterns established during the FA demonstration continued during the follow-up period. Fewer new hotlines were received for demonstration families, as has been shown. However, the original demonstration families also experienced significantly fewer family-centered services (FCS) case openings during the five-year follow-up period (.85 FCS per demonstration family, 1.1 FCS per comparison family, $p < .0001$)—taking into account the lower rates of new CA/N reports. Only 60.7 percent of demonstration families had a new FCS case opened during the five-year follow-up period compared to 75.7 percent of comparison families. Such cases were generally opened in demonstration areas for more severe cases. An indicator of this is the average number of days with an open FCS case for demonstration families was significantly longer—480 days—versus 422 days for comparison families.

These differences may reflect the increased emphasis under the FA approach on informal short-term services to families by family assessment workers along with referral to community services. The working assumption was that workers could and would find ways to link families up with other non-DFS resources, and for this reason, no new agency resources were made available to family assessment workers to work directly with families. As noted, linkages occurred significantly more often with community agencies in demonstration areas during the original evaluation. However, it was unknown how extensive such services were or how long families were served. The goal of community linkage is laudable but the danger also exists, as the quote above implies, that it can be an occasion to pay less attention to families than under the traditional system. *The group most at risk in this scheme consists of families in the same "FA-services-needed/non-FCS" category discussed above, who have more difficult needs essential for the long-term safety and welfare of their children yet receive little or no help.* The probability of this occurring increases, as the quote also implies, as staff sizes decline, caseload sizes increase, and community resources become scarcer. The "difficult" services-needed cases are most at danger.

Removal and Placement of Children. This may be implicated in another recurrence difference found. Significantly more children in demonstration families entered out-of-home placement during the five-year follow-up period than comparison families. This can be seen in the Figure 2.5.

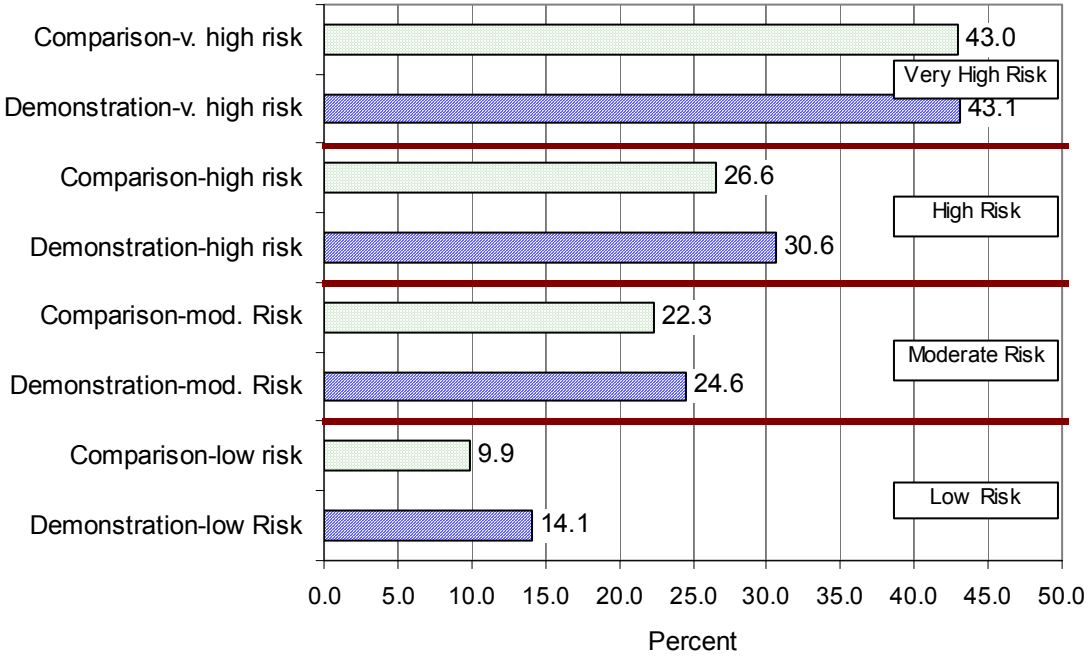


Figure 2.5. Percent of Demonstration and Comparison Families with One or More Children Removed and Placed during the Five-year Follow-up Period by Initial Risk Level

The overall difference in placement was statistically significant (28.2 percent of demonstration families had one or more children subsequently placed versus 25.7 percent of comparison families, p = .007). Figure 2.5 shows that this difference did not occur among very high-risk families but among the three other risk levels. It is significant that the greatest difference was among families rated as low-risk at the time of the target CA/N incident.

Further examination of the data revealed that the true difference underlying this table was more specific. *Significantly more demonstration families had a later removal if 1) they had never had a child removed before and 2) they had only teen-age children in the families at the time of the original hotline.* These kinds of families overall had fewer children removed during the subsequent five-years, as some of the teen children passed their eighteenth birthday, compared to families that had at least some preteen children. However, demonstration families of this type had more removals (26.1 percent) than corresponding comparison families (19.5 percent). Very high rates of removals among these kinds of families occurred in Pulaski County (Fort Leonard Wood), Texas County, and in the demonstration zip codes of St. Louis City.

The families of interest had only teen children and no previous history of removal. Over half (59.1 percent) were low to moderate risk. The initial response in over half was family assessment-services needed (57.3 percent) with a small proportion of unsubstantiated-preventive services (6.2 percent). Approximately four out of every five (39.2 percent) came to the attention of DFS because of parent-child conflicts: locking in or out of home, expelling

from home, rejection, blaming, verbal abuse, threatening, fights (other physical abuse), and the like. A substantial portion came in as a result of neglect reports (educational neglect: 11.9 percent; lack of supervision: 16.6 percent; failure to supply basic needs 7.4 percent). The majority of these families, therefore, were similar—based on information available through the MIS—to the types of families that we are suggesting were helped under the FA approach. Yet, one of every four (28.2 percent) had one or more later reports investigations and child removals.[2] It is possible that these families had other needs and that the initial response may have been too limited under the FA approach.

Chronic Child Abuse and Neglect

A minority of families can be identified in the DFS system that appear numerous times over a period of years, that account for the bulk of staff time, as well as expenditures for services and for placement of children. These are *chronic child abuse and neglect families*. It appears that they are unaffected whether they are approached with traditional investigations or with the newer family assessment approach.

While we have conducted several analyses of such families in specific geographic areas (e.g., the City of St. Louis) and statewide, IAR has the most complete data on the families being considered in the present analysis. As noted above, we have tracking data on the 7,711 families in demonstration and comparison counties dating from July 1993 thorough November 2002.

Defining Chronic CA/N. Chronic CA/N can be defined in many different ways. The most basic element in the definition of a chronic CA/N family is that the family comes into contact with DFS several times over a period of several years. Another element is that some of these contacts lead to a response by DFS beyond investigations or family assessments. These responses often involve extended contact with families, services of various types to families, or removal and placement of the children. The easiest means of measuring such contacts are the amount of money expended on the family and the length of time that families or children are in active cases.

We arbitrarily made a cutoff of three or more subsequent hotline reports. Chronic CA/N families, therefore, were those who received three or more hotline reports of any kind during the five-year follow-up period. Besides CA/N reports to which DFS is mandated to respond with a traditional investigation or family assessment, these included "mandated reporter" reports (defined above), safekeeping reports, and child fatality reports.[3] This means that every family defined as chronic had at least four reports: the initial target report that led them into the FA analysis plus three more during the follow-up period. A little over a third of the families (34.2 percent) had three or more additional hotlines.

The total number of days in open family-centered services cases and the total number of days that a child was in out-of-home placement (alternative care, AC) for the longest

[2] In analyses associated with the original study, we found that over 95 percent of the children who were removed in family assessment cases had a subsequent CA/N report that led to a traditional investigation prior to the removal of the child.

[3] High-risk infant reports (usually drug-exposed infants) were not included in the present analysis because consistent records of these reports were not made available.

period were calculated for each family throughout the follow-up period. In addition, total expenditures for each family during the follow-up period were summed. The 80th percentile (for families with any value greater than zero) on any of these three variables was taken as a cutoff. Overall, 13.5 percent of families fell above the FCS limit, 5.4 percent of families were above the AC limit, and 8.0 percent fell above the expenditure limit. These families were defined as "costly" families. Because of overlap between these three measures, 20.0 percent of families were identified as costly.

Three chronic categories were created. *Chronic Level 1*: three or four additional hotlines and costly; *Chronic Level 2*: five or Six additional hotlines and costly; and, *Chronic Level 3*: seven or more additional hotlines and costly. A little less than one in ten families (9.3 percent) were defined as chronic families under this definition.

Costs for Chronic Families. The costs of such families over a five-year period are illustrated in Table 2.1. These are broken down into the most general categories used in the DFS reimbursement system. Alternative Care refers to placement costs in foster care, group foster care, specialized foster care, and group homes. Residential treatment refers to placement costs in residential treatment facilities, hospitals, and some other institutional settings. Daycare consists of various kinds of daycare available in protective services cases. Children's treatment services refer to various services, such as counseling, family therapy, in-home services, etc. that DFS can purchase from contracted providers.[4] Total expenditures for all 7,711 families during the five-year period were $67.7 million. The bulk of this (79.1 percent) was in alternative care and residential treatment. For purposes of this analysis, the row in italics (Total Chronic) is most relevant. *While chronic CA/N families constituted 9.3 percent of all families, they accounted for 41.9 percent of all expenditures.*

Table 2.1. Expenditures for Chronic and Non-Chronic Families during a Five-Year Follow-up

	Alternative Care	Daycare	Children's Treatment Services	Residential Treatment	Total Expenditures	Percent
Not Chronic	$18,377,303	$9,243,578	$923,339	$10,817,552	$39,361,772	58.1%
Chronic Level 1	$5,497,972	$1,359,238	$187,951	$4,216,360	$11,261,521	16.6%
Chronic Level 2	$2,874,530	$749,581	$155,533	$2,652,413	$6,432,057	9.5%
Chronic Level 3	$4,889,360	$1,285,474	$274,244	$4,262,525	$10,711,603	15.8%
Total Chronic	$13,261,862	$3,394,293	$617,728	$11,131,298	$28,405,181	41.9%
Total	$31,639,165	$12,637,871	$1,541,067	$21,948,850	$67,766,953	100.0%

There were 720 chronic CA/N families out of 7,711 families selected over a two-year period in 32 Missouri counties. The average cost per family of chronic CA/N families was seven times that of other families served by DFS: $39,452 versus $5,630. The number of chronic families would, of course, be much larger were all 115 counties and a longer time period considered. The total expenditures would be correspondingly larger as well. However, the pattern remains the same in every analysis we have conducted. A relatively small core of families is responsible for the lion's share of DFS financial expenditures as well as worker and administrative time.

[4] There is a relatively small "other" category that was not included in these calculations.

If a way were found to identify such families *before* they became such a financial burden and to prevent reentry to the system, substantial saving might be achieved, not to mention the enhancement of the welfare of the children who are subjected to successive bouts of child maltreatment and spend long years in and out of foster care.

Characteristics of Chronic CA/N Families. *Participation in the FA demonstration made no difference for these families.* The proportion of demonstration and comparison families that became chronic during the follow-up period was essentially equivalent in demonstration and comparison areas. This is not unexpected. As noted above, the FA approach was most effective with families with problems that could be addressed through short-term services and referrals. A third way is needed with chronic CA/N families that might be called *long-term* family assessment (LTFA).

Most chronic CA/N families have later reports of child neglect in the areas of lack of supervision or failure to provide for the basic needs of their children, as is evident in Figure 2.6. Most of chronic CA/N families, therefore, could be called chronic neglect families. Another large category is parent-child conflict (locking in or out of home, expelling from home, rejection, blaming, verbal abuse, threatening, fighting, etc.). This category is strongly correlated with the presence of teenage children in the home and may in part be the consequence of lack of supervision, improper parenting, and inadequate child discipline (the primary form of less severe physical abuse) during preteen years. On the other hand, over one-third of chronic families had a report of sexual abuse for at least one of their children during the five-year follow-up period. We believe this is a significant indicator of family disorganization, as we suggest below.

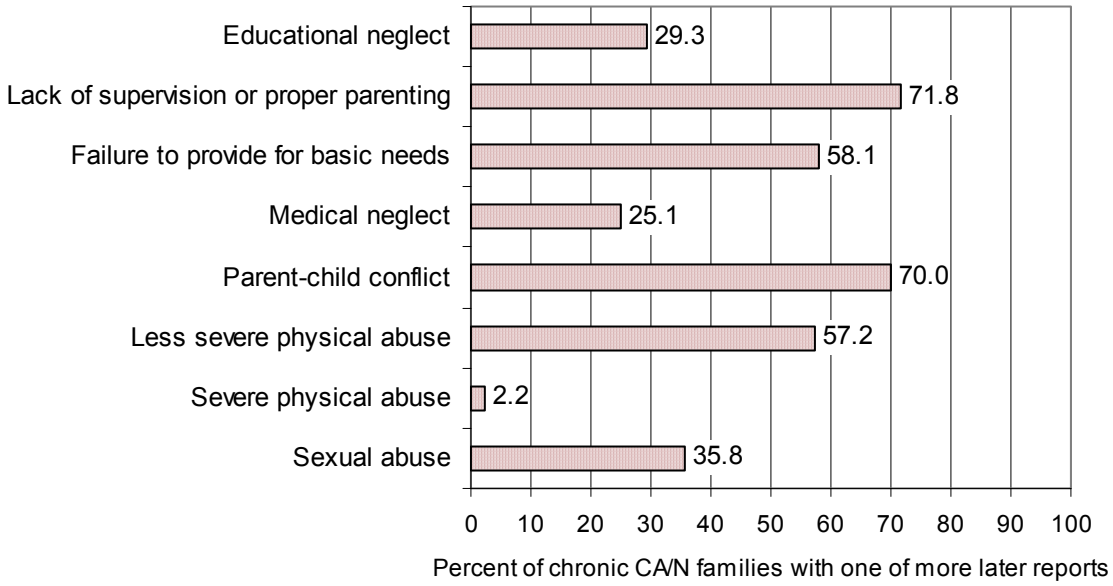


Figure 2.6. Types of Later CA/N Hotline Reports for Chronic CA/N Families

Only 6.3 percent of the 720 families were rated low-risk on our risk measure at the time of the target incident during 1995 to 1997. The risk measure was moderately successful, therefore, in detecting families that actually become chronic during a later period. Unfortunately, like many risk-assessment instruments, the reverse is not true. Among families that *did not have* later chronic levels of CA/N, 47.3 percent were originally rated as

high to very high risk. This shows that identification of chronic families will be dependent not only on initial assessments based on history with DFS and ratings on tools like the SDM scales (considered below) but also on *full assessments of families that examine underlying problems that may be related to Chronic CA/N.* This is discussed further in the conclusions to Chapter Five.

Higher risk scores are in fact measures of *past chronic abuse and neglect*, since the risk measure we have developed is largely based on multiple past reports, service cases and child removals. Over 7 of every 10 chronic CA/N families (70.6 percent) had a past report, compared to 43.2 percent of non-chronic families. And chronic families tended to have received multiple reports more often in the past: 47.4 percent had had two or more reports compared to 19.9 percent of non-chronic families. Chronic families had more previous FCS cases opened and closed before the target hotline than non-chronic families: chronic: 33.3 percent, non-chronic 15.0 percent. They had more FCS cases open at the time of the target hotline: chronic: 18.6 percent, non-chronic: 9.0 percent. More families had had a child removed before the target hotline: chronic 16.9 percent; non-chronic, 6.6 percent; or, in placement at the time of the target hotline: chronic 13.5 percent, non-chronic 5.2 percent.

A More Detailed Look at Chronic CA/N Families. To understand chronic child abuse and neglect, it is necessary look inside families at those characteristics that explain their continuing appearances in the DFS system. To do this we turned to sample cases. Case reviews were conducted for a sample of 559 demonstration and comparison families in the original study. Of these, 27 families were found among the 720 that were designated as chronic CA/N. Because detailed information was collected on these families, it was possible to look for common characteristics that might be associated with later chronic neglect. *The following is not meant to be a definitive analysis but to illustrate a method that could be employed (on a slightly larger scale) to reveal the key characteristics of potential chronic CA/N families.*

Nearly all of these 27 families could be characterized as multi-problem at the time of target incident, with needs that extended far beyond any services that DFS could purchase or that DFS workers could deliver directly.

1. *Serious problems in the relationships between parents and children.* Virtually all cases could be described in this way. Workers explicitly noted a serious problem with parenting in 18 of the 27 families, but parenting difficulties were implicit in others. Discipline tended to be inconsistent and when it was applied it was physical in nature involving hitting, pushing, shoving, coercion, or fighting between parents and children. While lack of supervision was a problem in every family at some point during the tracking period (from 1993 to 2002) the underlying problem at the time of the target case was most often the inability of parents to exercise control over the children. This sprang from a number of sources:

    a. *Behavior problems and disabilities of children.* This was both a cause and effect of poor parent-child relationships. Looking at each of the 27 families, the following child characteristics were found: developmental disabilities (1), severe mental health problems (1), learning disabilities (2), ADHD (4), uncontrollable behavior (3), delinquency (2), runaway (1). Many other less severe problems

were mentioned, and it is also likely that some workers neglected to focus on child behavior problems and disabilities.

b. *Drug or alcohol use by a parent/caretaker.* Among all families, drug use by the mother and/or father was noted in 4 and in another the mother was an alcoholic.

c. *Mental health or emotional problems of parent/caretaker.* Separate from the drug and alcohol problems, in 5 families a parent had a serious mental health problem (such as severe depression or delusional behavior) and another 2 were considered too emotionally immature to parent effectively. Another parent had a hearing disability that interfered with her ability of communicate with her children. A larger group of parents were emotionally distraught from financial stress (see below).

2. *Chaotic and disorganized family life.* This is the broader context of parent-child relationship problems. It refers to living situations, relationships between adults in the family, and relationships with extended family members. This sprang in part from or was evidenced by the three sources already mentioned. In addition there was:

d. *Financial stress.* Extreme financial stress was explicitly noted in 11 families, and of these, imminent eviction was a potential problem in 4 at the time of the original investigation/assessment.

e. *Domestic violence.* Abuse of the mother by a boyfriend was known in 3 families.

f. *Sexual abuse.* Sexual abuse was the reason for opening the target case in only 3 of the 27 chronic CA/N families. However, children in 14 families were exposed to sexual abuse at some point during the tracking period. Sexual abuse in some instances occurred because the parents did not sufficiently supervise the children (for example, in two families a known sexual perpetrator was permitted to care for children). The widespread occurrence of sexual abuse is itself an indicator of chaos and disorganization in family life.

In no cases that we could identify were the fundamental problems addressed effectively in either the demonstration or comparison areas during the original evaluation. This was primarily because these problems require *sustained intervention beyond the capacity of DFS.* Workers provided various services for families and monitored them to determine that the particular child protection problems that led the family into the system did not recur. In some instances, workers got families or individual family members into therapy, but this was transitory, apparently lasting only until the end of DFS casework with the family. Drug or alcohol treatment, mental health services, and specialized services for children in need were handled through referrals. In some instances, DFS workers followed up to make sure that children received services (for example treatment for ADHD, mental health services, or counseling), but this was only for the duration of the family assessment and/or the subsequent FCS case, if one was opened.

In these families, things went downhill after the initial case. Families averaged 8 new hotlines during the follow-up period, with a minimum of 4 and a maximum of 22. Only a

portion of these hotline reports were subsequently investigated or given a family assessment. Of those that were, the allegations (counting by families) included: sexual abuse (6 families), severe physical abuse (1 family), less severe physical abuse (15 families), parent-child conflict (21 families), medical neglect (7 families), failure to provide for basic needs (18 families), lack of supervision or proper parenting (19 families), and educational neglect (8 families). Families commonly had multiple instances of particular types; for example, the 19 families with lack of supervision average nearly 3 hotlines each of this type. Children were later removed in 21 of the 27 families. Looking at the child in these families that was in placement for the longest period during the five-year follow-up period, the average total time out-of-home was 60 months. Again, 26 families had FCS cases opened during the follow-up period. Adding up all cases that opened during this period, families averaged about 34 months in FCS. Spending during the follow-up period for residential treatment and/or foster care amounted to $810,000. Daycare costs were $166,000 and various Children's Treatment Services amounted to $18,000. In other words, *nearly a million dollars was expended during a five-year period for purchased services and placements for 27 families*, and as we pointed out above, this does not include worker and administrative costs, which without a doubt exceeded the purchased services costs. (Part of a full analysis of the cost of chronic CA/N families should also include an estimate of DFS worker and administrator time and travel and court costs.)

Identifying Chronic CA/N Families. If chronic families such as these could be identified early, more intensive and long-term services might be provided to avert the staggering later costs. This would involve a three-step process:

1. Flag families that have a history with the agency as "potentially chronic" at the time a hotline report is received based on the risk criteria outlined here. This process would be automated in the computer system.

2. Conducting a detailed chronic-CA/N family assessment on flagged families to determine those that are already chronic or are likely to become chronic. This assessment would focus categories known to be associated with chronic CA/N. (The following are derived from the limited analysis of sample families above. A more comprehensive and nuanced list could be created if detailed information were assembled on a larger sample of both chronic and non-chronic families.)

    a. Inadequate parenting abilities stemming from any of the following or other sources, particularly families with a history of inappropriate physical discipline and lack of supervision or inability to communicate with children.
    b. Drug or alcohol problems that interfere with the care of children or supplying their basic needs.
    c. Mental health or emotional problems that interfere with care of children or supplying their basic needs.
    d. Children with special medical, psychological or behavior problems that have not been adequately handled by caretakers and are disruptive of family life.
    e. Financial problems that arise from underlying problems (lack of education, training or job experience; lack of financial support from relatives or absent spouses; single parent status, other barriers).
    f. Domestic violence and/or a pattern of damaging relationships of the current caretaker with others.

3. Enlisting the family in a program designed to offer long-term, intensive approaches to averting future child abuse and neglect.

These are the first steps in LTFA. Many examples of effective programs could be cited (e.g., extended home visitation, mental health and developmental disabilities support programs, community and volunteer family support programs, etc.) but that would go beyond the scope of this report. Since almost all of these families become court-involved within a few years, special long-term court programs might be in order, similar to current family drug court programs in Missouri and other states. (One person in DFS has suggested a Chronic CA/N Court.) The one approach that is clearly a mistake is the traditional minimalist approach utilized by child protection services (CPS) agencies, including DFS. This is the practice of closing cases and terminating support of families when they have returned to a "minimal level of family functioning." *This is a costly recipe for disaster for chronic CA/N families—after repeated hotlines (the average in this sample is 8), investigations and family assessments over a period of years it should be apparent that the traditional approach is ineffective and a different approach is needed.* The children in the 27 families examined here experienced pain and unhappiness during the five years we followed them, as they were taken from their families (sometimes several different times) and as they experienced the abuse and neglect that led to removals—all this at a cost to Missouri that most citizens would find shocking. Would it not be better to spend some of that money for preventive services to promote the welfare of families and children in order to avert those experiences? A preventive approach might even be more cost-effective.

Chapter Three

DFS Children's Services County Staff Surveys

A series of statewide surveys of DFS county offices were carried out as part of this study. The surveys focused on Children's Services practices in general and the family assessment (FA) approach in particular. Among those surveyed were County Directors, Children's Services (CS) Directors, CS Circuit Managers, CS Supervisors, and CS field workers. Responses were received from administrators and supervisors representing 90 Missouri counties and the City of St. Louis along with 264 CS social workers in these counties. The map on the following page shows the counties from which survey responses were received from county administrators and/or CS supervisors. The following is a summary of the major results of these surveys.

Administrators and Supervisors

An effort was made to obtain feedback from knowledgeable administrators and Children's Services supervisors representing as many counties as possible. This group includes DFS county directors, CS Directors in certain large counties, CS Circuit Managers where these arrangements have been instituted, and county CS Supervisors.

There were some inter-group variations among respondents who occupied different administrative or supervisory positions in the DFS-CS system. However, the differences in the responses of these groups were generally not statistically significant. Differences among respondents representing counties that implemented the FA approach in different years (from 1995 through 1999) were also rarely significant. Statistically significant correlations were found, however, between attitudes of administrators and CS supervisors toward FA on the one hand, and the percentage of reports screened for the FA approach, on the other. Generally, administrators and supervisors who expressed a more positive attitude toward FA were in counties in which a higher proportion of reports were screened for FA. This correlation is discussed in the report section on Screening.

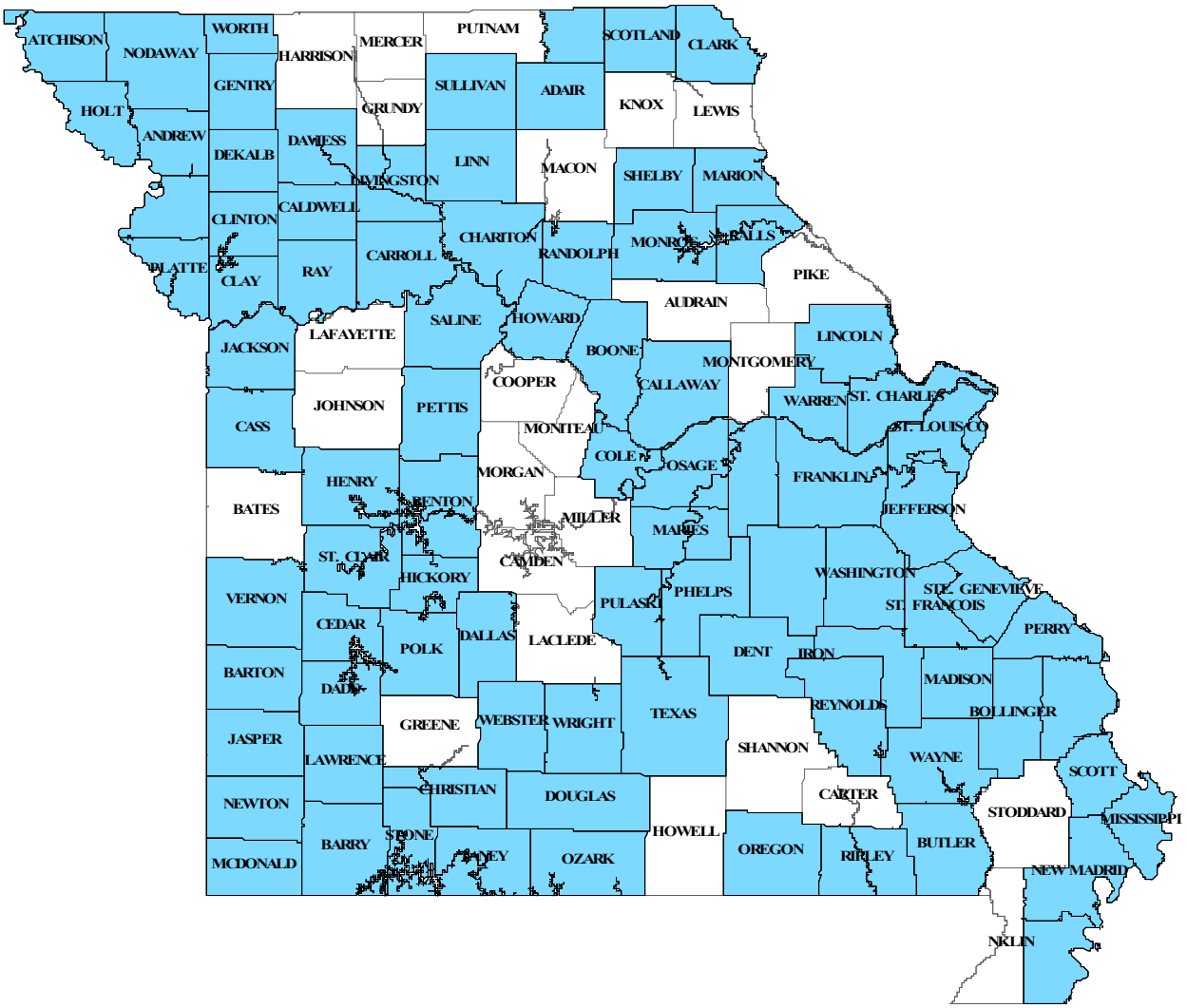
CS Practice. The basic equation of the Family Assessment approach can be expressed as: a + b = c; where:

(a) involves approaching families as a unit and in a positive manner consistent with sound family-centered practice, determining the safety status of the children, focusing on the needs and problems families may be experiencing, and involving them in decision making about what to do;

(b) involves developing a child safety plan, when needed, for the family, providing services and assistance that fit the needs and situations of families, linking them to other community resources when possible; and

(c) is the outcome or results desired by the family and the public service system: assuring that children are protected, planning for their future safety, reduction in future risks to children and the enhancement of child and family well-being.

Counties Responding to Survey of Administrators and Supervisors



Changes in practice are a precondition for changes in outcomes. A key question, then, is: Has practice changed? We asked administrators and supervisors a set of questions designed to find the answer to this question.

We asked whether CS workers were doing anything differently when they approached families screened for FA than they had been doing before. The survey question was: "To what extent has FA affected how your CS workers approach families or perform their work?" As can be seen in Figure 3.1, 90 percent reported that FA has had some impact

on worker practice. Some (18 percent) described the impact as great. The largest group (42 percent) said FA had affected practice in a few important ways. Three out of ten (30 percent) said it had affected practice in small ways. One respondent in ten said FA had not affected child protection practice in their county at all.

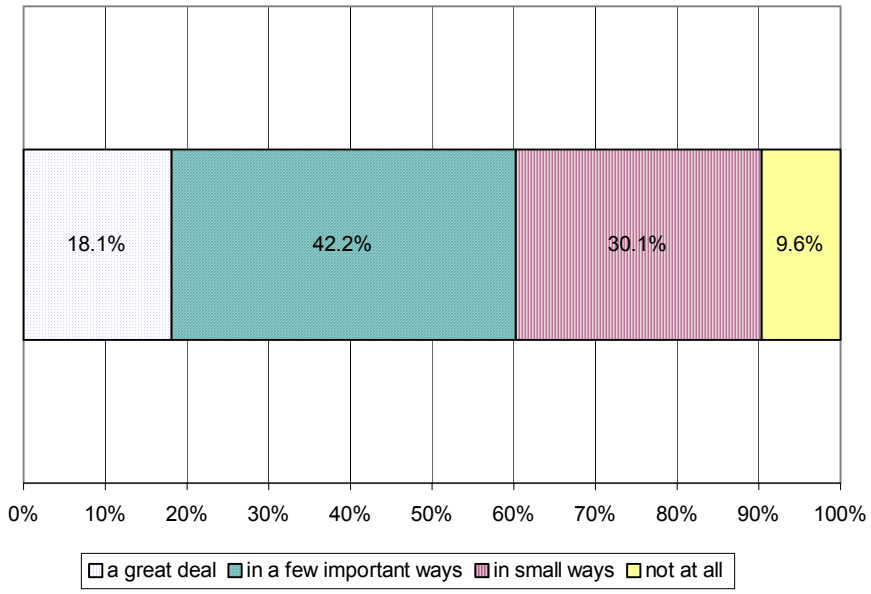


Figure 3.1. To what extent has FA affected how CS workers approach families or perform their work?

In commenting on this question, a number of respondents described how workers approached families differently through FA. In their comments, they displayed an understanding of the underlying distinctions between assessments and investigations that gave rise to the two-track approach in the first place. Such as in the following:

> *"In family assessments, families are approached in a less threatening, more family-friendly and family-focused manner."*
>
> *"Workers more often use a strengths-based approach that is much more positive."*
>
> *"Police don't go with workers on family visits."*
>
> *"Workers spend more time assessing needs and connecting families to resources. There is greater use of community networking and linkages to service and utilization of informal supports."*
>
> *"Workers concentrate more on family strengths which then makes the family more open to working on their needs."*

"Family assessments are less adversarial and less confrontational, more family friendly and convey the message of wanting to assist family resolve issues."

On the other hand, some respondents indicated that the implementation of FA had had no effect on CS practice. As one said: "We have always emphasized the importance of obtaining the family's cooperation and building a positive relationship with our families." Such comments indicate recognition of the importance of applying sound family-centered practice, an objective of child protection in Missouri for a very long time now. What was not clear from such answers was whether the respondent understood how FA was meant to be different from traditional investigations. That there may be some confusion about this was suggested in other comments, such as this one: "The family assessment tool takes a lot of time and is intrusive, and it does not give a clear picture of what happened around the incident that was reported." Continuing to see the CA/N incident as the centerpiece of the interaction with the family suggests either a reluctance to move beyond traditional investigation goals or, perhaps, a failure of training.

If a worker does not understand the difference between an investigation that incorporates sound FCS practices, on the one hand, and a family assessment, on the other, it is unlikely he/she is implementing the FA approach. If a supervisor or administrator does not recognize the difference, he or she would not be able to provide adequate direction or training to field workers. And what one worker said could be expected to be all too true: "The approach is not different, just the paper work."

Finally, the comments of a few respondents suggest the presence of a different, but critical problem and are represented by this remark: "I perceive the workers treat the assessment more superficially usually than an investigation." If many workers approach assessments in this light, the use of FA places the quality of child protection in jeopardy.

Returning to other items on the survey: About two-thirds (64 percent) of the respondents said that FA had given their workers greater flexibility in working with families and had improved their effectiveness. About 3 in 10 (31 percent) thought it had not increased worker effectiveness including 5 percent who were quite definite about this. (Five percent were uncertain.) A majority (61 percent) reported that FA has increased the appropriateness of services provided to families and children. Two-thirds saw significant benefits to children and families as a result of the FA approach. And 45 percent thought children and/or families probably had been given services or assistance because of FA that they would not have otherwise received; an equal percentage thought this was not the case in their counties.

Seventy percent of respondents indicated that FA had increased the involvement of families in decision-making; 28 percent said this was not the case in their counties. The FA approach had increased the involvement of extended family members according to 63 percent of respondents and had increased involvement of unfounded community resources according to 56 percent of responding administrators and supervisors.

The comments of many respondents indicated that family assessments have resulted in referrals to a broader spectrum of services and often to unfunded community resources. Such as these comments:

"FA families are more engaged and more receptive to accept assistance and make use of referrals."

"Families are more willing to develop treatment plans with us."

"Families are more accepting of services offered or suggested and, as a result, outcomes are accomplished sooner."

"Faith-based and community-based resources are accessed more now through family assessment."

At the same time, a number of respondents indicated that workers did not know what to do when faced with families that refused services or offers of assistance.

Attitudes. An important element in practice is the attitude of administrative and direct service staff. Without a conviction that a certain approach to practice is effective, it is unlikely or, at least, much less likely, that it will be. The social psychological dynamic of the self-fulfilling prophesy impacts practice both positively and negatively.

A majority (68 percent) of CS administrators and supervisors responding to the survey reported "generally positive" to "very positive" attitudes towards the family assessment approach. Another 29 percent of respondents said their attitudes were "mixed," that is, partly positive and partly negative. A small percentage said their attitude toward FA was "generally negative." None described their attitudes toward FA as "very negative." See Figure 3.2.

About 4 in 10 (37 percent) respondents indicated that their attitude toward FA was more positive now than when it was first implemented in their county; 17 percent said their attitude was more negative now than at first.

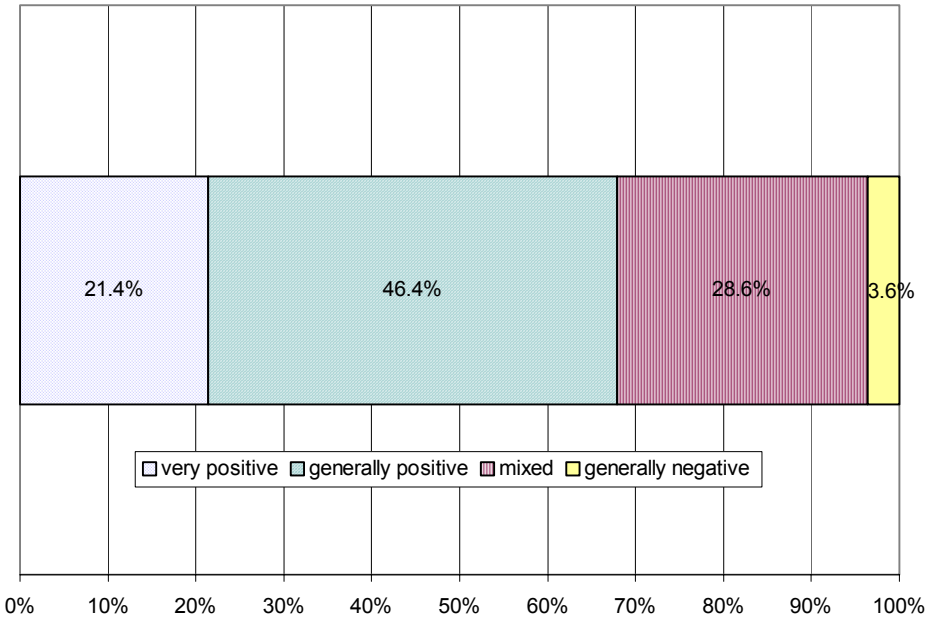


Figure 3.2. How would you describe your attitude towards the FA approach at this time?

A majority (61 percent) reported that CS social workers in their counties have a positive attitude towards FA. About 3 in 10 (31 percent) reported that county social workers had mixed attitudes towards the new approach, while 8 percent reported mostly negative attitudes on the part of field staff.

Safety. The safety of children is the paramount goal of Children's Services. Any change in the approach taken to child protection must first be measured against its ability to protect children and keep them safe. We asked administrators and CS supervisors this question: In your experience, how often has the safety of children been put in jeopardy in this county or circuit because their family received a Family Assessment rather than an Investigation? A majority of respondents reported that the safety of children has never (58 percent) been put in jeopardy because their family received a family assessment, and 23 percent said it would only have happened rarely. A relatively small number (4 percent) said it had happened often in their counties, while 5 percent said it happened sometimes. (See Figure 3.3.)

When asked how they would compare the FA approach with a traditional investigation in identifying threats to child safety for reports usually screened for FA, one-third of the respondents said they thought investigations were either much better (12 percent) or somewhat better (21 percent). Similarly, these respondents also believed that a traditional investigation was much better (18 percent) or somewhat better (16 percent) in identifying risks or potential risks of CA/N among reports generally screened for FA.

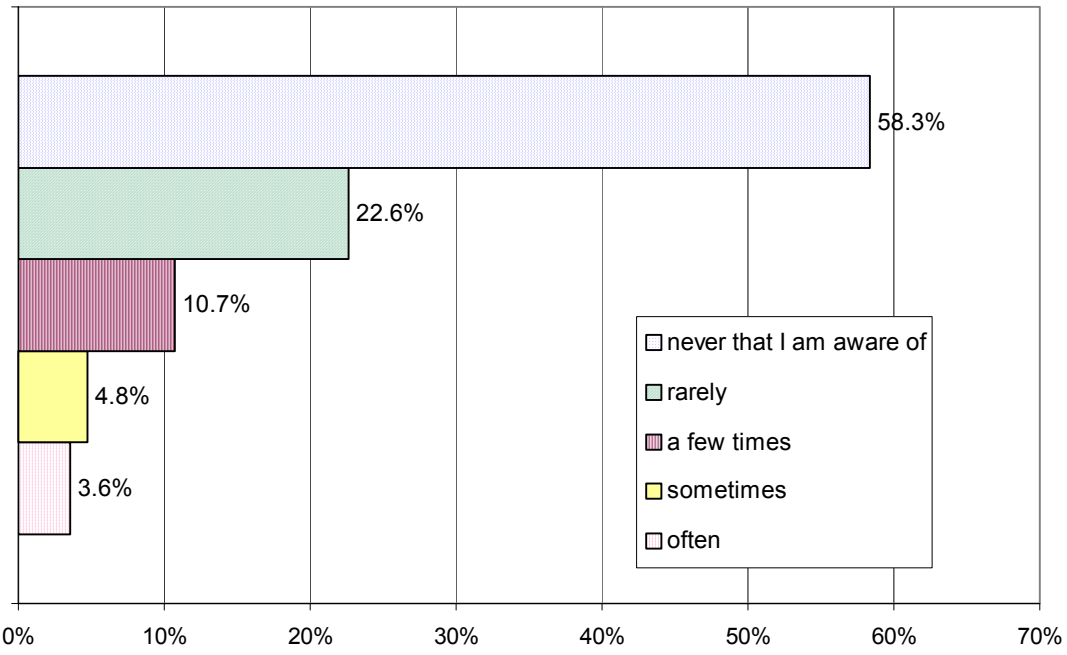


Figure 3.3. How often has the safety of children been put in jeopardy in this county or circuit because their family received a Family Assessment rather than an Investigation?

If the safety of any child is being put in jeopardy through the use of family assessments, there should be pause for concern. However, it is not possible to know the

extent to which these responses reflect actual safety threats to children in FA cases, or whether the concept of safety (a situation that is present or not present) is being confused or conflated with risk (the prospect of future abuse or neglect), or whether the response is simply a cautious or conservative reply to the question, or whether some of these responses represent a simple distrust or dislike for the FA approach on the part of some workers.

A number of respondents commented that there is no reason why family assessments should compromise child safety:

> *"Safety is the number one priority no matter if it is assessment or investigation. Both reports require safety first, family needs next."*

> *"We emphasize that it's safety, safety, safety whether an assessment or investigation."*

> *"We request custody when necessary on either assessments or investigations. We don't consider the tracking as criteria to request custody and it shouldn't affect the safety of the child one way or another."*

> *"The CS workers are very careful about screening for child safety--something that can be accomplished with either approach, assessment or investigation."*

However, there were respondents who alluded to a problem discussed above, that some workers do not take reports screened for FA as seriously as they should. One said: "I think initially workers treated FA's as less important or less serious than investigations. I think that this has improved and that workers are more aware that child safety is the first priority regardless of the track." Another said: "Workers are sometimes lax in assessing the situation and not upgrading assessment to investigations when needed." And, in a comment that should send up a red flag: "Children have fallen through the cracks and have been seriously hurt as workers did not take the assessment as seriously as an investigation." Moreover, there may be practical issues or problems that intervene and create frustration for workers. One said: "Liability issues continue to be high. Family assessment procedures are not always possible here. Our county policy overrides SB595. For example regarding contact time. And the court doesn't like unclear conclusions-they understand unsubstantiation and probable cause, and that's what they want."

Effectiveness. For the type of reports that are screened for FA, 37 percent saw FA as more effective or preventative than a traditional investigation, and 34 percent saw the two approaches equally effective. About one respondent in four indicated that they thought FA was either somewhat less effective or much less effective than the traditional investigation. (See Figure 3.4.)

A majority of respondents saw FA as more effective in working with certain types of cases. These were cases involving poverty, non-severe physical abuse, child behavior problems and poor parenting skills. Traditional investigations were not viewed as more effective by a majority of respondents with respect to any specific type of problem generally screened for FA. A majority believed that FA had either probably (36 percent) or definitely (18 percent) prevented certain cases from re-entering the CS system.

Explaining why they thought FA was effective, respondents said:

"Families are sometimes more willing to cooperate and accept help--less defensive--with FA approach."

"More time is spent with the family and indicators might be overlooked in an investigation which is incident-specific."

"Family assessments are less intrusive than investigators. In general families are less defensive and more open without law enforcement."

"An assessment provides a better atmosphere for gathering information."

"Families are more willing to talk with workers in a less defensive manner. It is a less fearful approach."

Explaining why they thought FA was not effective, respondents said:

"Clients view family assessments as no big deal."

"Courts feel they have no weight in trying to improve situations especially if removal is being considered."

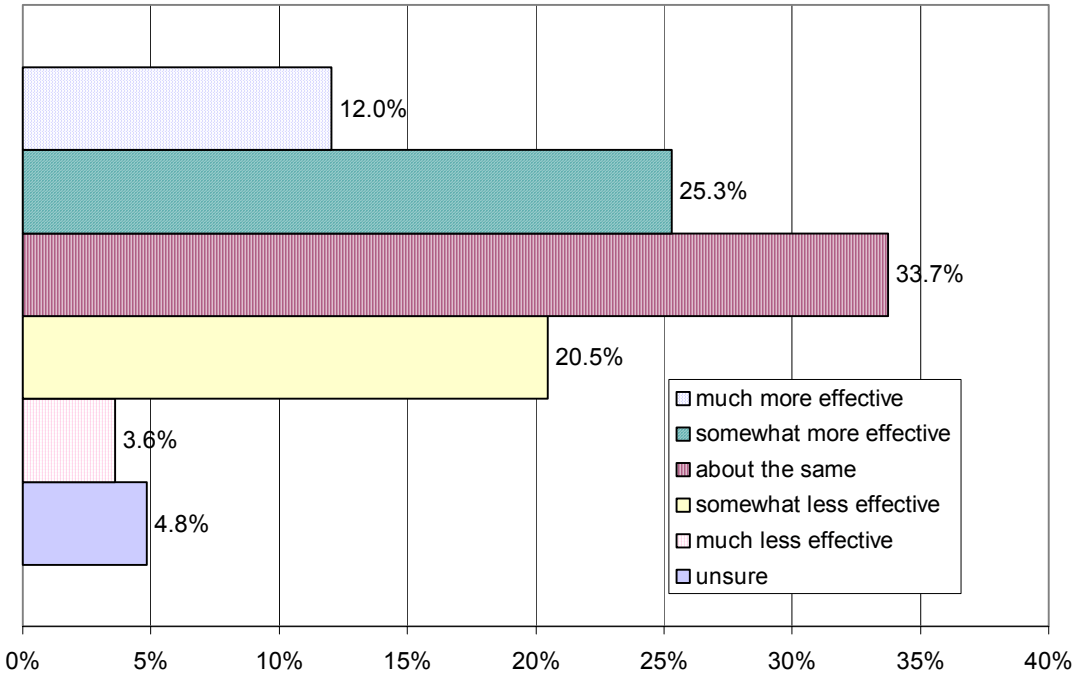


Figure 3.4. Is the FA approach any more or less effective or preventative than the traditional investigation approach for reports screened for FA?

Family Response. Two out of three administrators and supervisors (66 percent) participating in the survey said that FA had increased the satisfaction of families with

Children's Services. Sixty-six percent also reported that FA had increased the cooperativeness of families.

Community Response. Administrators and supervisors were asked about the current attitudes of key stakeholders in their counties or circuits towards the family assessment approach. These specific stakeholders were the Juvenile Judge, the Chief Juvenile Officer, the Police Departments, and School personnel. Less than half of the respondents described the attitudes of these groups as either very positive or generally positive. About 10 percent of the respondents described the attitudes of each of these groups as "very positive." Between 20 and 30 percent described these stakeholders as having "mixed" attitudes towards the approach. Juvenile Judges were viewed as least negative overall, while school personnel were seen as more negative than the others. A substantial minority of respondents said they did not know what attitudes these individuals might have. (See Figure 3.5.)

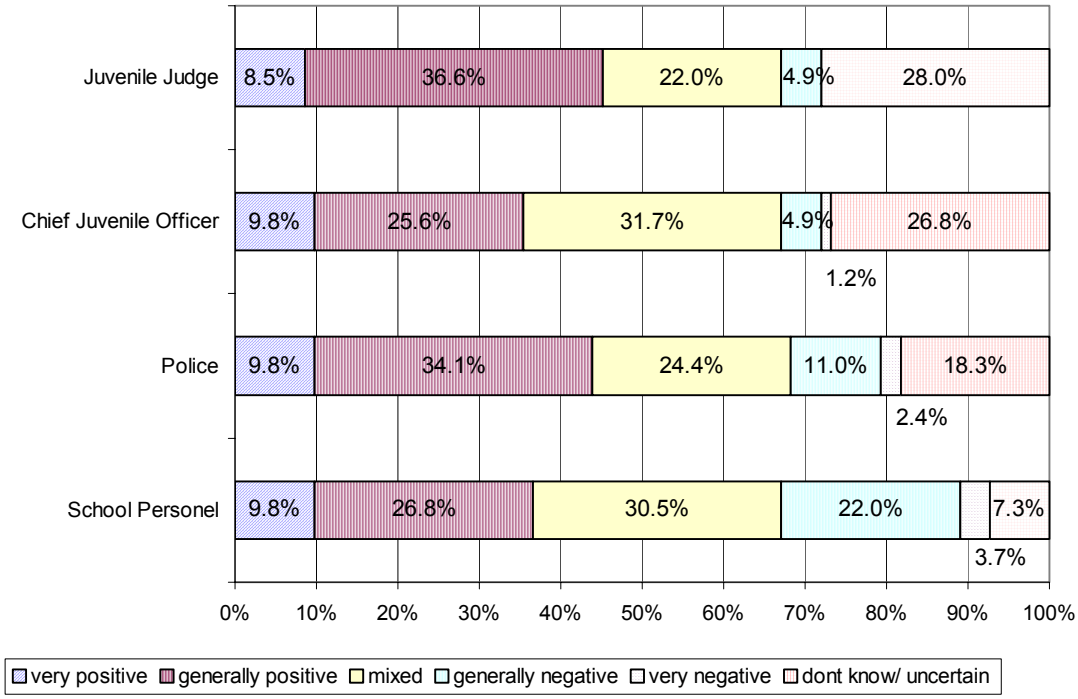


Figure 3.5. What are the current attitudes of the following towards the family assessment approach?

Administrators and supervisors were also asked whether the FA approach had improved the working relationship between the Children's Services office and specific community groups. The largest impact was seen in relations with community agencies and schools. A majority saw no change in the working relationship with Juvenile Court and the Police as a result of FA. Some (between 6 and 15 percent) reported that FA had had a negative effect on their office's relationship with these groups. (See Figure 3.6.)

System Issues. We asked county administrators and CS supervisors about a number of CS system issues and about factors that may have impacted implementation and utilization of the family assessment approach.

Screening. A majority (63 percent) of respondents said they would prefer to have the screening of reports for FA/TI conducted locally by county or circuit staff; 22 percent they would prefer screening to be done by the central hotline unit; and 15 percent had no preference.

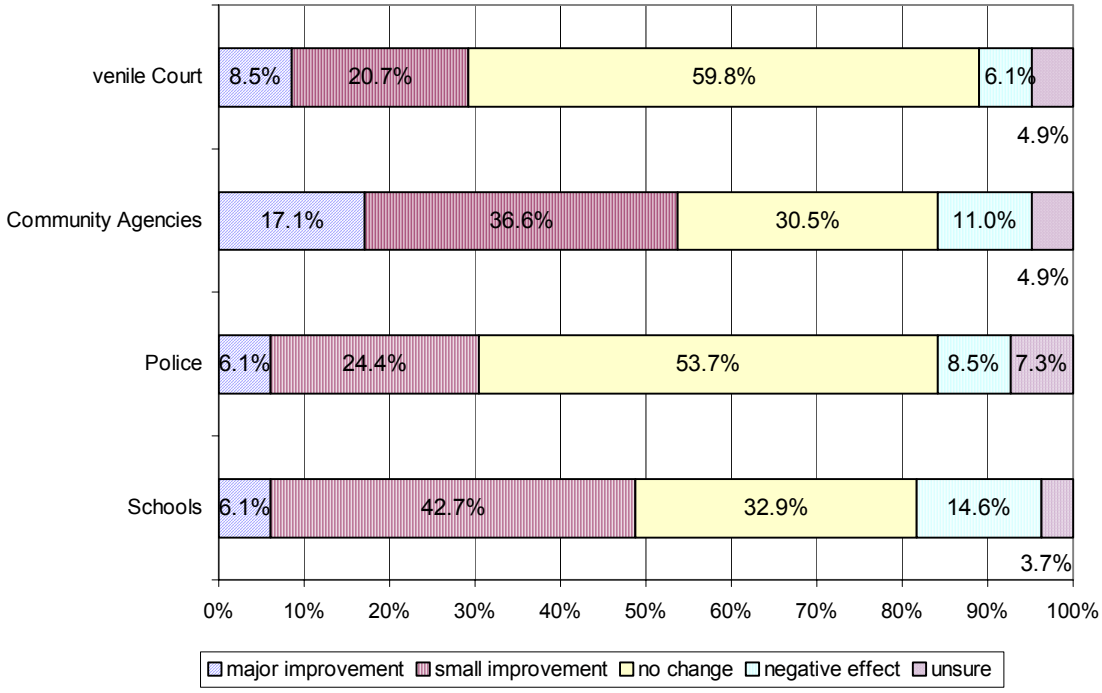


Figure 3.6. Has the family assessment approach changed the working relationship between the county Children's Service office and the following?

Some respondents said they thought there were certain types of reports usually screened for FA that should be investigated instead. This included 6 percent who thought there were "many" such reports and 33 percent who thought there were some. When asked what types of reports they had in mind, they said:

> *"Non-severe physical abuse of young children, extreme unsanitary living conditions, severe neglect. Criminal exploitation, severe physical abuse of teens, giving drugs/alcohol to minors, numerous priors for similar allegations."*
>
> *"Many mandated reports should be investigated and not treated as non-vital or not 'crisis oriented.' They should be treated as a regular report"*
>
> *"Physical abuse."*
>
> *"Bruising on back and legs in some cases, if there were priors of this."*
>
> *"Neglect, minor physical abuse."*

"Dirty houses. Workers do not upgrade when the situation is more serious than the report reads."

"Educational neglect."

"If FA reveals circumstances that were unknown at time of report, then investigation should be conducted."

"Chronic cases."

"I believe all reports should be investigations. They are more fact oriented and time friendly. They also are less intrusive with the families."

A majority of the respondents (61 percent) did not believe that there were any types of reports that are now usually screened for FA that should be investigated instead.

Factors that hinder FA utilization. We asked administrators and supervisors about a number of things that may hinder utilization of the family assessment approach. Their responses can be seen in Figure 5.

Over 80 percent of the respondents reported two problem areas: insufficient resources to buy needed services and insufficient staff time. Both of these were viewed as "major problems" by over half of the respondents, and both of these arise out of the same general area—the level of resource allocation by the state to child protection services. Over 60 percent of the respondents said there was insufficient time to administer the program and too few service providers in their county. Over 40 percent reported difficulties encountered with Juvenile Court and confusion over screening criteria. Over 30 percent reported problems arising from insufficient training of child protection workers and supervisors, confusion over state policies or requirements, and reluctance or negative attitudes of county staff.

Three of the areas on this list would appear to be directly amenable to remedial action on the part of the state agency. These are: confusion over screening criteria, insufficient training of workers and supervisors, confusion over state policies or requirements. Were these areas to be adequately addressed, staff attitudes might be expected to improve (although these attitudes are more likely affected by the press of cases and workload). Reports of difficulties encountered with probation offices and juvenile courts are wide spread enough to require a system-wide response. On the other hand, problems cited most often, insufficient staff and insufficient resources to assist families and address their needs, are beyond direct remediation by the state agency, which must live with the budget and personnel constraints it is handed.

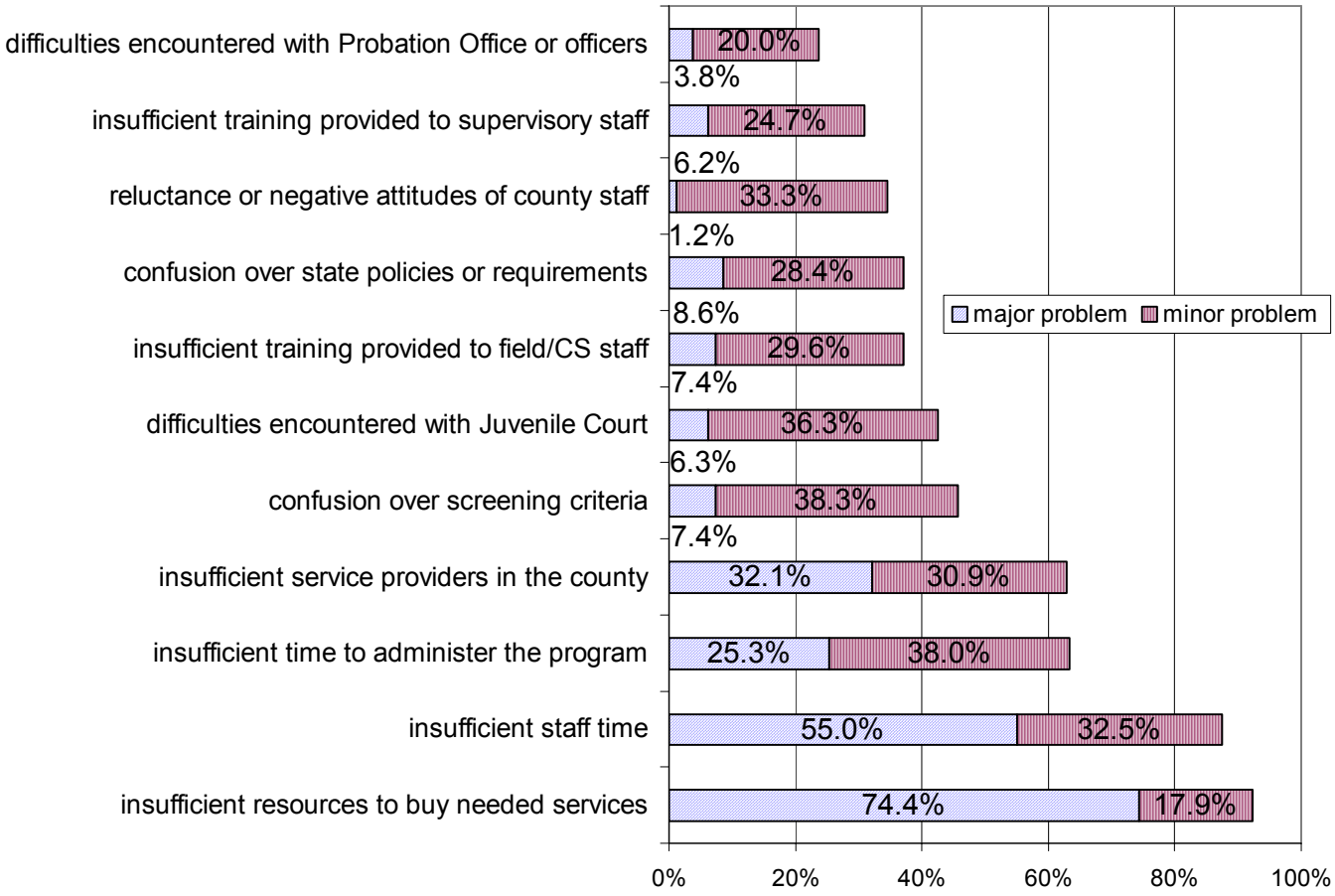


Figure 3.7. Have any of the following things hindered full implementation of FA in your county or circuit?

Continuation of Family Assessment. Administrators and supervisors were asked if they would like to see the family assessment approach continued or would they prefer to return to the situation in which all reports receive a traditional investigation. While a majority (60 percent) of respondents said they would like to see the FA approach continued, a sizable minority (40 percent) said they would prefer a return to traditional investigations for all reports. A few respondents commented on this question. Some of these said that investigations were easier and quicker to do and more certain to assure the safety of children. Others said families were more receptive to assessments and that this was a better way for workers to learn what they needed to know, to intervene effectively.

Organization by Circuits. Of the administrators who manage or supervise CS staff in more than one county, a majority (65 percent) reported positive to very positive opinions about this, 26 percent said they had mixed opinions and 9 percent said their opinions were negative. Commenting on this arrangement, those who favored it tended to recognize benefits of specialization, program consistency and quality control. One said: "Oversight of a circuit by a person with experience and education gains the respect of staff and community partners. Programs are becoming more consistent. Information is flowing smoother between all points in the system." Those expressing less enthusiasm for the change tended to point to

practical problems, such as time spent traveling and the difficulty of keeping in touch with workers in more distant counties. One said: "It is good to a point. But I don't feel as though I can do what needs to be accomplished due to travel time and inability to get much accomplished when in other counties due to limited time.

State Policies and Conditions. We asked administrators and supervisors whether there were any state policies or conditions that reduced or limited the effectiveness of the family assessment approach. In response, some pointed to specific issues or policies within the control of the state agency (although some comments argue for changing key aspects of the family assessment approach). Typical of these types of comments were these:

"Duplication of paperwork, bulky forms."

"Children are not interviewed alone in neutral setting."

"Notification of parent/perpetrator prior to interviewing child."

"Workers do not know how to assess families, they are trained in how to use a form."

"Information technology needs updating."

"Accepting all type of referrals (M, P, SK, PSR etc.) takes time away from actual abuse/neglect reports."

" Completing the assessment form when the allegations of the report are bogus and have no merit is not a good use of resources."

"F.S.T. meetings regardless of case plan are a waste of workers time."

" There is a desire to make everything uniform but our families are not uniform. They are individuals and we need to have fewer policies that make all things uniform."

An equal number of responses focused on the crush of work required with too few staff and, often, the lack of financial resources to help families.

"Hiring freezes and understaffing of workers makes it impossible to complete assessments on time while looking at all aspects of a family."

"Workers are unable to provide needed attention to open cases consistently due to high number of family assessments. We are unable to fill vacancies."

"Time constraints on staff means we cannot do what we must to ensure child safety."

"Staff do not have the time to spend on these cases to address all issues adequately."

There were also comments on the lack of resources within communities and problems with certain stakeholders. One said: "The Juvenile office does not buy into family assessment. They need training too."

Administrator/Supervisor Recommendations. We asked administrators and supervisors what recommendations they had or changes they would like to see made for improving the family assessment approach or Children's Services more generally? There were many comments and they tended to fall into four areas of need, some very broad and some quite narrow. The four areas of need were: 1) additional CS social workers; 2) more funds to provide services and help to families; 3) staff training; 4) various procedural changes and system improvements.

1. The need for additional CS social workers. There were more comments about the need for additional front line workers than any other specific issue. The comments of respondents echo those listed above. Importantly, it is suggested that not only does limited staff (and the large caseloads that result) increase the stress under which workers perform their duties and limit the effectiveness of their interventions, but, some say, it reduces child safety.

> *"We have increased the number of reports and decreased workers--it is impossible to complete required time frames and see children and verify safety without staff."*
>
> *"If we had the correct number of staff in an office we could provide the preventive services that could make family assessments more effective but staff is overworked and cannot do the things needed to be more effective. "*
>
> *"We need more staff to provide family friendly assessments and services or referrals for services from community resources. More staff and smaller caseloads would give workers time to work with families at the family's pace. Not in the "hurried assembly line, get the job done because there are 20 more cases waiting" approach to working with families that we do now. "*
>
> *"Need more staff-there is no way 595 can be done with the staff shortage we have in our county and the time constraints and caseloads. I had one worker assigned 42 assessments one month—ridiculous. "*
> *"Get us some more workers so they can devote time to real work with families. You can have all the policies you want but if there are not enough warm bodies to implement it becomes worthless anyway. "*
>
> *"More human resources--we need workers, if we are ever going to realize the ongoing benefits of this approach. "*
>
> *"We need staff-at least let us fill allocations—to get the job done successfully."*
>
> *"Adequate staffing to enable specialization or contract out some of the programs, i.e. investigation to Highway patrol, case management to private contractors. "*

"The hiring freeze is very detrimental to us providing for the safety of children."

2. The need for funds to provide for services to families. Some of the respondents calling for more child protection workers and numerous others pointed out the parallel need for sufficient resources to provide assistance identified in assessments. Both of these issues are seen as related to the ability of workers to intervene effectively.

"We need adequate funding for temporary or crisis assistance. "

"Available funds are essential to allow us to help families with their needs and then get out of their lives immediately. Some families just need a little help. "

"The allotment of more funds to assist families as needed to help prevent placements of families having an on going history with CS. "

"More funding for CTS services so we can offer more preventive help. We are extremely limited now in what we can do for families. "

3. Increased training. Many respondents point to the need for additional training of child protection social workers and supervisors.

"I would like to see central office be more supportive through the training of workers & supervisors. These are good fundamentals and it is beginning to make a real difference. "

"Workers should receive at minimum the 30 hours of in-service training required, but it is not currently provided. Formally it was offered in a structured manner. We need ongoing training in the field and on the job at least once per month by a mentor who can model effective casework or a contracted professional. "

"We need more in-service training for staff and supervisors. This should include Juvenile Court. They need to better understand their roles and responsibility. They "dump" cases and leave DFS in the lurch. "

"There seems to be the belief among some staff that if you offer services & family declines, nothing more can be done. Training is needed on how to engage families in identifying issues and concerns and in identifying services available to address those issues. "

"Refresher training for all frontline staff and supervisors is needed so that everyone is doing things the same way—consistency. "

"I would like to see the services staff trained in how to assess a family--not just on how to use a form. "

"More local training for local needs. We need more staff. Training for investigative staff in interviewing children. More pay for staff. More supervisors. We have had a lot of staff turnover. More local on the job training, e.g. job shadowing. If you had the supervisors they could do visits with new workers. "

"Many of us need to realize that we are not above being put into the same situations as our clients. We can hold a hundred meetings without empowering the client and we have still failed as an agency to meet clients' needs. We have a tendency to tell them what they need, must have, gotta do, etc. We need effective training to address this. "

One respondent summarized the implications involved if the needs identified in these first three areas are not addressed: "If there is an inadequate number of staff, inadequate funding for services, inadequate training for supervisors and workers—things aren't going to change for the families we deal with."

4. Procedural Changes. A number of both general and specific suggestions were made pertaining to a variety of procedural issues.

Drop FA. Some, with sharp negative view toward the introduction of the family assessment approach, suggested eliminating FA.

"Rewrite the policy to eliminate assessment."

"I would like to revert back to the full time investigation approach on all reports so as to better ensure child safety."

"We do what we always have to do—approach families just without the politically correct titles. Why create more programs-more confusion for clients. To families DFS is DFS no matter what we call it. Workers can have an attitude of assistance to families no matter what state office calls it. We need to simplify-simplify-simplify."

Consistency. Others respondents called for improvements to ensure consistency in screening and in how assessments are done.

"We need consistency among supervisors regarding what is and isn't a family assessment."

"There needs to be consistency in what is taken as a report, what is an emergency, what callers to the hotline are told."

"Needs to be straight forward definitions on how something should be screened."

"There needs to be a stated time limit on how long FA's are kept. Needs to be straight forward definitions on how something should be screened."

Forms and SDM. Some respondents expressed the need for improved, clear forms, while others praised new forms being tested:

"We are presently in a demonstration site with the new CPS-1 form and everyone loves it."

"I believe the new change with the form is a positive step. And another: "Some changes that are on-going are very welcome. (i.e., CS-16 & CAN-1 made into a single form and structured decision making.)"

"The state is beginning structured Decision making which should help in all aspects--from verifying safety to writing up cases."

Organizational Issues. A number of comments dealt with various organizational arrangements.

"Combining children's services counties into a circuit concept presents many challenges. With tough economic times as we are having now was not the right time to make changes. The idea this could be done with no additional resources or funding is ridiculous!"

I think with the new circuit structure, the supervisory staff is spread too thin. They are responsible for monitoring more staff and are not available as needed. "

"Organizing Children's Services by circuits solves most of the difficult problems we have faced."
"Leave the comprehensive assessment function to case carrying staff who can form the therapeutic relationship needed to conduct the assessment as it should be intended."

"Lower caseloads to do a thorough assessment, extend update of assessment reports from 30-45 days, create specialty loads, such as for ed neglect, community development and substance abuse."

"We have a specialized family assessment unit which has helped tremendously."

"We need a community development specialist or I just need more time to work with community leaders to set up programs which can be used by families with whom we work. There's just not enough time to attend all meetings and do the networking I need to do."

System Improvements. Some comments were broad and multi-faceted.

"My recommendations would be to focus on: 1) quality improvement; 2) evidence-based tools; and 3) improve community understanding of child protection versus child welfare versus child well-being."

"We need to nurture this (FA) practice. Reinforce the centrality of the safety of the child. Provide on-going training to all levels of staff on community collaborations, FST's, and child safety. Introduce automatic reporting forms. In addition, we need to 1) develop a better understanding of the importance of using investigative techniques during assessment, 2) clarify when we should interview a child alone or at a place other than home, and 3) improve how we use "pattern" information to determine needs with the family."

CS Social Workers

In most important respects, the surveys responses received from CS social workers across the state are similar to those of county administrators and CS supervisors discussed above.

Safety. Three out of four workers (75 percent) reported that the safety of children had not been put in jeopardy in their counties because their families received a family assessment rather than a traditional investigation. A small number (4 percent) said it happened often; 8 percent sometimes; and 13 percent a few times.

Workers were asked to elaborate on their responses and their comments tended to fall into one of six groups:

1) Family assessment does not jeopardize safety/ No difference between family assessment and Investigations.

"Verification of safety should be handled the same regardless of whether it is family assessment or Investigation. "

"The safety of the children does not get put in jeopardy because of anything at DFS only because of the perpetrators. "

"In my experience, I have never had a case where the child's safety was in jeopardy because the report was screened an family assessment instead of an investigation. "

"We always assure the safety of the child per state regulations as a part of our Family Assessments. "

2) Family assessment does not jeopardize safety: workers can upgrade from family assessment to Investigation if needed.

"I believe that while some assessments should be investigations, if there are serious concerns the worker can still address the concerns and upgrade the report if necessary to protect the child. "

"If an assessment turns out negative (dangerous), the worker would immediately notify police and actually report it as an investigation or hotline it themselves. "

"Assessment can be changed to an investigation if circumstances allow. "

3) Safety depends more on workers knowledge and expertise

"The workers in this county are all very conscientious about the children's needs and would never compromise regarding safety. We often go above and beyond and aren't hesitant to do so. "

"The experienced workers will not leave a child unprotected if they have the cooperation of the juvenile court

"It is our responsibility as workers to be thorough. I get more information from assessments than investigations sometimes. "

4) Concerns about safety

"I can think of one instance where a child died from physical abuse during an open family assessment. I'm not sure an investigation would have prevented the death—we can't predict the future. "

"Assessment workers don't always understand they can remove children without coming back to the office and upgrading a report, and sending out an investigator. "

"Assessment approach is not given the priority that would insure timely investigation/response to insure the safety of children. "

"Our chief assessment worker is very good but when an alternative care worker is on rotation and receives an assessment, they are likely to compromise a complete assessment due to the demands of their responsibilities. "

5) Investigation compromises safety

"Safety is more likely being compromised during investigations as we have to wait on law enforcement. "

6) Safety is jeopardized in family assessment by role of family assessment or other agencies

"In our unit, we treat family assessments as serious as investigations. However, the problem comes in at the end when the family gets to decide whether to open a case or not. In investigations the worker makes the decision."

Effectiveness. For reports typically screened for FA, 40 percent said the FA approach was more effective or preventative than the TI approach; 42 percent saw the two approaches to be about equal in effectiveness; and 18 percent saw TI as more effective. Social workers tended to agree with administrators and supervisors on the types of cases in which the FA approach was more effective—those involving poverty, child behavior problems, poor parenting skills, and non-severe physical abuse. In such cases about half of the workers saw FA as more effective; about 7 to 10 percent saw TI as more effective; and the others saw no difference.

Family Response. CS social workers were a bit less sanguine or positive than supervisors and administrators in assessing the reaction of families to family assessments: 44 percent said families who received FA were more likely to be cooperative than if a TI had been conducted; 43 percent said it made no difference. Asked whether families who receive a family assessment were more likely to be satisfied with DFS and DFS services, 43 percent said yes, while 48 percent said it made no difference. Just over half (52 percent) reported that families who received FA were more likely to view DFS as a resource and source of support than if they had received a TI; 38 percent said there was no difference.

Staff Organization. CS workers were asked questions about staffing arrangements. In general, they tended to favor arrangements currently in place in their counties, arrangements with which they were familiar. First they were asked which arrangement they thought was more effective: a) having workers who conduct family assessments also conduct investigations, or b) allowing FA workers to specialize only in family assessments and not be responsible for investigations as well. Thirty-nine percent favored (a), the generalist approach, while 29 percent favored (b), the specialist approach; 31 percent saw no substantial difference. When asked which of the two approaches they preferred, their responses broke down in nearly the same percentages.

Secondly, workers were asked which of these arrangements they thought was more effective: a) having workers who conduct initial home visits carry the formal FCS case if one were opened, or b) handing off the family to another worker if an FCS case were opened. In this instance, 25 percent favored (a), representing case continuity, and 67 percent favored (b), case segmentation; 8 percent saw no substantial difference between the two approaches. Again, when asked which approach they preferred, there was little change in these percentages.

Satisfaction with Family Assessment Approach. Workers were asked how satisfied they were with the FA approach in their county or circuit. They were asked to give their response on a 10 point scale, where 1 meant they were "very dissatisfied" and 10 meant they were "very satisfied." On this scale, 60 percent of the responses were on the positive side of the scale, while 40 percent were on the negative side. Their responses were simplified to a five point scale, and can seen in Figure 3.8.

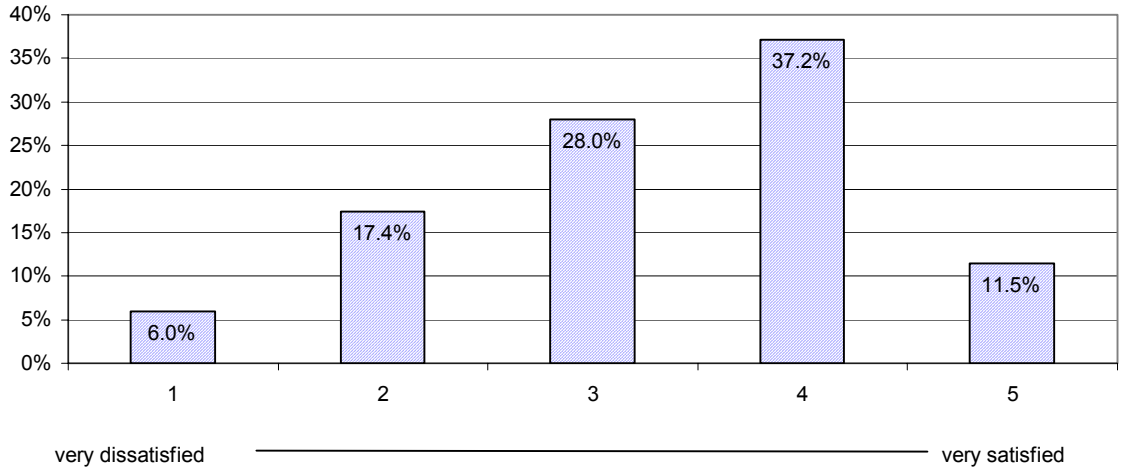


Figure 3.8. How satisfied are you with the family assessment approach in your county or circuit?

Worker Recommendations. In the survey, workers were asked whether they had any recommendations for improving Children's Services or the family assessment approach in their county. Their comments tended to fall into 5 categories: 1) the problem of too few workers and too many cases; 2) the need for service funds; 3) issues around reports and screening; 4) various procedural matters; and 5) the importance of worker training.

1. Staffing and caseloads. There were more comments from CS workers about personnel issues than any other. Many of these dealt with the need for more workers and the filling of openings and the rising size of caseloads that result from staff reductions. Some address issues of pay and retention. Adequate staffing is seen as essential for the safety of children and for the effective functioning of the family assessment approach.

> *"There is a desperate need for more workers to do investigations and assessments, as well as workers to provide services. Not having enough workers is what causes safety issues of children."*

> *"Employ enough workers in order to effectively carry out this (FA) approach. "*

> *"We need more workers, so we can keep an FCS case if one is opened. We are carrying double caseloads in CA/N unit, and do not have time to use the tools & skills we have. We need more workers to ensure safety & assist families. "*

> *"We need more workers—there is no way with our case load sizes that either the investigators or treatment workers can provide the kinds of services that families need. "*

> *"We need more front line workers. It is difficult to do a proper assessment when you are limited by time and lack of resources (low CTS funds). "*

"Increase personnel—lift the hiring freeze. Increase pay so that workers will stay, thereby increasing experience level. "

"More staff, turnover is high and office morale is low. Better incentives, so employees will stay (ex: lower insurance premiums, better pay, lower case loads, etc). "

"Staff needs to be recognized and appreciated for what they do by receiving appropriate pay raises and incentives. Morale is very low statewide (not specifically in this county). "

"Pay more--attract more qualified workers. "

"Utilize financial resources on retaining staff and having additional staff to fill vacancies. "

"Consistency. We need more competent workers. Strategies to help burn out. "

2. Funds for services.

"If we are going to utilize the assessment process the way it was intended then we must be able to provide our clients with services. "

"CTS funds are necessary so the families can get essential services such as FMAS, PRAD or mentoring. "

"More money for services for clients & pay raises. Changes in the number of hoops you have to go through to get services for your families. "

3. Reports and screening. A number of workers commented on hotline reports and the screening process.

"Do not take anonymous reports. Do not take incidents that happened a few months ago."

"Some assessments are bogus hotlines and shouldn't be taken at all. So, many assessments are unnecessary. People use it as revenge--stiffer penalties for that. "

"A high percentage of assessments should be accepted as a "referral" rather than assessment to address CA/N. "

"Better screening at the central registry unit. I receive too many cases where the care, custody, or control has not been established. "

"Being consistent with what qualifies a hotline for an investigation or family assessment. FA workers should not carry open cases. It is difficult to manage both. Having specific worker do FCS open cases. "

"Not mixing investigations and assessments. Being consistent with what constitutes severe abuse and neglect for an investigation. Looking at previous hotline calls to help screening process. Not making screening based on whether or not reporter is anonymous."

"I think statewide our system needs to be revamped—we take so many calls, especially custody battles, and we have very little time. Families who do need services need more time than we can give. "

"I believe that all hotlines should be handled by an investigation team that specializes in this area. All hotlines should probably be investigations. "

"The only thing I'm dissatisfied about is all the marginal reports we have to deal with. We are not the family resource center. We wish we had the time for it though. "

"Return to Investigation only. Put law enforcement (Highway patrol) in charge of investigating sexual abuse). "

4. Procedures. There were many comments about various procedures and forms. Issues of specialization and the new circuit arrangement were also addressed by some.

"I like the new CPS-1. The process is not nearly as intrusive on the family. "

"I think a genogram and much of the information gathered on the 16 is intrusive. downgrading to assessments is supposed to be more family friendly but doing it correctly makes it lengthy and can be more intrusive. "

"Revise the CS 16. Some of the information is something only an ongoing worker would benefit from. Genogram questions make parents angry if they haven't done anything wrong, and the form is time consuming for worker. Thirty days not enough time to complete. "

"If conclusion is K, worker should not have to complete CS 16. Need alternate form. DFS should have a protection from the high percentage of custody & revenge reports we receive. "

"If a worker can assess that the report is a false report-the worker needs to be able to leave the residence and should not have to complete the entire CS 16. "

"More flexibility is needed in approaching clients. Emphasizing strengths and need versus ecological model produces more intervention options. Secondly, focus on natural existing systems rather than NGO's should produce longer lasting results & skill acquisitions. "

"I think it will be better with the new SDM screening tools. "

"PS workers are not following up with families quickly or thoroughly enough once an assessment worker opens a case for services, which usually generates more reports which should be avoided. "

"Workers should be specialized and broken into two groups investigators and treatment workers. When a treatment worker does an investigation it destroys rapport. "

"Specialization in children services is not as efficient as generalization because all facets are intensive and employee absence creates serious problems with efficiency."

"We need a night team that responds to serious allegations when notified. Waiting until next day loses ground. "

"Allow more time for the assessment period so that effective communication takes place and the family has time to get past covering up concerns that they need to share. Rapport is an act that can't always be rushed in high risk families. "

"The circuit system is poorly done. Workers are too spread out and the overtime is high. "

"The biggest improvement occurred when workers became specialized. This allows workers with experience to be responsible for all hotlines. "

"We need more voice with the courts. We are not on an equal footing with them and workers have been "punished" in various ways for disagreeing with JO or court. "

"We need to work on improving day to day relationship with law enforcement."

5. Training. There were many comments about training—the need for more ongoing and on-the job training, and for competent trainings that give workers the knowledge and skill to be more effective when encountering families.

"Of course we need more staff--but all staff needs to be trained and confident in their ability to do investigation or assessments. "

"Basic training deals primarily with how to fill out the forms, and then no follow up training. "

"On the job training with appointed mentor would be most effective."

"It takes at least 2 yrs to get the hang of things. I believe a mentor and/or on the job training is the best. Basic training with the state is not always useful. New workers have no clue on paperwork and computer systems. "

"Training needs to be ongoing. "
"We need training in the realities we face everyday instead of perfect cases out of books. Such what to do with children who refuse to talk or children who disclose one time and are not protected. "

"DFS needs to implement duty-specific training. Training now is way too general. "

"Would have liked formal training not-here you go. "

"I have been in this position for almost 2 1/2 years and have only received the basic training. I continue to request in depth training. I currently want to be involved in the interviewing training 'Finding Words.'"

"For staff without a social work degree--the training is inadequate--in my opinion."

"There is a lack of consistency from county to county in how things are done and trainers say 'it depends.'"

"We are given different views on how to do an assessment--not consistent."

"When I went to training for my position at DFS it was very confusing, but the trainers were sufficient. I learned more on the job than in the formal training."

Conclusion

County staffs are not of one mind about the family assessment approach. Some use it more and like it more. Others use it less and like it less. Others are ambivalent about it or use it but do not trust it. Some see it as a more effective way of helping families in cases of less severe abuse or neglect, of providing assistance and support they need rather than a punitive response that benefits no one, including the children. Others see it as a kind of triage program, in which an overburdened system can distinguish between those cases it has to respond to and those it does not have to take as seriously. There are administrators, supervisors and workers who have apparently never understood the underlying philosophy behind family assessments and the two-track approach and fail to see how it is any different from regular family-centered practice. And, for these, it represents yet another exercise in new words and forms for the same old practice. There are those who do understand it, but are frustrated that it cannot be fully implemented with incomplete staffing and few resources to assist families whose needs have been identified and who would accept assistance if it were available. And there are counties that make it work despite all the obstacles, convinced

it is a better approach, and that all families and situations are not the same and should not be treated the same.

Systems change is difficult and complex in the best of times, and problems inherent in introducing new approaches can be easily underestimated. Some of the counties that began utilizing the two-track system with the family assessment approach since the conclusion of the initial demonstration appear to understand it and are approaching it correctly. Other new counties appear to be struggling with the basic concept or have not yet been convinced that it represents anything different, much less anything better than what they had been doing. Some continue to assume that investigations keep children safer than assessments, although there is no evidence to support this, unless assessments are not properly done or if safety is a priority in investigations but not in assessments. A well-planned, statewide training program appears to be an important step yet to be taken—one that focuses less on forms and procedures and more on what happens when workers interact with families. Ongoing, skill-building training is essential. Opportunities for supervisors and social workers to interact on a regular basis across counties and regions to discuss the problems they are encountering and what works and what does not would provide both practical assistance and much-needed morale boosting inter-personal support. However, all the best intentions and plans can be undermined if county staffs continue to operate with excessively large caseloads and few monetary resources to help the families they work with.

In our final report on the evaluation of the initial SB595 demonstration we wrote that the results of the family assessment approach were positive but modest. And we asked: "If it made a (statistically) significant difference, why not a more substantial one?" We hypothesized that part of the answer was to be found in the newness of the approach, especially one in which a key element was the development of new relationships within communities and key institutions like courts and schools and the identification of formerly untapped resources. Such efforts are "labor intensive and take time." We continued: "Moreover, although workers were asked to do more, and to look at a wider set of problems and needs that often exist within CA/N families, they were not provided with additional funds or other resources within the child welfare system to use in remediating what they found. They were asked to rely on untapped resources in the community." The final three sentences in the final evaluation report were these: "Child welfare workers in Missouri have high caseloads. The impact of the family assessment approach will likely improve over time if current initiatives at community collaboration are sustained and built upon, and if offices receive other assistance in community development. More substantial results would require a commitment to reducing worker caseloads."

Chapter Four

Family Assessment Implementation Issues

Screening

With the introduction of the family assessment approach in Missouri, all accepted hotline reports have been screened for their appropriateness for a family assessment response or a traditional investigation. This screening has always been done at the county level by Children's Services staff within county DFS offices. One of the key questions about screening is: How can we account for the variation that is found among counties in the proportion of cases screened for a family assessment versus an investigation? To try to answer this question we examined the screening data from the beginning of the initial SB595 demonstration in 1995 through last year, 2002.

As described in the introduction, the initial FA demonstration took place during the period 1995 through 1997. In 1998, the FA approach was expanded and implemented in 53 other counties. In 1999, statewide implementation of FA was completed with its introduction in the remaining 46 counties in the state. The first full year of statewide implementation occurred in the year 2000.

Overall, the percentage of reports screened for FA across the state has remained generally constant, with some fluctuations from month to month. Figure 4.1 shows the percentage of reports screened for FA since the initial demonstration period. (It takes into account the staggered startup of the new approach in different counties. Prior to 1998, the figures apply only to the original demonstration counties. As new counties began

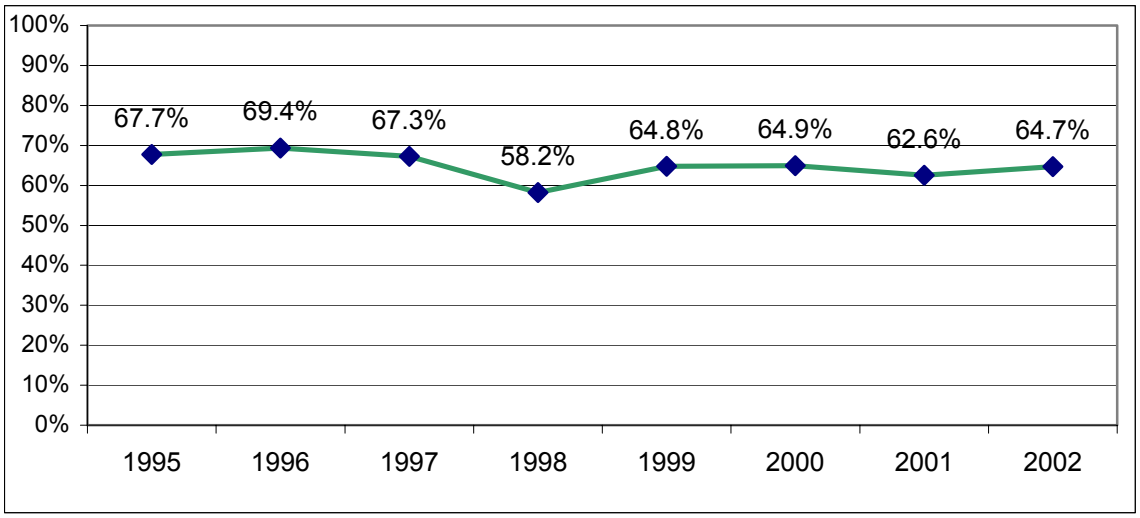


Figure 4.9. Percentage of CA/N reports screened for FA, 1995 through 2002

coming on line in 1998 there was an apparent drop in the overall proportion screened for FA. This appears to have been caused mostly by the introduction of the approach in Jackson

County, the state's second largest county (and it would appear that FA was either phased in here over a number of months or begun with a large degree of caution). By the second quarter of 1999, the percent of reports screened for FA had risen to nearly 65 percent and has remained in this vicinity since.

Screening Differences in 2001. The most recent year for which we have full data is 2001.[5] Table 1 shows the number of screened reports for each county and the City of St. Louis for 2001 and the percentage of these reports screened for a family assessment (FA) and a traditional investigation (TI). Statewide, 62.6 percent of all reports were screened for FA in 2001. The median among the counties was 40.2 percent. This means that half of the counties in the state screened a percentage higher than this for FA and half screened a lower percentage.[6] As can be seen in the table, the percentage of reports screened for FA ranged from a low of 21.6 percent in Ozark County to a high of 88.9 percent in Worth County. Most of the larger and more urbanized counties in the state tended to screen a higher percentage for FA. For example, in Jefferson (80.7 percent), Clay (79.3 percent), Buchanan (77.5 percent), and St. Charles (75.9 percent) counties, at least three of every four screened reports were judged to be appropriate for FA. The City of St. Louis (71.1 percent) and St. Louis County (70.0 percent) also screened a high proportion of their reports for family assessments. Cape Girardeau (69.8 percent), Franklin (67.3 percent), Boone (66.4 percent), Jasper (63.6 percent), and Jackson (62.6 percent) counties all screened at or above the statewide average of 62.6 percent. The major exception to this trend was Greene County (44.6 percent). Christian (39.4 percent) and Cole (25.4 percent) were the only counties other than Greene with populations over 50,000 and family assessment screenings of under 50 percent. Among counties with the lowest FA percentages, there were five including Cole below 30 percent and nine others between 30 and 40 percent. Counties that participated in the original demonstration as demonstration sites can be found scattered across the spectrum. Jefferson, St. Charles, Callaway, St. Louis City and County all screened above 70 percent for FA, while Boone, Jasper and Newton screened above 60 percent. Washington, Texas, Phelps, and Maries counties screened at or near 50 percent for FA. Pulaski County (40.9 percent) screened less than half for FA, while Barton, Cedar and Dade screened less than 40 percent.

The data in Table 4.1 show, with the major exception of Greene County, that there is a stronger tendency toward FA in more urbanized and populated counties. At the same time, at least in 2001, counties that screened a majority of reports for a traditional investigation tended to be smaller and more rural. Two questions that arise are: 1) Is 2001 representative of how counties generally screen the reports they receive? That is, is there general internal consistency within counties from year to year in screening?

[5] We have data on hotlines and screening through the third quarter of 2002. All references to 2002 data, therefore, pertain only to the first three quarters of the year. Even these data, however, are somewhat incomplete, due the natural lag that exists in entering data into the information system.

[6] That the median is so much lower than the mean indicates that more populous counties tend to screen a higher percentage of their case for FA and that many (but certainly not all) smaller counties screen a lower percentage.

Table 4.1. CA/N Reports and Percent Screened for FA and TI during 2001

COUNTY	*reports*	*FA*	*TI*	*COUNTY*	*reports*	*FA*	*TI*
ADAIR	214	61.2%	38.8%	LIVINGSTON	121	76.0%	24.0%
ANDREW	110	64.5%	35.5%	MCDONALD	259	62.5%	37.5%
ATCHISON	73	50.7%	49.3%	MACON	150	50.7%	49.3%
AUDRAIN	270	52.2%	47.8%	MADISON	145	60.0%	40.0%
BARRY	409	42.5%	57.5%	MARIES	89	49.4%	50.6%
BARTON	151	36.4%	63.6%	MARION	443	49.4%	50.6%
BATES	212	35.4%	64.6%	MERCER	21	66.7%	33.3%
BENTON	152	59.2%	40.8%	MILLER	353	60.3%	39.7%
BOLLINGER	107	57.9%	42.1%	MISSISSIPPI	159	62.3%	37.7%
BOONE	1103	66.4%	33.6%	MONITEAU	110	75.5%	24.5%
BUCHANAN	1308	77.5%	22.5%	MONROE	68	51.5%	48.5%
BUTLER	517	64.6%	35.4%	MONTGOMERY	183	57.9%	42.1%
CALDWELL	135	66.7%	33.3%	MORGAN	234	60.7%	39.3%
CALLAWAY	620	70.5%	29.5%	NEW MADRID	174	82.8%	17.2%
CAMDEN	371	69.0%	31.0%	NEWTON	663	61.2%	38.8%
CAPE GIRARDEAU	496	69.8%	30.2%	NODAWAY	139	77.7%	22.3%
CARROLL	119	52.9%	47.1%	OREGON	144	44.4%	55.6%
CARTER	128	35.2%	64.8%	OSAGE	93	64.5%	35.5%
CASS	712	71.2%	28.8%	OZARK	116	21.6%	78.4%
CEDAR	222	34.2%	65.8%	PEMISCOT	281	59.8%	40.2%
CHARITON	79	51.9%	48.1%	PERRY	147	72.1%	27.9%
CHRISTIAN	467	39.4%	60.6%	PETTIS	517	70.2%	29.8%
CLARK	60	51.7%	48.3%	PHELPS	502	50.4%	49.6%
CLAY	1466	79.3%	20.7%	PIKE	205	39.5%	60.5%
CLINTON	195	63.1%	36.9%	PLATTE	475	76.6%	23.4%
COLE	713	25.4%	74.6%	POLK	326	27.0%	73.0%
COOPER	129	48.8%	51.2%	PULASKI	526	40.9%	59.1%
CRAWFORD	310	68.1%	31.9%	PUTNAM	50	72.0%	28.0%
DADE	109	33.0%	67.0%	RALLS	73	60.3%	39.7%
DALLAS	176	47.2%	52.8%	RANDOLPH	318	26.1%	73.9%
DAVIESS	80	57.5%	42.5%	RAY	257	75.9%	24.1%
DE KALB	77	68.8%	31.2%	REYNOLDS	79	64.6%	35.4%
DENT	228	57.9%	42.1%	RIPLEY	194	54.6%	45.4%
DOUGLAS	128	27.3%	72.7%	ST. CHARLES	1803	75.9%	24.1%
DUNKLIN	459	51.0%	49.0%	ST. CLAIR	89	42.7%	57.3%
FRANKLIN	882	67.3%	32.7%	ST. FRANCOIS	751	68.3%	31.7%
GASCONADE	160	62.5%	37.5%	STE. GENEVIEVE	168	76.8%	23.2%
GENTRY	68	52.9%	47.1%	ST. LOUIS CO	5600	70.0%	30.0%
GREENE	2912	44.6%	55.4%	SALINE	304	67.4%	32.6%
GRUNDY	115	57.4%	42.6%	SCHUYLER	36	47.2%	52.8%
HARRISON	76	61.8%	38.2%	SCOTLAND	40	47.5%	52.5%
HENRY	324	72.5%	27.5%	SCOTT	500	56.8%	43.2%
HICKORY	83	42.2%	57.8%	SHANNON	100	54.0%	46.0%
HOLT	42	85.7%	14.3%	SHELBY	74	51.4%	48.6%
HOWARD	105	50.5%	49.5%	STODDARD	275	60.7%	39.3%
HOWELL	588	50.3%	49.7%	STONE	274	42.3%	57.7%
IRON	115	65.2%	34.8%	SULLIVAN	54	72.2%	27.8%
JACKSON	7374	62.6%	37.4%	TANEY	544	65.6%	34.4%
JASPER	1788	63.6%	36.4%	TEXAS	318	53.5%	46.5%
JEFFERSON	1918	80.7%	19.3%	VERNON	350	53.1%	46.9%
JOHNSON	395	62.3%	37.7%	WARREN	267	41.6%	58.4%
KNOX	39	35.9%	64.1%	WASHINGTON	317	54.9%	45.1%
LACLEDE	372	71.5%	28.5%	WAYNE	182	78.0%	22.0%
LAFAYETTE	326	38.0%	62.0%	WEBSTER	345	51.0%	49.0%
LAWRENCE	469	68.4%	31.6%	WORTH	18	88.9%	11.1%
LEWIS	91	48.4%	51.6%	WRIGHT	260	46.5%	53.5%
LINCOLN	435	65.3%	34.7%	ST. LOUIS CITY	5165	71.1%	28.9%
LINN	132	59.8%	40.2%	**TOTAL**	56362	62.6%	37.4%

And, importantly: 2) Are there significant differences in the types of reports received by counties that account for differences in screening for FA versus TI?

Internal Consistency in County Screening. The broadest look at the relative consistency of screening over time is available in the original demonstration counties where we have eight years of data, from 1995 to 2002. Table 2 shows the percentage of screened reports that were judged appropriate for a family assessment for each year in the 15 demonstration counties and the City of St. Louis.[7]

Variation between Counties. By looking at any given year, we can see that these counties varied in screening decisions. In 1995, the percentage of FA screenings ranged from 39.3 percent in Pulaski County to 79.8 percent in Jefferson. In 2002, the percentage ranged from 39.2 percent in Barton to 81.5 percent in Jefferson.

Variation within Counties. Looking across the years at individual counties we see both consistency and inconsistency. Jefferson and St. Charles counties, for example, screened consistently high percentages for FA throughout the eight-year period. Barton and Cedar counties, on the other hand, screened higher for FA in some years and lower in others. Often, although not always, the variation within certain counties from year to year contributed to the variation between counties for certain years. Thus, for example, if Barton and Cedar counties continued to screen reports in 2001 and 2002 at a rate similar to what they had done in previous years, the amount of between-county variation would be less for those years.

Table 4.2. Percent of Reports Screened for FA in SB595 Demonstration Counties 1995-2002

COUNTY	1995	1996	1997	1998	1999	2000	2001	2002	st dev
BARTON	75.0%	72.4%	77.2%	79.0%	80.2%	76.2%	36.4%	39.2%	19.2%
BOONE	69.2%	63.9%	51.9%	56.6%	65.4%	69.6%	66.4%	65.0%	6.3%
CALLAWAY	69.4%	64.5%	58.5%	60.5%	57.6%	69.8%	70.5%	70.0%	5.2%
CEDAR	53.0%	58.1%	61.5%	64.4%	59.7%	53.6%	34.2%	44.8%	11.0%
DADE	73.3%	45.5%	62.5%	47.5%	63.9%	74.2%	33.0%	50.0%	16.3%
JASPER	65.8%	70.7%	68.1%	71.5%	71.9%	69.6%	63.6%	61.3%	3.9%
JEFFERSON	79.8%	82.0%	78.6%	77.0%	82.3%	82.8%	80.7%	81.5%	1.6%
MARIES	59.3%	51.5%	66.7%	68.0%	55.8%	76.4%	49.4%	45.8%	9.7%
NEWTON	60.4%	72.7%	70.3%	69.9%	68.1%	67.4%	61.2%	59.3%	6.1%
PHELPS	64.8%	60.5%	64.9%	57.1%	64.2%	52.8%	50.4%	50.8%	6.9%
PULASKI	39.3%	51.4%	57.4%	45.5%	57.1%	63.8%	40.9%	40.9%	9.6%
ST. CHARLES	73.9%	75.4%	75.0%	69.1%	73.6%	75.1%	75.9%	82.3%	3.2%
TEXAS	57.5%	61.2%	57.7%	54.3%	59.3%	63.2%	53.5%	51.3%	5.0%
WASHINGTON	77.3%	81.1%	80.0%	72.8%	66.5%	64.2%	54.9%	57.1%	10.9%
STL CITY	54.8%	56.1%	56.9%	67.2%	74.4%	80.0%	71.1%	76.0%	6.0%
STL COUNTY	63.5%	72.1%	64.3%	68.6%	69.5%	76.2%	70.0%	72.3%	4.2%
TOTAL	67.7%	69.4%	67.3%	67.7%	68.4%	74.9%	68.2%	70.9%	2.0%

[7] Note that in the City of St. Louis and St. Louis County, Family Assessment was piloted only in selected zip code areas. The screening percentages shown for St. Louis City and County for the eight-year period, accordingly, only apply to these zip code areas.

Note that the last column in Table 4.2 shows the standard deviation within counties for their FA screening percentage across the years. The higher this figure, the greater the variance in a county's screening percentage for FA, while a lower standard deviation means there has been less variance from year to year. Jefferson County, with 1.6 percent, has had the least variation, and Dade County, with 16.3 percent, has had the most among the original demonstration counties.

Figure 4.2 shows the percent of reports screened for FA for four demonstration counties--Jefferson and St. Charles, which tended to screen consistently high, and Barton and Cedar, which had greater variation. As can be seen, from 1995 through 2000, Barton's screening percentage was very close to that of Jefferson and St. Charles, but then reduced FA screenings during the last two years. Cedar County never screened as high as the others, but, like Barton, reduced FA screenings in 2001 and 2001.

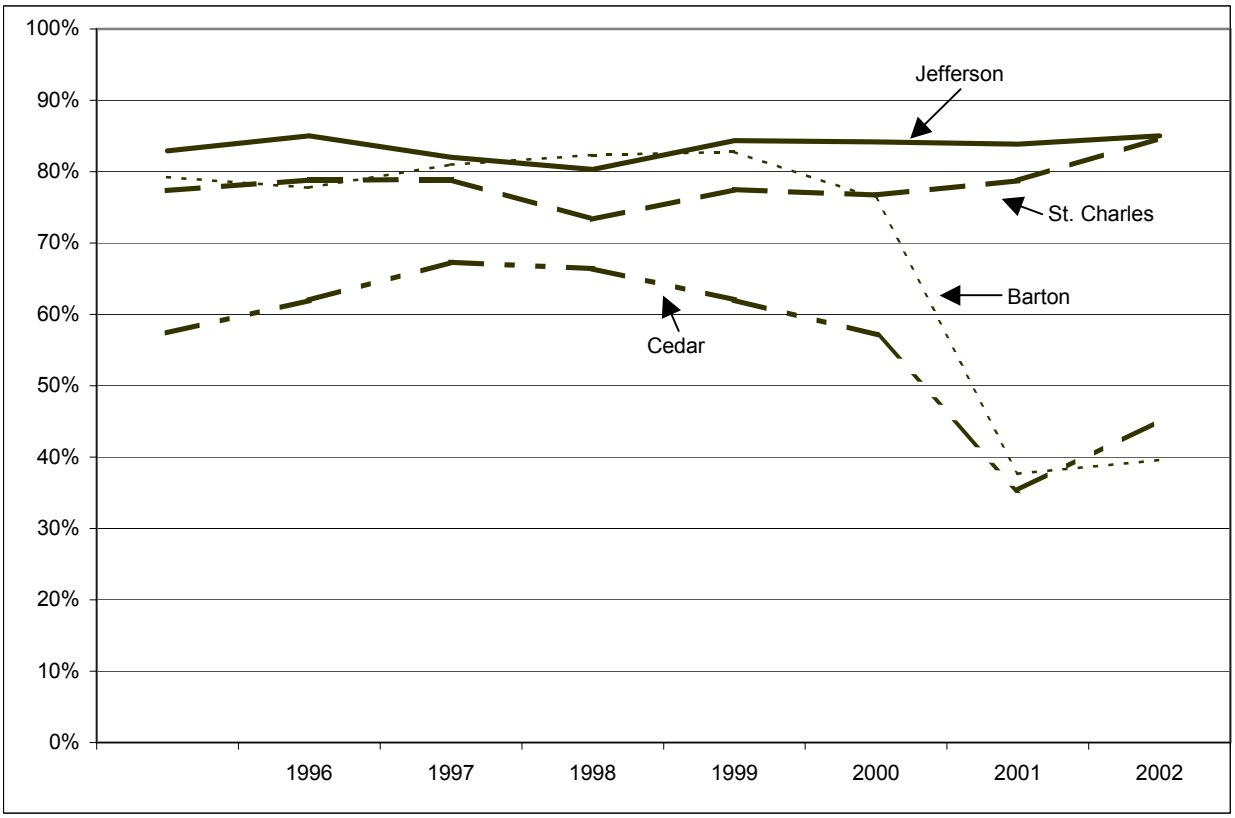


Figure 4.10. Percent of Reports Screened for FA for Four Demonstration Counties

This begs the question: Why did Barton and Cedar screen at such a reduced rate in the last two years compared with previous years? Did the types of reports coming into these county offices change?

Screening Form and Criteria. Each of the counties utilized the same screening form and screening criteria during these years. The form identified seven conditions that would lead a report to be assigned to the investigation track. If any one of these conditions were met an investigation was required. In addition, when certain other factors were present,

the report could be assigned to an investigation even if one of the seven primary conditions were not present.

The seven criteria for assignment to the investigation track were:

1. a child fatality
2. sexual abuse
3. serious physical abuse (as defined in statute)
4. serious neglect (as defined in statute)
5. law enforcement or a physician has taken custody
6. child is in danger and law enforcement is needed
7. the alleged perpetrator was someone outside the household

The other factors that could be taken into consideration and lead to an investigation even if one of these seven were not present were: violent activities on the part of household members; two or more prior referrals; substance abuse or mental illness; children under the age of five and/or unable to protect self; report indicates intent to harm by caretaker; and high likelihood that the child will need placement.

In the screening procedures in place, a family assessment was the residual category—that is, any report, based on the results of the screening process, that was not assigned to the investigation track was assigned to the family assessment track and the FA approach was utilized.

The similarities and differences in the presence of screening conditions from year to year are shown in Table 4.3 for two demonstration counties, Jefferson and Cedar. The table shows the percent of reports in each of the eight years in which the county screener checked that one of the automatic seven conditions requiring an investigation was present. Because it was possible for more than one condition to be present in a single report, the table also gives the percent of reports in which "any of the 7" were present. And, finally, it shows the percent of reports in which one or more "other factors" was present even though one of the automatic seven was not checked.

As can be seen in Table 4.3, there was a great deal of consistency in Jefferson County in the percent of reports checked as having specific conditions present across the eight-year period. At the same time, Cedar County shows a little more variation from year to year in all categories, with the greatest differences occurring in the areas of serious abuse and serious neglect. And the variation in these areas primarily involves a larger percentage of these categories being checked in recent years compared with earlier years. In fact, the increase in these two categories accounts for virtually all the decline in screening for FA in recent years in Cedar County that was seen in Table 4.2 and Figure 4.3. Moreover, the increase in the checking of these two categories in Cedar has also paralleled a decline in the checking of "other factors" when one of the automatic seven were not checked; so those other factors have not accounted for the decline in FA screenings there.

Table 4.3. Screening Conditions Checked in Two Counties, 1995-2002

Jefferson	1995	1996	1997	1998	1999	2000	2001	2002
1. Child Fatality	0.2%	0.2%	0.4%	0.1%	0.1%	0.1%	0.1%	0.1%
2. Sexual Abuse	8.4%	9.2%	10.7%	12.2%	11.0%	10.0%	9.6%	8.2%
3. Physical Abuse	4.6%	2.6%	3.1%	2.6%	1.5%	2.5%	2.7%	2.3%
4. Neglect	1.4%	1.6%	2.0%	3.0%	1.4%	1.7%	1.6%	2.7%
5. Custody	0.5%	0.2%	0.1%	0.4%	0.1%	0.3%	0.2%	1.1%
6. Law Enforcement	1.0%	0.4%	0.4%	0.5%	0.3%	1.0%	2.8%	2.0%
7. Non-relative perp	2.4%	1.5%	1.4%	1.4%	1.0%	1.5%	0.4%	0.4%
Any of the 7	16.0%	14.7%	16.9%	18.2%	14.6%	15.3%	15.3%	14.5%
Other Factor	35.8%	32.8%	33.8%	39.8%	47.1%	38.1%	34.3%	38.2%
Cedar	1995	1996	1997	1998	1999	2000	2001	2002
1. Child Fatality	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2. Sexual Abuse	11.5%	15.7%	18.7%	13.3%	10.9%	11.4%	14.0%	9.7%
3. Physical Abuse	9.8%	9.9%	6.5%	7.0%	7.0%	10.5%	14.0%	18.1%
4. Neglect	8.2%	9.9%	4.7%	3.1%	10.1%	22.9%	28.8%	22.9%
5. Custody	6.6%	1.7%	0.0%	0.8%	0.8%	1.0%	0.5%	2.1%
6. Law Enforcement	9.8%	5.0%	3.7%	2.3%	2.3%	5.7%	4.2%	5.6%
7. Non-relative perp	3.3%	0.0%	3.7%	7.0%	2.3%	1.0%	0.5%	0.7%
Any of the 7	34.4%	34.7%	31.8%	27.3%	28.7%	40.0%	56.3%	50.0%
Other Factor	47.5%	43.0%	49.5%	39.1%	31.0%	28.6%	24.7%	14.6%

Correlates of Screening. A linear regression analysis was conduced on data from all counties from 2001 and 2002. The analysis looked for a correlation between the screening for investigations on the one hand and conditions checked on screening forms on the other. The three conditions that explained the largest amount of variation in screening from county to county were the amount of reported sex abuse and the number of times reports were checked as indicating serious neglect and serious abuse. Figure 4.3 shows the variation across counties in the percent of reports involving sex abuse during 2001. The percent of reports with allegations about sex abuse ranged from none in Worth County and 4 percent in Livingston, on the low end, to 23 percent in Monroe and Ozark counties. Figure 4.4 shows the variation in reports checked as involving serious neglect. The percentage of such reports varied from under 1 percent of all reports in Holt, Reynolds and Howard counties to 29 percent in Pulaski, Dade and Cole counties. The range in the percent of reports judged to involve serious abuse was similar: from under 1 percent in Worth and New Madrid to 24-26 percent in Pulaski, Barton and Barry counties.

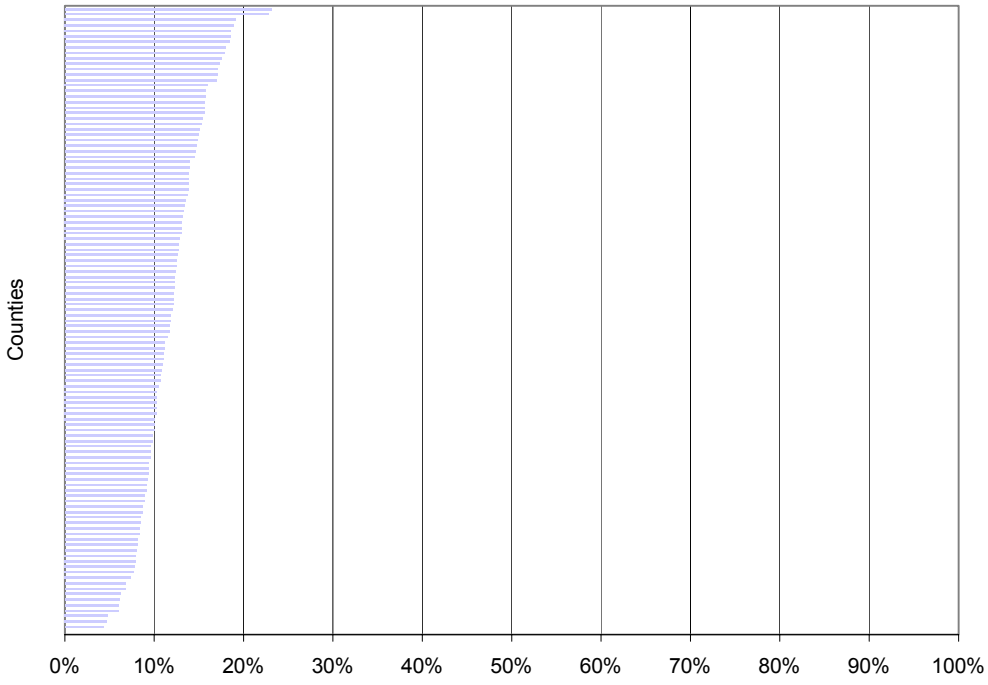


Figure 4.11. Percent of County CA/N Reports Screened as involving Sex Abuse in 2001

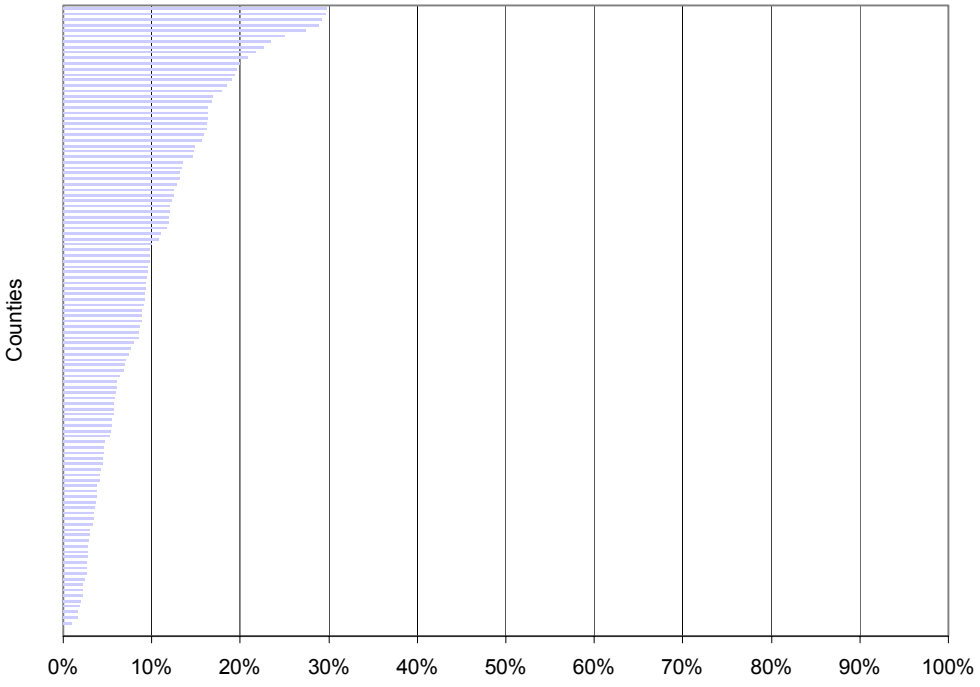


Figure 4.12. Percent of County CA/N Reports Screened as Involving Serious Neglect in 2001

Figure 4.5 shows the relationship during 2001 between the percent of reports screened for a traditional investigation and the percent checked on screening forms as involving sex abuse, serious physical abuse and serious neglect. Counties have been sorted based on the percent of reports screened for an investigation, from high to low. Linear regression lines have been added to the percent of reports checked for sexual abuse, neglect and abuse. The regression line for sexual abuse declines the least as the rate of investigation screenings declines while the line for neglect has the sharpest drop. We can see here that while all three of these categories explain some of the variation among counties in screening percentages, differences in classifying incoming reports as involving serious neglect is the strongest explainer.

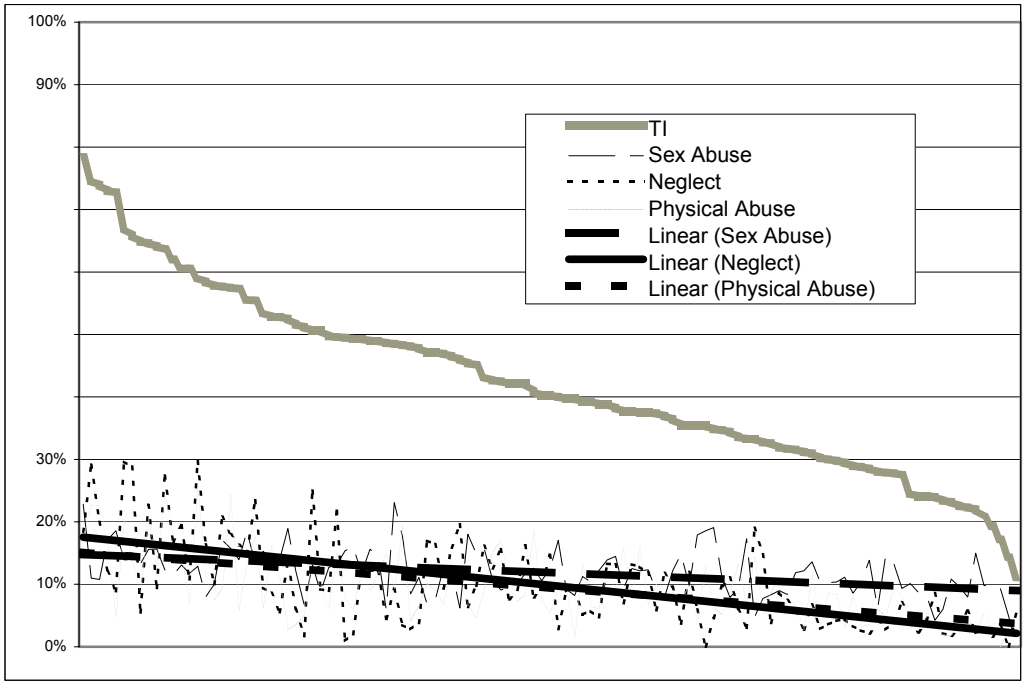


Figure 4.13. Relationship between TI, Sex Abuse, Serious Neglect and Serious Abuse in 2001

The strong correlation between TI screening percentages and categorizing reports as involving serious neglect can be seen even more clearly in Figure 4.6. This figure limits the 2001 data to the 16 original demonstration counties. And, it shows three data elements not four, excluding physical abuse reports. Accordingly, Figure 6 shows 1) the percent of reports screened for investigations (TI), 2) the percent of reports alleging sexual maltreatment, and 3) the percent of reports assessed as involving serious neglect. The data points are percentages of actual reports, not regression lines.

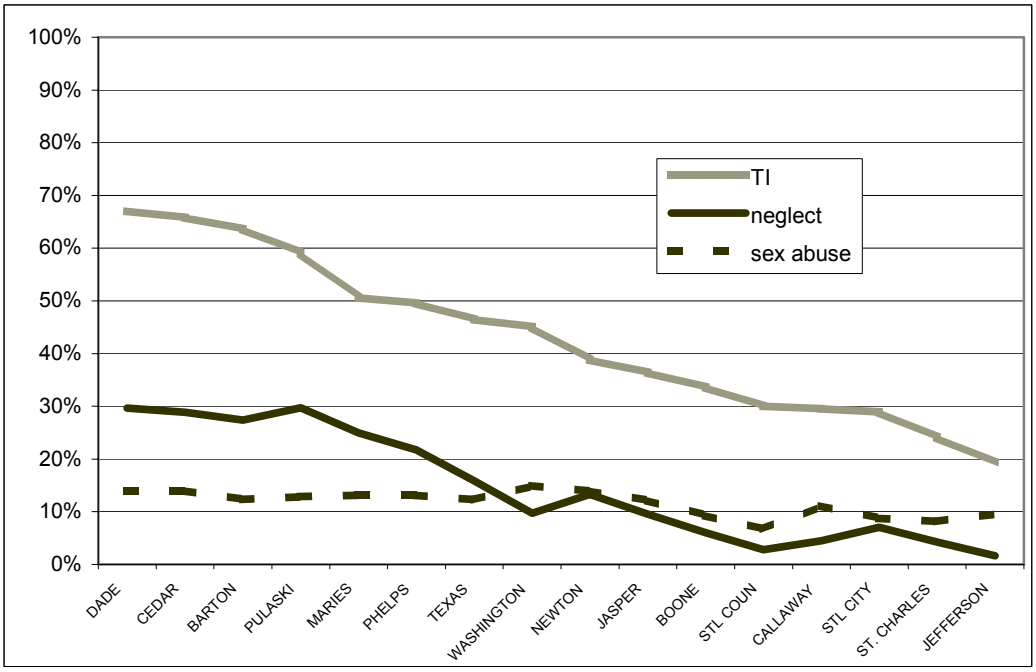


Figure 4.14. Relationship between TI, Sex Abuse and Serious Neglect in 16 Demonstration Counties during 2001

There is an important difference in reports alleging sex abuse and those categorized as involving "serious" abuse or neglect. While the former all contain a specific allegation of some type of specific sexual maltreatment, the latter require the judgment of screeners and the application of statutory definitions. A report either does or does not allege sexual abuse, making this condition a categorical item. However, whether or not a report of abuse or neglect rises to the level of "serious" is more a matter of judgment, making these items more continuous in nature rather than categorical. Thus, while differences in the types of reports received by counties account for some of the variation in screening percentages, it appears that there are differences in the assessment process itself that accounts for inter-county variation in screening percentages. When confronted with a report of physical abuse or neglect, some counties are much more cautious and, therefore, are less likely to assign it to the FA track than are other counties.

The fact that there have been dramatic differences in some counties in the percent of reports screened for family assessments from one year to the next, as was seen in Table 4.2, and that these differences tend to coincide with variations in reported conditions that are more continuous (e.g., neglect) and less categorical (e.g., sex abuse; custody) in nature, as was illustrated in Table 4.3, suggests that screening differences are not the result simply of differences in the nature of reports, on the one hand, or even random variations in the judgment of screeners, on the other. Assuming that practice occurs within a general policy framework—that is, that it is unlikely that screeners below a supervisory level initiate a sudden change in practice on their own—this pattern suggests that there have been administrative or policy decisions made at the county or, perhaps, regional level that have modified screening practices. Such changes are most likely to occur when there are changes

in administrative or supervisory personnel or perhaps represent a new response to a dramatic event within the local child protection system (such as a child's death in a family assessment case within a region).

Regional Differences. That there may be some top-down effect at work is further suggested by regional differences in screening percentages. There are substantial variations in screening from one DFS region to another. (See Figure 4.7.) The size of these variations reinforces the probability that screening practices are being guided by administrative/supervisory directions and not simply driven by differences in report type or in random differences among screening staff.

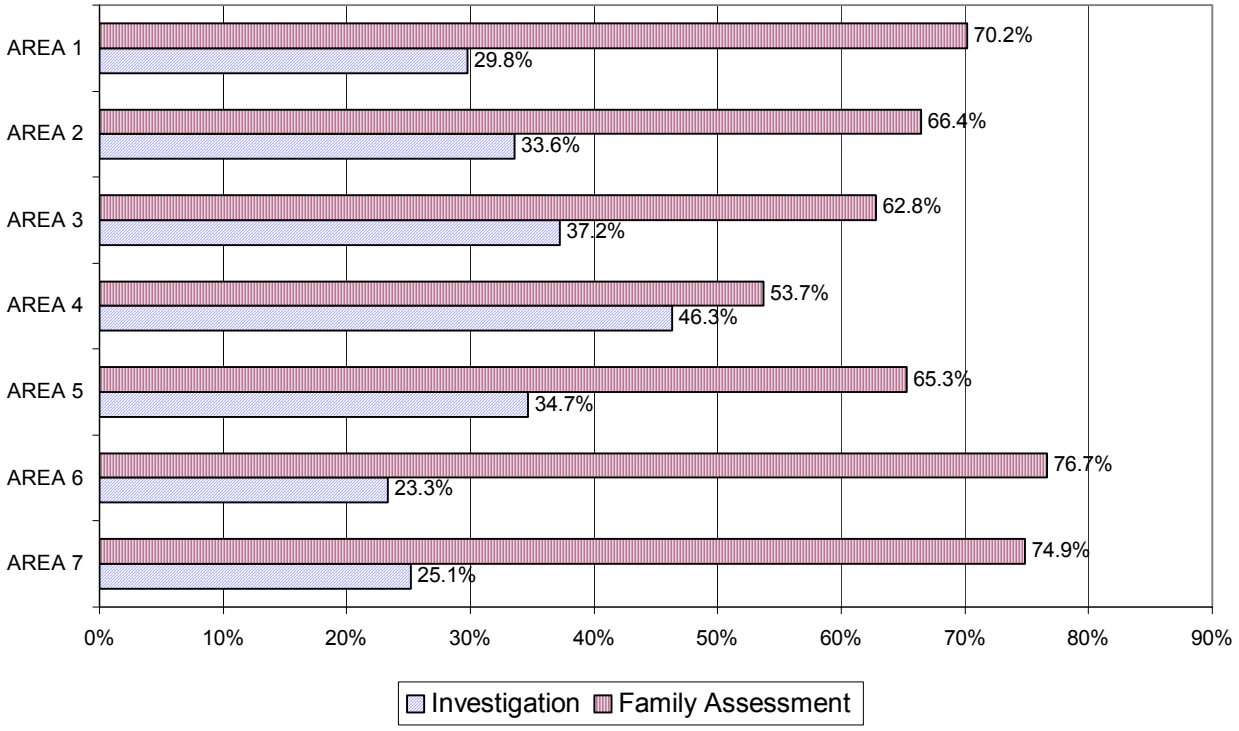


Figure 4.15. Percent of Reports Screened for TI and FA approaches within DFS Regional Areas during 2001

Attitudes about FA and Screening Percentage. In surveys conducted of county offices we asked a number of questions about the attitudes of administrators and CS supervisors about the family assessment approach. When survey responses were compared with screening percentages there were some instructive findings. In general, counties in which administrators and CS supervisors expressed a more positive view toward the FA approach tended to screen a higher percentage of reports for FA.

This general finding can be seen in Table 4.4. Administrators and supervisors were asked this question: "How would you describe your attitudes towards the FA approach at this time?" They were asked to describe their attitudes as either very positive, generally positive, mixed, generally negative, or very negative. Nearly three out of four respondents reported a positive attitude—13.5 percent said their attitude toward FA was very positive; and 59.6 percent said it was generally positive. None said their attitude was very negative.

However, 5.6 percent said they held generally negative attitudes towards FA and 21.3 percent said their attitudes were mixed. Counties were grouped by their responses and the mean FA screening percentage was calculated for each group. As the table shows, respondents who said that their attitude towards FA was either very positive or generally positive were from counties with an average FA screening percentage of over 60 percent. On the other hand, respondents who described their attitudes as either mixed or generally negative were in counties where the average percent of reports screened for FA was below 50 percent.

Table 4.4. Mean FA Screening Percentages of Counties and Attitudes of Administrators and CS Supervisors towards FA

Attitude towards FA	*Percent of reports screened for FA*	*Percent of survey respondents*
very positive	60.4%	13.5%
generally positive	63.0%	59.6%
mixed	47.6%	21.3%
generally negative	49.0%	5.6%
very negative	-	0.0%

A similar result was found when counties were grouped by their response to this question: "How would you describe the attitudes of your Children's Services staff toward the FA approach?" Respondents who said their attitudes were positive were from counties where 62 percent of the reports were screened for FA. Whereas, respondents who described their attitudes as mixed were from counties with an average FA screening of 54 percent and those who said they were generally negative about FA were from counties where an average of 49 percent of the reports were screened for FA.

Administrators and supervisors were asked whether FA had affected how CS workers approached families—whether workers were doing anything differently now than before FA was implemented. Those who reported that FA had affected how workers approached families "a great deal" (16 percent of all respondents) were from counties with an average FA screening percentage of 61 percent. Those who said FA had affected how CS workers performed their duties "in a few important ways" (42 percent of respondents) were from counties that screened 58 percent of reports for FA. And respondents who said FA had affected workers "not at all" (6 percent of respondents), were in counties where 54 percent of reports were screened for FA.

This pattern held up with respect to a number of other important questions about the FA approach. For example, respondents who expressed any concerns that FA ever placed the safety of children in jeopardy were nearly always in counties that made less use of FA. Similarly, respondents that thought traditional investigations were better in identifying risks or potential risks that children face from abuse or neglect were more likely to come from counties that screened fewer reports for FA. And while a majority tended to see FA as generally more effective and preventative than TI, for reports generally screened for FA, those who did not tended to be from counties that screened fewer reports for FA.

Counties that screened higher percentages of reports for FA also tended to report that FA has increased the cooperation of the families they work with and that FA has increased the involvement of family members in decision making. These findings were, in turn,

correlated to responses about whether FA has led to differences in how workers approached families.

Administrators and supervisors were asked about the kinds of factors that may have hindered full implementation of the FA approach in their county. Perhaps most telling, those who identified confusion over screening criteria as a problem were from counties that averaged the lowest percent of FA screenings, 43 percent; whereas those who said this was not a problem averaged 60 percent. Respondents from counties where fewer reports were screened for FA were also more likely to say that there had been insufficient training of supervisory staff about FA and that there was insufficient time to administer the FA program.

All of the differences described here—between counties that screened more or fewer reports for FA and their attitudes and assessment about FA as expressed in the survey—were statistically significant ($p<.05$).

Implications. These data indicate that there is a set of counties that have accepted FA, express a conviction about the approach and see it as advantageous. There are also a group of counties that have generally positive attitudes towards FA but who have not embraced it with the same degree of confidence or have been more cautious and tentative in utilizing the approach. And, finally, there is a set of counties, a minority to be sure, that have not bought into FA and who have used it less. Some of these are counties that once had used it more than now.

It may be that variations in screening data should be viewed as the canary in the coalmine. That is, as an indication or symptom of other, underlying factors. Addressing the symptoms alone rarely cures the illness, although in certain instances it brings about some relief. But a more comprehensive response would require reexamining how well and systematically counties were trained and guided in the implementation of the two-track and family assessment model as a whole, and what variation of the model is being employed. Changing the manner in which screenings are done should not be expected to address the situations that have given rise to the variations in screening percentages that have created concern. Removing the screening process from counties to a more central unit, while reducing inter-county variation, may cause an added amount of stress and confusion in counties towards the ends of the screening spectrum, some of which have effective two-track systems operating with a high use of family assessment, and some of which have used FA very sparingly, which may be a signal that other and more basic assistance is called for.

Changes in Response

To examine changes in DFS response to families two sets of families were selected, before and after the implementation of the FA system. Since the purpose of the analysis was to compare changes in practice, families from the original demonstration areas were excluded.[8] The Before-FA group consisted of families with a CA/N report and an investigation during the period from October through December 1997. The After-FA group

[8] Families from the demonstration zip code areas in the St. Louis City and County were not excluded. While this led to some contamination of the system, given the mobility of low-income families in these urban areas it was impossible to exclude simply on a geographic basis.

was composed of families with a CA/N report and an investigation or family assessment during the period from October to December 1999. The design permitted 21 months of baseline date for each family (drawing data from the periods 7/95 through 9/97 and 7/97 through 9/99) and two years of follow-up data (drawing data from the periods 10/97 through 12/99 and 10/99 through 12/01). Using this method, 8,105 Before-FA families and 7,066 After-FA families were selected. Because of Chronic CA/N and long-term cases, a total of 567 families were members of both groups.

This kind of analysis is problematic because of "historical" experimental errors. Changes in the economic context, for example, lead to changes in the DFS caseload and in the response of the agency to families. Another historical difference during this period was the effects of the Adoption and Safe Families Act (ASFA), which placed a much greater emphasis on adoption and, therefore, on faster termination of parental rights of families with children in placement. Thus, it is difficult to determine whether the differences observed in the response of the DFS to these families were the result of the implementation of the FA approach statewide or to other historical changes that occurred simultaneously.

A difference of some importance was that the before group tended to be composed of more lower risk families (Figure 4.8). There were significantly more low and moderate risk families in the 1997 group and significantly more high- to very high-risk families in the 1999 group (see the method of risk determination outlined in Chapter Two). Since families were drawn from the same counties using the same criteria 24 months apart, we must assume that something changed either in the families reported to DFS or in the kinds of families accepted by the CA/N hotline unit for investigation and/or family assessment. In fact, there was a child fatality in Kansas City in 1999 that led to a state child fatality task force report and the following year to a study and recommendations by the State Auditor. These are the kinds of events that can affect the CA/N reporting system causing shifts in the kinds of reports that are accepted for further action by the agency. However, there is no clear way to determine whether changes observed arose from events of this kind or simply from changes among Missouri families generally.

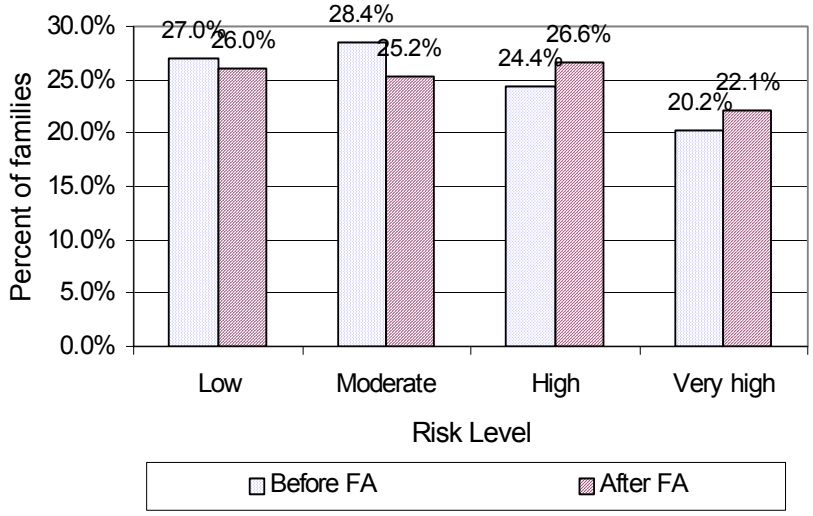


Figure 4.8. Risk Levels of Before-FA and After-FA Families

Change in Response to Hotline Reports. The DFS responses to hotline reports for these families are shown in Figure 4.9. Follow-up refers to the 24 months that each family was tracked (see definitions on previous page). What is apparent is the proportion of families with substantiated or preventive service investigation was lower for the After-FA families relative to the Before-FA (11.6 percent versus 13.8 percent), while the family assessment-services needed increased (15.1 percent versus 7.8 percent).[9] The diagram shows the trend away from investigations and toward family assessments as more and more families around the state were screened for FA.[10] This pattern held up for families in each of the four risk categories, that is, there was a trend toward fewer investigations and more family assessments regardless of the risk levels of families.

Family-Centered Services and Alternative Care. During the FA demonstration, the total number of newly opened family-centered services (FCS) cases declined. In the present study, we considered whether a family encountered by DFS had a FCS case open during the initial encounter in the selection periods (10/97-12/97 and 10/99-12/99) or had one or more cases opened during the follow-up period. This yielded a measure of service response to each family over 24 months. During this period, some families had only the initial CA/N hotline report while others had several reports. If FCS cases were opened significantly less often for families with FA rather than TI responses, then we would expect the proportion of FCS cases for After-FA families to be lower than the proportion for Before-FA families.

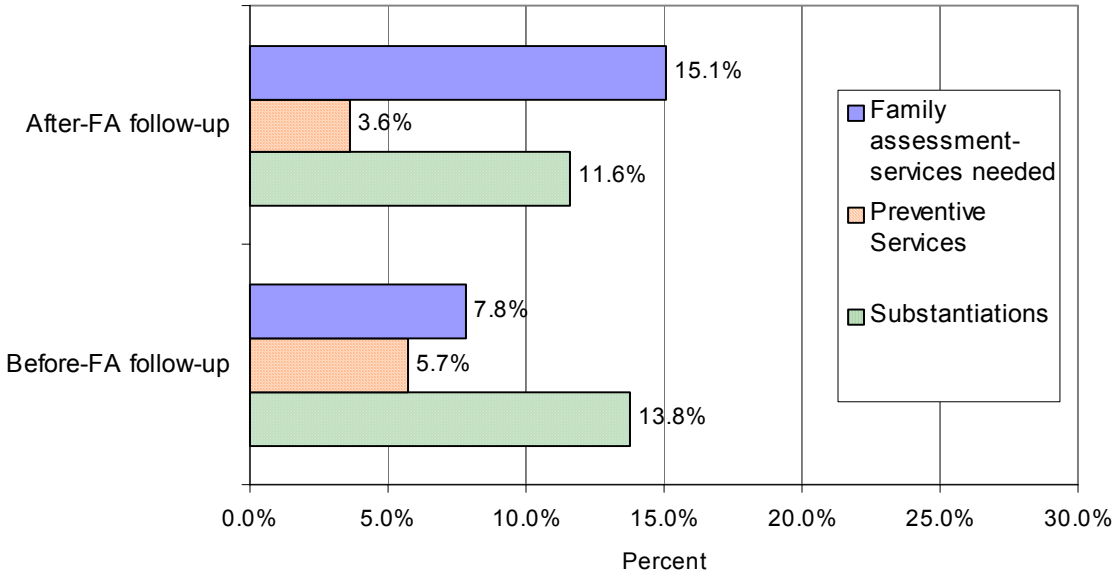


Figure 4.9. Agency Responses to Before-FA and After-FA Hotline Reports during the Follow-up Period

[9] Recall that the follow-up period for the Before-FA group extended through the end of 1999. FA had begun to be implemented in many counties during this period. This is the reason that 7.8 percent of these families had a family assessment with these results during this particular two-year period.

[10] The figure shows only the response to families with *one or more new CA/N reports* after the first report in the two selection periods (10/97-12/97 and 10/99-12/99). It is shows the DFS response to families that had been reported before. The same pattern was apparent in monthly DFS screening and responses to hotline reports during the After follow-up period without regard to previous hotline reports, as was implied in Figure 4.1.

This was *not* the case, as is evident in Table 4.5. Levels FCS case openings across the state remained fairly constant. This represents perhaps the more mature phase of the FA system. The percentage difference between before- and after-families in the four different risk levels were very small and in no instance were they statistically significant.

On the other hand, the pattern of children entering alternative care (AC) resembled the findings of Chapter Two. More children were removed and placed in alternative care among the After-FA families after the FA system was established throughout the state. The percentages in Table 4.6 reflect removal of placement of children either at the time of the initial hotline report during the selection periods or during the 24 months of follow-up.

The table reveals that the differences occurred among the high- and very high-risk families: 20.3 percent of high-risk After-FA families had a child removed compared to 17.6 percent of corresponding Before-FA families. Similarly, 43.4 percent of very high-risk After-FA families had a child removed compared to 38.2 percent of Before-FA families. Both differences were statistically significant ($p = .018$ and $p = .002$, respectively). As we have noted, these differences may be due to other causes that intervened during this period. However, to the extent that child removals reflect the response of DFS to extreme child safety problems, these findings suggest that the introduction of the FA system did not reduce the diligence of the agency regarding protection of vulnerable children.

Table 4.5. Percent of Families with FCS Case during the 24-month Follow-up Period

Risk	*Family Group*	*No FCS (percent)*	*Any FCS (percent)*
Low	Before-FA	73.4	26.6
	After-FA	74.5	25.5
Moderate	Before-FA	70.2	29.8
	After-FA	69.6	30.4
High	Before-FA	55.9	44.1
	After-FA	55.0	45.0
Very High	Before-FA	32.6	67.4
	After-FA	33.2	66.8

Table 4.6. Percent of Families with Children Removed and Placed during the 24-month Follow-up Period

Risk	*Family Group*	*No Removals (percent)*	*Any Removal (percent)*
Low	Before-FA	93.4	6.6
	After-FA	93.2	6.8
Moderate	Before-FA	88.3	11.7
	After-FA	87.7	12.3
High	Before-FA	82.4	17.6
	After-FA	79.7	20.3
Very High	Before-FA	61.8	38.2
	After-FA	56.6	43.4

Chapter Five

Structured Decision Making Tools

The state of Missouri is in the process of adopting versions of the Structured Decision Making (SDM) tools that are now being used in several other states.[11] Two of the proposed instruments are considered here: 1) the Safety Assessment tool and 2) the Family Risk Assessment tool. These instruments are utilized at the local office level by investigators and/or family assessment workers.

IAR was originally asked to analyze these two instruments along with three other proposed SDM tools that were to be used by workers at the hotline unit in Jefferson City. Hotline workers receive CA/N incident reports via a telephone hotline from around the state. The SDM tools for the hotline unit were designed to centralize the TI/FA screening process (see Chapter Four) and to determine the response priority of cases. These instruments were to be implemented in the hotline unit in January 2003 but this process was delayed. Consequently, that part of the planned research could not be conducted. One of the planned methods involved comparing the judgments of hotline workers about reports with those of local workers. This method had to be abandoned as well. The implementation of the safety and risk tools at the local level began in November 2002 but proceeded slowly. Contacts with administrators and workers in local offices were delayed until March 2003.

The ideal method to determine the value of the safety and risk tools would be follow-up of families for whom the tools were used. Were ratings of children in families as safe, conditionally safe or unsafe in fact accurate? Were ratings of family risk of child abuse and neglect predictive of future reports of child abuse and neglect? This kind of research should be considered for the future after sufficient time has passed to follow-up on families.

Safety Assessment. This instrument is used in all CPS investigations and in family assessments. It is intended to guide the decision to leave children in the home while intervening to address potential safety threats or to remove and place children. There are 11 specific safety areas to which the instrument requires the worker to respond. Two of these are further divided into several types of potential causes of the safety problem. A twelfth open-ended category is also included for any unique problem not covered in the other areas. Workers are to provide a simple yes or no response to each safety area. If any safety factors are identified a safety plan must be created. The safety assessment culminates in a final safety decision with three possible outcomes. When no safety factors are identified for any child in the family, the overall evaluation will be that the children are safe. When one or more safety factors are identified but safety interventions have been taken that protect the children, the instrument is coded as conditionally safe. In this event, children remain in the home. Several specific kinds of safety interventions are listed in the instrument. If one or more safety factors are identified and children remain in danger of serious harm the

[11] The Children's Research Center of Madison, Wisconsin and administrators of the Missouri Division of Family Services jointly created the current instruments.

instrument is coded as unsafe. In this instance, children are to be removed from the home. The specific safety items are shown the following list:

1. Yes No	Child(ren) is in danger because parent/caretaker's behavior is violent or out of control.		
2. Yes No	Parent/caretaker describes or acts toward child(ren) in predominantly negative terms or has extremely unrealistic expectations.		
3. Yes No	Parent/caretaker caused serious physical harm to the child(ren) or has made a plausible threat to cause serious physical harm.		
4. Yes No	The parent/caretaker's explanation of an injury to a child(ren) is inconsistent with the nature of the injury and/or there are significant discrepancies between explanations given by parent/caretaker, other household members, or collateral contacts.		
5. Yes No	Parent/caretaker is currently refusing access to child(ren) or has refused access to child(ren) on prior interventions.		
6. Yes No	Parent/caretaker is unwilling or is unable to provide supervision necessary to protect child(ren) from potentially serious harm. If "yes," is the parent/caretaker's lack of supervision due to:		
	___Alcohol or other drug use	___Hospitalization	___Incarceration
	___Physical, mental health or cognitive incapacity	___Domestic Violence	___Other
7. Yes No	Parent/caretaker is unwilling or is unable to meet the child(ren)'s imminent needs for food, clothing, shelter, and/or medical or mental health care. If "yes," are the child(ren)'s basic needs unmet by the parent/caretaker due to:		
	___Parent/caretaker's physical, mental health, or cognitive incapacity	___Alcohol or other drug use	___Incarceration
	___Child's physical, mental health, or cognitive incapacity	___Hospitalization	___Other
8. Yes No	Child(ren) is fearful of parent/caretaker, other family members, or other people living in or having access to the home.		
9. Yes No	The child(ren)'s physical living conditions are hazardous and immediately threatening.		
10. Yes No	Child(ren) sexual abuse is suspected and circumstances suggest that child(ren) safety may be an immediate concern.		
11. Yes No	The parent/caretaker's maltreatment history is significant to the current circumstances, and suggest that the child(ren)'s safety is an immediate concern.		
12. Yes No	Other (specify) _____		

Family Risk Assessment. This instrument is also used in all CPS investigations and in family assessments. It is divided into a risk of neglect index and a risk of abuse index (subscales). Each index is completed and results in a numeric score. The scores are then grouped as follows:

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

The highest risk category under either index is taken as the scored risk level. Policy overrides are possible that raise the risk to very high: sexual abuse in which the perpetrator has access to the child, non-accidental injury to a child under age 2, severe non-accidental injury, and death of child due to CA/N with other children remaining in the home. In addition, discretionary overrides (up one level) are possible. The numeric score on this instrument has broad implications in that it is supposed to be a guide in the decision to open a case for ongoing services or to close the investigation or family assessment. It also is to

guide decisions concerning the frequency of ongoing contacts with the family. The specific items in the neglect and abuse indices are:

NEGLECT	Score	ABUSE	Score
N1. Current Report is for Neglect a. No ..... 0 b. Yes 1		A1. Current Report is for Abuse a. No ..... 0 b. Yes 1	
N2. Prior Investigations/Assessments(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		A2. Number of Prior Abuse Investigations/Assessments (#: _____) a. None ..... 0 b. One or more 1	
N3. Household has Previously Received Services as a Result of a CA/N Investigation/Assessment a. No ..... 0 b. Yes 1		A3. Household has Previously Received Services as a Result of a CA/N Investigation/Assessment a. No ..... 0 b. Yes 1	
N4. Number of Children Involved in the CA/N Report a. One, two, or three ..... 0 b. Four or more 1		A4. Prior Injury to a Child Resulting from CA/N a. No ..... 0 b. Yes 1	
N5. Age of Youngest Child in the Household a. Two or older ..... 0 b. Under two 1		A5. Primary Caretaker's Assessment of Incident (check applicable items and add for score) a. Not applicable ..... 0 b. _____ Blames child ..... 1 c. _____ Justifies maltreatment of a child 2	
N6. Primary Caretaker Provides Physical Care Inconsistent with Child Needs a. No ..... 0 b. Yes 1		A6. Domestic Violence (two or more incidents) in the Household in the Past Year a. No ..... 0 b. Yes 2	
N7. Primary Caretaker has a Past or Current Mental Health Problem a. No ..... 0 b. Yes 1		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	
N8. Primary Caretaker has Historic or Current Alcohol or Drug Proble that interferes with his/her/family's functioning (check applicable items and add for score) a. Not applicable ..... 0 b. ____ Alcohol (current or historic) ..... 1 c. ____ Drug (current or historic) 1		A8. Primary Caretaker has a History of Abuse or Neglect as a Child a. No ..... 0 b. Yes 1	
N9. Characteristics of Children in the 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		A9. Secondary Caretaker has Historic or Current Alcohol or Drug Problem that interferes with his/her/family's functioning a. No ..... 0 b. Yes, alcohol and/or drug (check all applicable) ..... 1 _____ Alcohol _____ Drug(s)	
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		A10. Characteristics of Children in Household (check applicable items and add for score) a. Not applicable ..... 0 b. ____ Delinquency history ..... 1 c. ____ Developmental disability ..... 1 d. ____ Mental health/behavioral problem 1	
TOTAL NEGLECT RISK SCORE		**TOTAL ABUSE RISK SCORE**	

Supervisors may override final decisions of workers in order to increase the safety or risk levels.

Two research instruments were utilized. The first was a general survey instrument. The second was case-specific, and requested workers to respond concerning the safety and risk factors that they had encountered with a specific family they had investigated or assessed.

General Survey of Workers concerning SDM Safety and Risk

A sample of 261 workers was selected from counties that had reportedly received training on the SDM risk and safety tools in the period from November 2002 through January 2003. Some counties in fact had not received training during this period and others had received training but had not begun to use the tools by the time of the survey in March 2003. This significantly reduced the number of workers with sufficient experience to respond. By May 15 responses to the general survey had been received from 98 separate Missouri workers representing 37 of Missouri's 115 counties. The counties were: Adair, Barton, Bates, Bollinger, Caldwell, Cape Girardeau, Cedar, Clay, Crawford, Dade, Dent, Dunklin, Greene, Henry, Howell, Jackson, Jasper, Jefferson, Knox, Lewis, Livingston, McDonald, Mississippi, New Madrid, Newton, Oregon, Pemiscot, Perry, Platte, Pulaski, Scott, St. Charles, St. Clair, St. Francois, Stoddard, Vernon, and Washington. Responding workers had been working for DFS for an average of 6.6 years. The majority of these responding conducted both traditional investigations (TI) and family assessments (FA); 81.6 percent indicated that they conducted investigations and 89.8 said they conducted family assessments, but only 7.2 percent conducted investigations exclusively and 15.5 percent conducted family assessments exclusively. Based on worker estimates, they had employed the SDM tools in an average of 68 cases. The general survey instrument can be found in the Appendix.

Safety

Because safety assessment were conducted as a part of family assessments since the inception of the FA approach, workers were asked whether the new safety assessment form change the way they conducted safety assessments. Responses are illustrated in Figure 5.1.

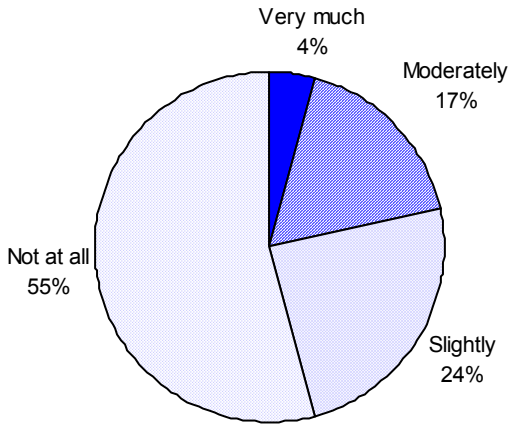


Figure 5.1. Has the new safety assessment form changed the way you conduct safety assessments?

The majority of workers utilizing the SDM safety assessment felt that their practice was generally unaffected by the introduction of the new form. A large minority, however, felt that the changes had positive benefits, while a small minority saw negative consequences.

A little more than one worker in five said that the new form had affected their practice moderately or very much. Over half indicated that the form had not affected the way they

conducted such assessments. The minority who felt that they were now practicing differently explained the change in the following four ways.

1. The SDM safety tool is more specific and concise:
   "It is more concise."
   "There are more specific things to consider."
   "It is more clear-cut."
   "Specific safety issues are more focused."
   "It makes things more clear for all involved."

2. It stimulates the worker to examine more safety issues or not to skip over important issues:
   "It allows more information on family."
   "It allows for a more thorough-complete assessment."
   "I am more observant."
   "I am more careful about going through each point with the family."
   "It has made me more aware of issues and… addressed issues with the family."
   "It insures that all [safety] aspects are checked out more completely."

3. It is less time consuming and/or better organized:
   "It is quicker, easier."
   "It is faster—more organized paperwork."
   "It takes less time, and I try to do it with the family."
   "It is more efficient and detailed."
   "It is less time consuming, less invasive, requires less information and is more structured."
   "Form is worker friendly-quick to evaluate safety."

4. It is easier to use with families.
   "It involves the family more."
   "It is more family friendly."
   "This [form] seems to encourage more family participation."
   "The forms are family friendly."

There were also more critical comments that were in some ways the mirrors of these. For example, while some lauded the shortening of paperwork ("*It cuts some unnecessary areas, e.g., genograms and echograms"*), others felt this was a defect ("*We no longer have genograms or a place to document safety of child insured"*).

5. It does not promote more detailed (narrative) information:
   "Check lists are always easier--check lists are always lacking, however."
   "More detail is needed."
   "…More box checking, less info gathered by interviewing."
   "I have to use a new form but I still prefer using CS16a's when forming plans w/families."
   "I still use CS-16a because it is more comprehensive than this new form. New form does not have enough room and I cannot be as specific as I want to be."

The safety form includes a page, however, for a chronological narrative and most of the forms we examined included narratives that were sometimes lengthier than the single page provided.

Worker's written comments were also reflected in answers to subsequent questions. The following proportions illustrate that the four positive comments listed above corresponded to a minority of workers.

> To your knowledge, has the form changed the comprehensiveness (thoroughness) of DFS safety assessments? Over two thirds of respondents (65.3 percent) felt that comprehensiveness was about the same, while a little less than one-third (29. 5 percent) felt safety assessments were more comprehensive and only 5.3 percent felt they were less comprehensive.
>
> In your own safety assessments, has the form affected the time it takes to assess child safety? The proportions were similar: speeded up (30.4 percent), about the same (63.0 percent), slowed (6.5 percent).
>
> In any of your investigations or family assessments using the new form, have you found yourself considering safety issues you might have overlooked in the past? Again, the majority appeared unaffected: no (57.0 percent), yes occasionally (38.7 percent), yes often (4.3 percent).

Concerning specific items on the safety assessment, about one in ten workers (10.8 percent) said that a few items were unclear. However, when asked to explain, workers provided little specific information.

The safety assessment form requires the worker to determine a safety response and to list eight specific interventions that will improve the safety of the children.

> ____ 1. Direct intervention by CPS worker as a safety resource.
> ____ 2. Use family, neighbors, or other individuals in the community as safety resources.
> ____ 3. Use community agencies or services as safety resources.
> ____ 4. Have the alleged offender leave the home, either voluntarily or in response to legal action.
> ____ 5. Have the non-offending parent/caretaker move to a safe environment with the child(ren).
> ____ 6. Parent/caretaker places the child(ren) outside the home.
> ____ 7. Other: _____
> ____ 8. Legal action must be taken to place the child(ren) outside the home. Note: child(ren) is considered unsafe in the home; it is contrary to the child(ren)'s welfare to remain in the home.

The form then requires that any item that is checked be described in greater detail. Figure 5.2 shows the responses to a series of questions about this section of the safety assessment form.

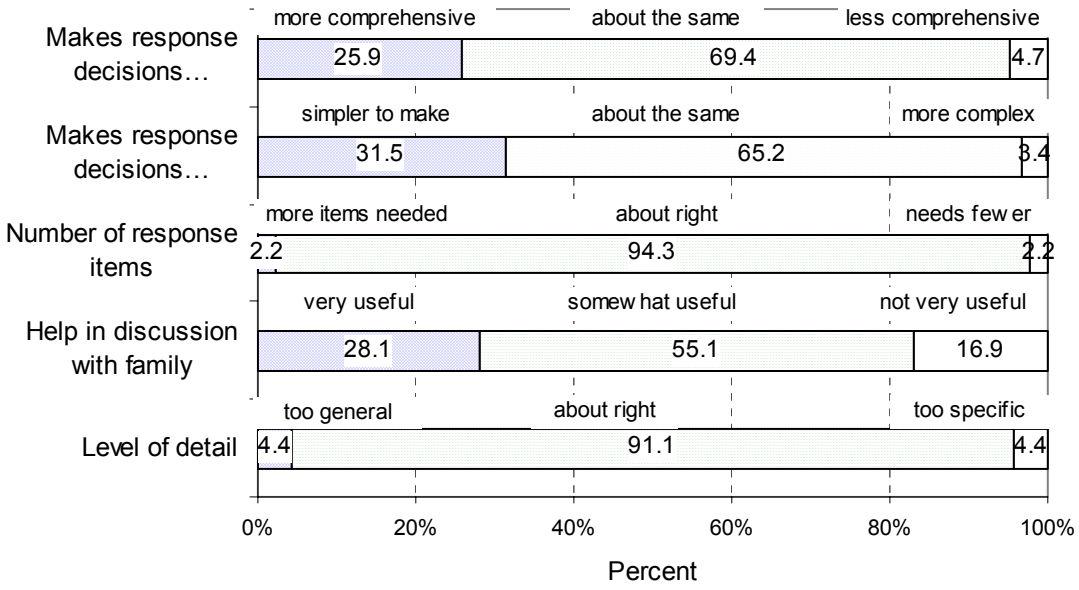


Figure 5.2. Concerning the Safety and Response Section of the Safety Assessment, Please rate the following:

The level of detail and the number of response items (8, shown above) were considered 'about right' by the large majority of respondents. The answers concerning whether the response categories make response decisions simpler or more comprehensive resembled those to the safety assessment items. A little less than a third of the respondents felt the form made decisions simpler and more comprehensive while over two thirds thought it made no difference and a very smaller percentage (less than five percent) felt the effects were negative. The large majority felt that they response categories were helpful in discussions with families.

Family Risk

As shown above, the family risk assessment tool has a neglect and a risk subscale each containing 10 items. We asked first whether there were other items that workers felt were other important indicators of future child abuse and neglect that were not currently in the form but should be included. It is interesting that the items correspond to some degree to those suggested in Chapter 2. Workers suggestions included:

1. *Prior CA/N incidents coded as unsubstantiated should be or should not be included.*
2. *Mental health, alcoholism, substance abuse, behavior problems of secondary caretaker*. The form currently does not permit these risk factors to be considered under abuse and neglect, and some workers felt it should.
3. *Item that permits scoring based on actions of secondary caretaker*. The secondary caretaker whether an abusive spouse living the home or an abusive non-custodial parent may also be an important factor in future abuse and neglect.
4. *Domestic violence should not be limited to only the abuse subscale but should be included in both*. Abusive spouses provide insufficient emotional support for children.

5. *Criminal characteristics of those living in the home, whether the parents or other adults.*
6. *Out of control teens.* The current form permits checking for developmental disabilities or delinquency but does not permit indication of other less formal types of behavior problems.
7. *Sexual abuse.* Sexual abuse is unacknowledged on the form as an explicit category, yet sexual abuse frequently occurs during the history of chronic CA/N families.
8. *Educational problems of children.*
9. *Delay the risk assessment until the end of the investigation or family assessment.* A few workers pointed out that some of the items do not become known immediately but may be known after several family contacts. In addition, conditions may change that reduce the risk.

Each of these suggestions of workers merits consideration. The first suggestion (1) may indicate an area of misunderstanding. The current form does permit scoring for reports with these outcomes. Some may have been confused about this. Others wondered whether both N2 and A2 should be checked if the allegations were for both abuse and neglect. More importantly, a relatively large number of workers felt that unsubstantiated reports should *not* be included in an assessment of family risk. Many indicated that families that received harassment reports were being unfairly penalized. An effort should be made in training to show that *any* past report is *statistically* predictive of future reports. In addition, workers commonly refer to harassment reports, yet the proportion of reports coded as in this way in the DFS system is suspiciously small. Workers should also be encouraged to code investigations and family assessments as harassment when they have discovered this to be the case.

Some suggestions (2, 3, 4, and 6) would, if added, only require a modification of current items included in the form. Others (5, 7, and 8) would represent new items. These items might be considered for inclusion in a longer-term follow-up study of Missouri families that come into contact with DFS that are also subjected to a family risk assessment. Such a study and suggested improvements to the risk assessment process are suggested below.

The risk assessment scale permits discretionary overrides by a supervisor. Most respondents who said that this had happened to them also said that it was rare (less than one percent of the time). However, only about three-quarters (76.3 percent) of respondents said that it had never happened in their cases.

The two risk subscales and the final risk score is requires a categorization (based on the numeric score) into low, moderate, high, and very high risk. Figure 5.3 shows workers responses concerning how well these rating generally correspond with their own personal rating of CA/N risk. The overall finding from the table is that the family risk assessment tool is pushing risk assessment higher. Looking at the overall risk categorizations (scored risk level), about one of every three workers (32.9 percent) felt that the tool resulted in higher risk ratings than they would generally make, while only 3.7 percent said the ratings were generally lower than their own.

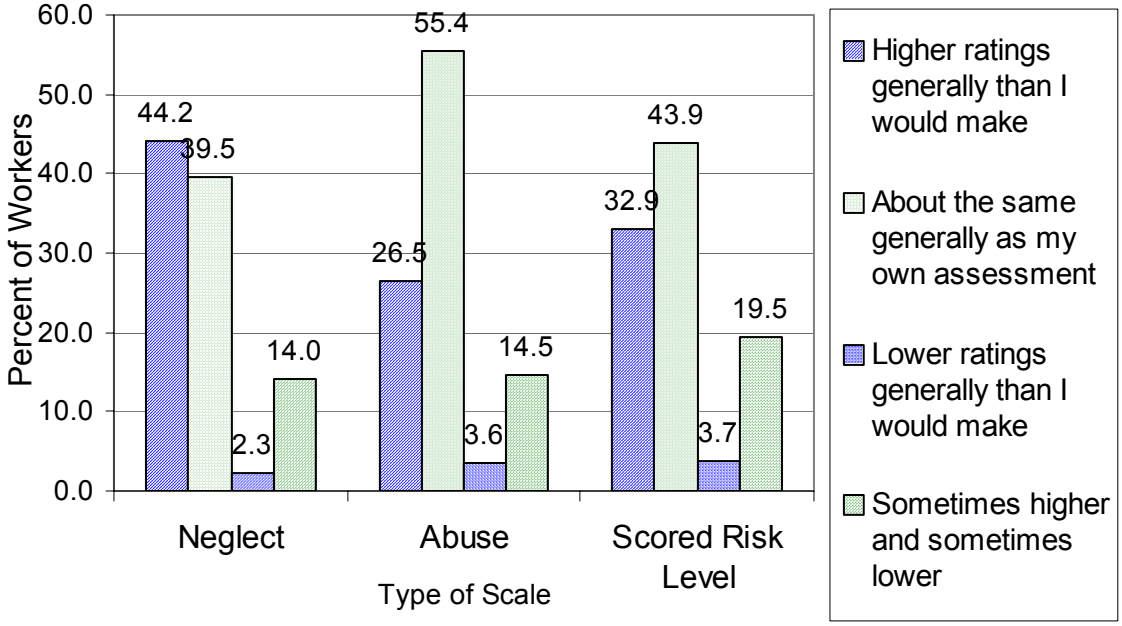


Figure 5.3. Based on your experience with the risk assessment so far, how well do the categorical ratings (low, moderate, high, very high) usually correspond to your personal assessment of risk?

The reasons for this are not entirely clear, although one may be that some of the items, while considered dangerous and not in the best interest of the children, may not be considered predictive of *future* child abuse and neglect. In addition many workers do not consider unsubstantiated reports and family assessments as predictive of future reports, and some workers are unconvinced that the number of children is in any way predictive.

Written Instructions and Training

Respondents were asked to rate the written instructions that accompany the safety and risk assessment tools on clarity (understandability), comprehensiveness, applicability to their caseloads, and conciseness. About 20 percent consistently rated them as fair. The majority rated them as good and about 20 percent or a little fewer rated them as excellent. Ratings for training were somewhat lower. Respondents were asked about time set aside for training, instructors, materials and examples, and overall. A consistent response to each of these topics was: about half rated them as good and about a third rated them as fair. Generally, five to eight percent rated them as poor and 10 to 13 percent as excellent. This is shown in Figure 5.4.

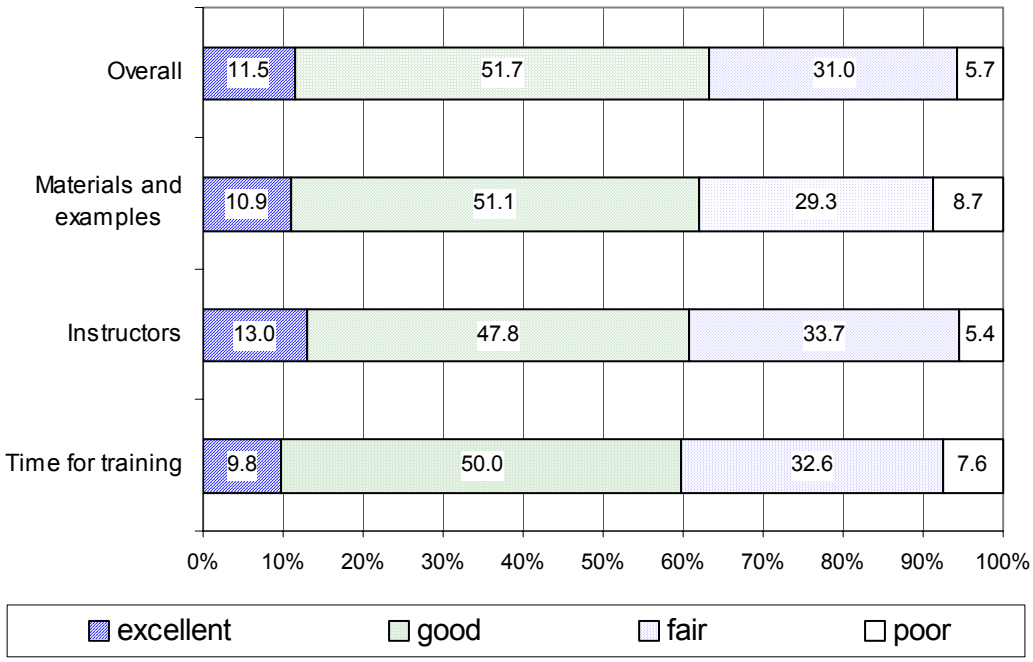


Figure 5.4. How would you rate the training you have received on the safety and family risk assessment process?

Case-Specific Survey concerning SDM Safety and Risk

Each worker contacted also received a second form. This form asked a series of questions related to safety and risk about a specific CA/N hotline report for which they were the investigator or family assessment worker. The incident number and certain other identifying information were printed at the top of the form. Workers were instructed to complete the questions with reference to their contacts with this particular family. They were also asked to photocopy the completed version of the safety and family risk tool and attach these to the survey instrument. The case-specific survey instrument can be found in the Appendix.

Reports were selected from DFS CA/N data by isolating the worker ID's in counties and examining all CA/N hotline records by worker within a targeted date range.[12] DFS data available to evaluators for this study extended through the third week of February 2003. One report was selected for each worker to be surveyed. Preference was given to investigations with either conclusion of "substantiated" or "unsubstantiated-preventive services needed" or family assessments with the conclusion "services needed." The latest possible report for each worker was selected in the hope that the SDM tools had been utilized for this family. Cases were selected for all 268 workers surveyed. Of the 98 responding workers (see explanation above), 84 returned both the completed case-specific survey form and photocopies of the safety and risk tools for that case.

[12] Because the SDM process is new, no record of utilization of the SDM tools is stored in the DFS client information system. However, evaluators knew the scheduled dates of training for SDM in each Missouri county and judicial circuit. Based on this information, we were able to estimate when the SDM tools began to be used for reports.

The items on the case-specific form consisted of a longer list of more specific safety and risk items than those in the SDM tools. The survey items first asked workers to respond: yes, no or don't know. If the response was "yes" they were asked to rate the severity of the threat on a seven-point scale. The complete list of safety and risk items are provided at the beginning of this chapter. The 54 questions on the case-specific instrument can be found in the appendix. Here is an example of how they corresponded:

The first item on the SDM safety assessment is:

1. **Child(ren) is in danger because parent/caretaker's behavior is violent or out of control.**
□ Yes □ No

The corresponding survey items were:

1. Did a caretaker speak in a hostile way to any of the children? □ Yes □ No □ DK	mild	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	extreme
19. Did a caretaker threaten any of the children with harm? □ Yes □ No □ DK	mild	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	extreme
36. Did a caretaker injure or restrain a child (non-disciplinary)? □ Yes □ No □ DK	mild	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	bizarre/extreme
2. Had a child been exposed to domestic violence recently? □ Yes □ No □ DK	less severe	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	very severe
20. Did a caretaker direct a weapon, a knife or such at a child? □ Yes □ No □ DK	minor	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	serious
37. Did a caretaker exhibit strange behavior or beliefs? □ Yes □ No □ DK	mild	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	bizarre/extreme
3. Did a caretaker seem unstable, explosive, without self-control? □ Yes □ No □ DK	mild	❑1❑2 ❑3 ❑4 ❑5 ❑6 ❑7	extreme

As can be seen by the numbering of items, the corresponding items were scattered systematically throughout the case-specific form. The items in the case-specific survey were derived either from the written instructions or by breaking the SDM items into their constituent parts.

The purpose of this methodology was 1) to determine the extent to which responses to items in the safety and risk tools represented selections from observed characteristics of and events within families, and 2) to suggest whether a subsequent more extensive study of the validity and reliability of the SDM tools is warranted.[13] Valid tools are those that measure what they purport to measure. A valid safety tool will show that children are unsafe when they *actually are* unsafe and that they are safe when they actually are safe. A reliable safety tool will produce the same results were different workers to approach the same family at the same time.

Analysis

The complete analysis of case-specific data involved about 150 comparative sub analyses of items in the SDM and research instruments. It is unnecessary to review all these here. A few illustrative examples will suffice.

[13] Minnesota, where similar versions of the SDM tools have been used in many counties for over two years, is planning a follow-up study of the tools.

A Safety Example. We begin with the example shown above, Item 1 in the Safety Tool (Table 5.1). The question at the top is the first SDM safety item. It concerns whether children are in danger because of violent or out-of-control parental behavior. Children were rated as either safe or unsafe on the item. By looking at the upper right portion of the table, we see that workers in these cases considered children in only 5 out of 84 families unsafe on this item. The six items on the left (1, 19, 36, 2, 37,3) are six of the seven questions shown above from the case-specific survey that also related to violent and out-of-control parental behavior. In each case, the rating scale is also provided. Ratings of 5, 6, and 7 could be considered somewhat severe to severe. In other words, ratings in this range might be considered indicative of safety threats in this family.

Notice that a small percentage of families that were considered safe on the SDM item were rated as 5 to 7 on each case-specific item. For example, on the last item (caretaker behavior that is unstable, explosive, or lacking in self-control) 11.3 percent of children rated as safe on the SDM item nonetheless had caretakers rated as extreme on this item. This amounted to 9 of the 79 families in this category. In each case—hostile language, threatening behavior, injury or restraint, domestic violence, strange behavior or beliefs and unstable behavior—some of the children rated as safe on the SDM tool were checked in one of the extreme categories on the case-specific scale item.

This pattern was present for most of the eleven safety items utilized by the workers in these cases. When safety questions were asked in a different way or in more detail with the possibility of checking the severity of the item, workers responded in different ways—for a minority of families. These findings *do not prove* that the SDM tool is invalid or unreliable. Determinations of child safety and safety responses are not dependent solely on the 11 specific safety items in the safety tool. However, The lack of correspondence raises questions that are relevant to the usefulness and dependability of the SDM tools. There are several ways to explain these results.

It is possible for such behaviors to have occurred in families but at the time the SDM safety tool was completed the children were safe. For example, a caretaker that was engaging in threatening behavior may have left the family or a parent that was acting strangely may have resumed psychiatric medications. This depends in part on when the safety instrument was completed. Children that might be considered unsafe if rated on the initial visit with the family might be rated as safe during a subsequent visit. In other research that IAR is conducting in Minnesota this was found to be the case. The SDM safety tool in some counties was completed on the first visit and in other counties on the final visit (of the assessment worker) with the family. This resulted in inconsistencies between safety outcomes and other known characteristics of families.

Table 5.1. First SDM Safety Assessment Item rating Violent and Out-of-Control Parental Behavior compared to Six Corresponding Case-Specific Safety Items

SDM Safety Item: 1. Child(ren) is in danger because parent/caretaker's behavior is violent or out of control:		SDM Safety Rating	
	Ratings on case-specific items:	Safe (n=79)	Unsafe (n=5)
1. Did a caretaker speak in a hostile way to any of the children?	*No*	67	3
	Yes, mild 1	4	
	2	2	
	3	2	1
	4	2	
	5	1	1
	Yes, extreme 6	1	
19. Did a caretaker threaten any of the children with harm?	*No*	74	4
	Yes, mild 4	2	
	5	2	1
	Yes, extreme 6	1	
36. Did a caretaker injure or restrain a child (non-disciplinary)?	*No*	75	5
	Yes, mild 2	1	
	5	2	
	Yes, extreme 6	1	
2. Had a child been exposed to domestic violence recently?	*No*	70	4
	Yes, less severe 1	2	
	3	1	1
	4	3	
	6	1	
	Yes, very severe 7	2	
37. Did a caretaker exhibit strange behavior or beliefs?	*No*	71	3
	Yes, mild 1	1	
	4	1	
	5	2	1
	6	2	1
	Yes, bizarre/extreme 7	2	
3. Did a caretaker seem unstable, explosive, without self-control?	*No*	61	2
	Yes, mild 1	2	
	2	3	
	3	2	1
	4	2	1
	5	5	
	6	2	1
	Yes, extreme 7	2	

The tolerance of investigators and assessment workers for various kinds of behavior and situations is dependent on their backgrounds and training. Worker judgments of safety are influenced by their interpretations of social context, including family structure, extended family, race/ethnicity, housing, neighborhood, and many others. For example, in a case we

followed several years ago, a new young investigator removed children in an active DFS case when a new report was received and she observed what she believed was a particularly dirty and unhealthy household. When we asked the ongoing caseworker about this, she pointed out that, unlike most families that DFS was working with in this part of town, this family owned their own home and that the house was relatively clean compared to other houses.

Alternatively, workers may simply interpret the tool differently because they have diverse understandings of the meanings and functions of items on the tool. Difference in interpretation could be one of the reasons for differences between responses of workers to the SDM tool and our case-specific instrument. An example of this can be found in Table 5.1, Question 3, where differences were found when we asked about behavior that was unstable, explosive, without self-control compared to the SDM terms, violent and out-of-control.

Workers vary in how seriously they take the tool. We have already seen from the general survey of workers that attitudes toward the SDM tools varied considerably. A few were very enthusiastic but many did not think these tools affected their practice that much. In our Minnesota research, we have found that some workers, particularly older and more experienced ones, regarded the SDM with a measure of skepticism.

Family Risk Examples. Many of the items on the family risk scale are factual in nature. The reader may review the items at the beginning of this chapter to confirm this. For example, the number of children (N4) or the ages of the children (N5) are not usually matters of debate. Some items, however, are open to interpretation and require worker judgement. Whether a parent is domineering (A7d), for instance, is very much a matter of judgment.

In table 5.2 the SDM risk item for housing is included. It shows that 4 of the 84 families were currently in physically unsafe housing and that 1 was homeless at the time of the investigation/assessment. These are the two possible response categories on the SDM risk tool for families with housing problems. The 4 families in housing considered physically unsafe on the SDM tool were also considered in unsafe and unhealthly housing on case specific instrument (ratings of 3, 5, and 6 on the first question (8) in the table). The items coincide in this case, and in fact, it would be a cause for real concern if they did not. The last two questions in the table, however, approach housing problems in other ways. Question 48 asked not whether the family was homeless but whether it was in danger of becoming homeless. Of the 79 families for which housing risk was checked as “not applicable” via the SDM tool, 5 were found on the case-specific instrument to be in danger of losing their housing, and 2 of these were considered nearly certain. In addition, 1 of the 4 families whose housing was considered unsafe was also thought to be in serious danger of this problem. Question 14 asked about families moving around, another problem of families with housing problems. Again, by asking the housing question in a different way, a family was discovered among the “not applicable” families on the SDM tool that was having housing difficulties.

Table 5.2. Ratings of SDM Family Risk—Housing Problems compared to Three Corresponding Case-Specific Safety Items

SDM Family Risk Item: N10. Housing		*SDM Risk Scoring*		
	Ratings on case-specific items:	*0 Not Applicable (n=79)*	*1 Current housing is physically unsafe (n=4)*	*2 Homeless at the time of the investi-gation (n=1)*
8. Was the housing unsafe or unhealthy?	*No*	66		
	Yes, minor 1	4		1
	2	3		
	3		1	
	4	4		
	5	1	2	
	6	1	1	
	Yes, serious 7			
48. Was the family in danger of losing its housing at the time of the investigation?	*No*	74	3	
	Yes, likely 1	1		
	2	1		
	3			
	4	1		
	5		1	
	6	2		
	Yes, certain 7			1
14. Was the family living on the street or moving nightly among residences?	*No*	78	4	1
	Yes	1		

The differences between the SDM housing question and the reponses on questions 48 and 14 of the case-specific instruments illustrate a problem with risk scales of this kind: *simplification of checklist items may mean that certain families with real risk characteristics are overlooked.* It is clear in this case that this occurred. Were other questions asked about housing and homelessness, it is possible that yet other families with housing problems would be discovered.

Another example of this kind is found on the family risk abuse subscale dealing with domestic violence. The analysis is shown in Table 5.3. The SDM tool gives a score of 2 for domestic violence, but only if there were two or more incidents during the past year. Otherwise the family receives a score of 0 for this item. The case-specific items asked about violence in the family in four different ways: present domestic violence, past domestic violence, law enforcement involvement relating to domestic violence, and a more general question about fighting, threatening, yelling berating—the kind of actions that typical occur in situations of domestic violence.

Table 5.3. Ratings of SDM Family Risk—Domestic Violence compared to Three Corresponding Case-Specific Safety Items

SDM Family Risk Item A6: Domestic Violence (two or more incidents) in the household in the past year:		SDM Risk Scoring	
	Ratings on case-specific items:	0 No (n=78)	2 Yes (n=6)
2. Had a child been exposed to domestic violence recently?	*No*	70	4
	Yes, less severe 1	2	1
	2		
	3	1	
	4	3	
	5		
	6	1	
	Yes, very severe 7	1	1
50. Had a child been exposed to past domestic violence?	*No*	62	3
	Yes, less severe 1		
	2		
	3	4	1
	4	5	
	5	2	1
	6	4	
	Yes, very severe 7	1	1
34. Had a caretaker been seen by law enforcement regarding his/her physical or verbal behavior toward other family members?	*No*	63	6
	Yes, minor 1		
	2	3	
	3	1	
	4	3	
	5	4	
	6	2	
	Yes, serious 7	2	
51. Was there a family history of berating, yelling, fights, or threats?	*No*	50	3
	Yes, minor 1		
	2	1	1
	3	3	
	4	6	
	5	7	1
	6	6	
	Yes, serious 7	5	1

In each case a set of families that received a score of 0 on the SDM tool were discovered whom workers reported to have severe problems related to violence. Question 2 (also used in Table 5.1) did not specify a time frame or quantity, 8 families of this kind were found in which "recent" domestic violence had occurred, and in at least two of these the problem was considered severe. Interestingly, only 2 of the 6 families that received a domestic violence score on the risk tool were rated on the case-specific instrument—

indicating a possible reliability problem in this area. Again, when the term "past" was substituted in Question 50, 16 families were found among the 78 that received a score of 0 on the SDM tool. This is not an inconsistency, since the SDM tool asked specifically about event in the household in the past year. However, the primary question is whether a threat of domestic violence *continues* to be present in the household.

Many additional families were discovered among the 78 rated as 0 on SDM under two additional related questions. Question 34 asked about law enforcement involvement related to family violence. Such involvement is an index of the gravity of the problem, and 15 families of this kind were found and in at least 8 of these the worker related the incident(s) as serious (rating of 5 to 7). The most general question about abusive language and behavior (Question 51) revealed 28 additional families among the 78 for whom such a history was know and in 18 is was rated as serious. Again, as with question 50, such a history is important if the threat remains in the household.

Like the housing example, this analysis illustrates the potential to overlook families in which risk factors of this kind are present by asking questions in a very simple fashion. Although other examples of this kind could be provided, these will suffice to make the point.

Conclusions

Brevity and conciseness are essential to screening instruments. The notion behind all screening is that a limited number of simple factors exist that can be used (in combination) to form an index of the problem. Doing this is truly difficult when the characteristics being screened are the basis of critical decisions. The instrument must be both reliable and valid.

Reliability. We suggested several ways that the safety assessment tool might be unreliable. These apply equally to the family risk tool. Reliability can be summarized under four categories:

1. The point in time when the tool is used (at the beginning or end of the investigation/assessment) is critical.

2. Individual differences among workers that affect their interpretation of screening items, including the way they are influenced by the social context. These differences in interpretations can be addressed in part through thorough and repeated training of workers.

3. Wording or complete items may lend themselves to different interpretations. This is also a subject for training. However, in regard to screening tools, empirical testing is also necessary to determine whether such problems exist.

4. The final reliability problem concerns attitudes of workers toward the screening tools. The general survey of workers indicated differences in their enthusiasm toward the SDM tools.

Some of these can be addressed through thorough and repeated training. Others require empirical research and possible modification of the assessment tools.

Validity. A screening tool must be valid. Two other terms are typically used in this regard: the tool must be both *sensitive* and *specific*.

Sensitivity refers to the capability of the tool to detect *true positives*. For example, if the threat of family (domestic) violence is a true measure of risk of future child abuse and neglect, a risk screening tool must not overlook families in which this threat truly exists. The item in the tool that asks about domestic violence must *screen in all families* in which such problems exists. Screening tools that do not do this are said to have poor sensitivity or to be insensitive.

Specificity refers to the capability of screening tool to detect *true negatives*. To use the family violence example again, some of the families with a history of domestic violence may *not* be presently threatened. A screening tool with poor specificity would indicate higher risk than is truly warranted in some families. In the general survey some workers complained (wrongly, we believe) that unsubstantiated past reports should not be counted in determining risk. What they were saying is that such families might be scored as high risk when in fact they are not high risk, that is, that the screening item counting prior investigations/assessments is not specific.

Sensivity and specificity can be shown through empirical testing in which other sources of information are used to collect that same data that the screening tool is designed to tap. The case-specific instrument used in this study is one example of this. A full approach would involve more detailed follow-up with workers and case records.

We are not saying, on the basis of these findings, that screening tools should not be used. Such tools are used extensively and with positive results in many fields including child welfare (e.g., healthcare and education) to identify individuals with potential problems. They can be efficient ways to determine which individuals or families merit more detailed attention and assessment. Nonetheless, a*ccuracy trumps efficiency* in child protection—particularly as regards sensitivity. Safety and risk assessment tools that misidentify families that have real safety and risk problems are unacceptable, particularly if the decision to continue working with families hinges on SDM scores. The analysis presented in this chapter suggests that sensitivity, specificity and reliability may be problems with the SDM tools that are now being adopted.

A Follow-up Study of SDM. Missouri might take its cue from Minnesota which is on the verge of funding a full evaluation of very similar SDM tools adopted some time ago and now in use in most of the state. It is too early to do such an evaluation of the Missouri tools. We suggest, however, that within 12 to 18 months the state issue an RFP for a follow-up study of SDM and other screening procedures and tools. Ideally, the study would include 1) a general survey similar to the one employed on a limited basis for this study, 2) a follow-up of cases focusing on family and child characteristics and behaviors that were or were not captured via the SDM tools, 3) an outcome study of recurrence of safety threats, CA/N recurrence, effectiveness of DFS in serving families, and 4) a study of the characteristics of Chronic CA/N families along the lines discussed in Chapter Two. The contractor should be required to develop specific recommendations for modifying and updating SDM screening tools and proceedures as well as more detailed assessments of families and children, such as the Chronic CA/N assessment tool discussed below.

A Suggested Approach to Using SDM. Until DFS is sure of the accuracy of the SDM tools, they should be supplemented in various ways.

1. In the follow-up study described in Chapter Two, we showed that it is possible to generate a risk score for families based on historical data in the DFS system. We also pointed out the lack of specificity of the measure that we generated, since many with high risk scores were not seen in the system again. Sensitivity was also a problem in that some families with low risk scores reappeared frequently during the follow-up period. Some of this is to be expected when using a measure based in large part on past appearances in the system. Some families seen for the first time will turn out to be high risk. The assumption is that other causal factors underlie the correlations. *An initial risk score may be system generated (based on the items identified in this study) and forwarded to local offices. Families with long and costly histories may be identified as potentially Chronic CA/N Families.*

2. Workers should be encouraged regarding both SDM tools reviewed here to treat safety and risk items conservatively. The concepts of safety and risk should be fully explained as well as the purpose of each safety and risk item. *When workers feel that a problem is present, even though it does not precisely fit the wording or description of the SDM tools, they should be encouraged to override the final results.* In general the emphasis should be on increasing the safety and risk scores. In addition, based on the general concepts of risk and safety, workers should be encouraged not to overlook other factors that are not contained in the risk instrument. (For example, the suggestion of workers that child behavior problems be considered in risk assessment is a good one. This kind of thinking should not be discouraged on the part of workers. They should be told that the *SDM tools are guides to decision making. The tools do not make the decision, workers and supervisors do.* They should be told that the tools are tentative and that based on future studies they may be modified.

3. *Supervisors should also be encouraged to override.* This will be dependent on their knowledge of cases. Workers should be told that supervisors will scrutinize SDM ratings and should provide whatever written or oral narrative is necessary for supervisors to do this. Workers should be encouraged to express their doubts about safety and risk outcomes to their supervisors.

4. *Final decisions about whether to continue working with families should not be based solely on final risk assessment scores.* This practice is itself risky, and if the risk tool indeed has sensitivity problems, the practice guarantees that truly at-risk families that are ignored will be seen again next month or next year. *The decision to continue with a family should be based on the joint assessment between the worker and family of near-term and long-term child safety and family needs.*

5. *A chronic CA/N assessment tool should be added for families identified under the system in this way*. Regardless of whether a reports is screened for investigation or assessment the chronic CA/N assessment should be conducted. This tool would document in much greater detail the characteristics known to be associated with Chronic CA/N, such as those discussed at the conclusion of Chapter Two of this report. It would examine in particular whether and in what way these characteristics of family members and entire families were related to past CA/N incidents and the success or failure of the agency,

other agencies, and the family itself in addressing and correcting them. A illustrative set of characteristics of this type were presented at the end of Chapter Two of this report. It would be most beneficial if *chronic CA/N workers* could be designated in larger counties and/or in circuits who would have special responsibility for these cases. Families that fit this category would potentially remain in contact with such workers for longer periods seeking the supports they need to overcome the problems that have led to past CA/N recurrence. We called this LTFA or long-term family assessment in Chapter Two.