A NEW APPROACH TO CHILD PROTECTION:

THE CRC MODEL

CHILDREN'S RESEARCH CENTER

A Division of the National Council on Crime and Delinquency

"[NCCD]...There is no other group in America that has cared so much about children's issues for so long and done so much to make a difference."

Attorney General Janet Reno
September 9, 1993
Washington, D.C.

COVER PHOTO BY JOHN DAVID ARMS

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PREFACE

The latter half of the 1980s was a time of significant change for the National Council on Crime and Delinquency. NCCD has served adult and juvenile justice agencies since 1907, and is respected nationally for its research, evaluation, and systems development work. The development and implementation of case management models for corrections have been among NCCD's most successful endeavors. In 1986, Alaska Social Services asked NCCD to work with Child Protective Services staff to devise a system that would provide the same level of structure for CPS. With this effort, NCCD expanded its child welfare mission beyond juvenile justice to child protection.

The success of the Alaska Child Protective Services project led to similar efforts in Michigan, Oklahoma, Rhode Island, and Wisconsin. With each new project, we learned more about the needs of Child Protective Services agencies and what is required to successfully implement major organizational change. Most importantly, we have assembled a substantial research database and developed systems for monitoring service delivery, improving efficiency, and measuring the effectiveness of CPS policies, programs, and service delivery strategies.

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

This document describes case management system development services offered by the Children's Research Center (CRC). Examples of research results, decision support systems, and data from past efforts are interspersed throughout to illustrate the value of the CRC model. We believe you will find the materials informative and thought provoking. For additional information, please contact the Children's Research Center.

THE CRISIS IN CHILD PROTECTIVE SERVICES

Fueled by the rise in drug abuse and the advent of mandatory reporter laws, the number of abuse and neglect allegations nationwide has skyrocketed in recent years. Few agencies have the resources needed to cope effectively with the new demands. As pressure to make critical decisions affecting children and families rises, so does the potential for error. Inappropriate decisions can be costly, leading to an overuse of out-of-home placements, or tragic, resulting in the injury or death of a child. Clearly, new methods are required to help workers make decisions as efficiently and effectively as possible. Without tools that provide accurate and reliable assessments of risk and case management systems which clearly define expectations for staff actions, staff are overwhelmed by heavy workloads and unrealistic demands, and children and families are jeopardized.

Estimates of the number of children abused or neglected in this country have tripled since 1980. The need for additional resources is obvious, but resources are difficult to obtain in an era of fiscal belt tightening. Funding bodies demand to know what they will receive for dollars expended. Responsible legislators must be reasonably certain that case actions are appropriate, that staff are accountable, and that agencies fulfill their mandates. The dual pressures of increased referrals and limited resources are both addressed by the CRC model.

THE CRC MODEL: A NEW APPROACH TO CASE MANAGEMENT

The case management model described in this document is based on two principles. ***First, decisions can be significantly improved when structured appropriately: that is, specific criteria must be considered for every case by every worker through highly structured assessment procedures.*** Failure to define decision making criteria and

identify how workers are to apply these criteria results in inconsistencies and, sometimes, inappropriate case actions.

The second principle stipulates that priorities given cases must correspond directly to the assessment process. Expectations of staff must be clearly defined and practice standards must be readily measurable. While individual service plans will specify services needed for each case, service levels can be established based on risk. Service standards, differentiated by level of risk, provide a level of accountability that is often missing in human service organizations.

We believe the model described in this document represents a significant step forward for Protective Services. When implemented properly, it will result in substantial improvements in case decision making, budgeting, staff deployment, and agency accountability. This model is based on work completed in five states, ranging from the largest, Alaska, to the smallest, Rhode Island. **While the scope of services delivered varies considerably among these agencies, each case management system incorporates five basic components:**

- **Highly structured assessments of family risk and family needs.**
- **Service standards that clearly define different levels of case contacts, based on risk levels.**
- **A workload accounting and budgeting system that translates service standards into resource requirements and helps deploy resources equitably throughout the organization.**
- **A system of case review and reassessment to expeditiously move cases through the system.**
- **A comprehensive information system to provide data for monitoring, planning, and evaluation.**

Our experience indicates that a single, rigidly defined case management model cannot meet the needs of every agency. State and county child welfare agencies are not all organized to deliver services in the same way and do not always share similar service mandates. Even the definition of what constitutes abuse or neglect varies considerably among jurisdictions. Clearly, agencies with different missions or legislative mandates require different case management approaches. Therefore, the CRC approach to system development is a collaborative one in which we engage agencies in a joint development effort. Each system is built upon a set of case management principles which is then adapted to local practices and mandates, incorporating a great deal of input from local managers and staff. The result is a case management system which is "owned" by the agency and builds upon its strengths as a service organization.

The CRC case management approach begins at different points in different organizations. In all systems, however, the worker applies objective risk and needs assessment tools to classify each family before a case is opened. The initial case decisions draw heavily upon these structured assessments which summarize critical characteristics of each family in a simple format, seldom more than one page in length.

Workers still exercise professional judgement in case decisions, but the assessment tools ensure that each family is systematically evaluated and that critical case characteristics are not overlooked. This "intelligence" about each case is carried forward from the investigating worker to all levels of agency management. Risk and needs assessment instruments do <u>not</u> make case decisions for direct service workers, but they structure those decisions by bringing objective information to bear on a few very important questions:

- **What is the likelihood that abuse or neglect will recur in this family in the near future?**

- **What priority for agency service resources should this family receive?**

- **What are the specific family problems which agency services may address to intervene effectively in this case?**

- **What progress is the family making as an active service case?**

Family Risk Assessment The Alaska abuse risk assessment instrument, Figure 1, is presented on page 5. (Two other instruments appear in Appendix A. Each instrument was derived from research conducted specifically for the respective child welfare agency.) Each research effort examined relationships between family characteristics and child welfare case outcomes. Results were used to develop assessment tools which estimate the likelihood that a family will again become involved in abuse or neglect. Because these risk assessment instruments are products of research which examined actual experience with CPS cases, it is possible to assess risk with a reasonably high degree of accuracy. The process is similar in many respects to methods that insurance agencies use to identify high risk drivers. Actuarial risk assessment has also been used effectively to classify criminal offenders for case management and parole decision making for more than 30 years.

One very important research finding is that a single instrument should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate risk scales are used to assess the future probability of abuse or neglect.

FIGURE 1

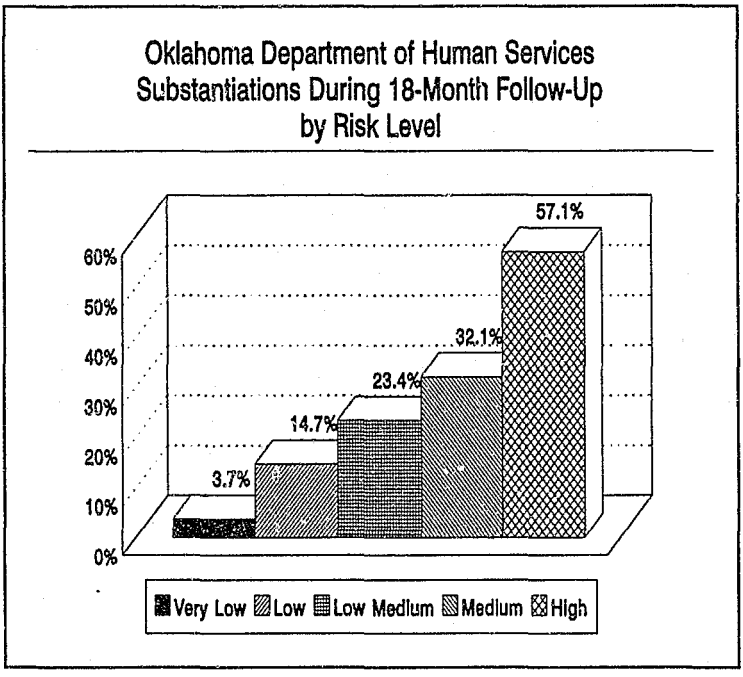
ALASKA CHILD PROTECTION ABUSE SCALE

			Score
1.	Number of Prior Reports of Abuse		
	None	0	
	One	1	
	Two	2	
	Three or More	4	____
2.	Number of Prior Placements Outside of Family Residence		
	None	0	
	One or More	1	____
3.	Number of Abuse/Neglect Types Noted in Current Referral		
	One	0	
	Two or Three	2	
	Four or More	3	____
4.	Number of Adults in Home (18 Years of Age or Older)		
	Two or Fewer	0	
	Three or More	2	____
5.	Number of Children in Home		
	Two or Fewer	0	
	Three or More	2	____
6.	Either Caretaker Abused as Child		
	No	0	
	Yes	2	____
7.	Caretaker History of Drug/Alcohol Abuse		
	None	0	
	One Caretaker	1	
	Both Caretakers	3	____
8.	One or Both Caretakers Previously Convicted of a Felony Offense		
	No	0	
	Yes	1	____
9.	Caretaker(s) Primarily Involved in Negative Social Relationships		
	No	0	
	Yes	2	____
10.	Caretaker(s) History of Depression		
	None	0	
	Significant, long term episodes by either caretaker	1	
	Episode(s) include suicide attempt by either caretaker	3	____
11.	Cooperation with Agency Demonstrated by Perpetrator/Caretaker(s)		
	Not Applicable	0	
	Cooperative	0	
	Uncooperative	1	
	Hostile/Threatening	3	____
12.	View of Abuse by Non Perpetrator/Caretaker(s)		
	Not Applicable	0	
	More Serious than Agency	-2	
	Consistent with Agency View	0	
	Less Serious than Agency	2	____
		TOTAL RISK SCORE	____

In the CRC case management system, risk assessment tools help the case worker make initial service decisions more objectively. The concept is simple. ***Risk assessment identifies families which have high, moderate, or low probabilities of continuing to abuse or neglect their children.*** By completing the risk assessment, the worker obtains an objective appraisal of the likelihood or risk that a family will maltreat their children in the next 18 - 24 months. This is obviously critical information. For instance, in many of the CRC risk assessment studies, it often has been possible to identify "high risk" families at investigation that have a 50% or higher probability of again abusing or neglecting their children. It has also been possible to identify "low risk" families where the chances of subsequent maltreatment were only 5% or below. ***The differences between these groups are substantial. High risk families have dramatically higher rates of subsequent referrals and investigations, more subsequent substantiations, and are more often involved in serious abuse or neglect incidents resulting in medical care and/or hospitalization.***

The chart on the following page (Figure 2) reflects research conducted in Oklahoma. Similar data from Rhode Island illustrating the relationship between family risk levels and subsequent serious abuse or neglect are presented in Table 1 on page 8.

FIGURE 2



In Oklahoma, families assessed as "high risk" are more than 15 times as likely to have another incident of abuse or neglect substantiated within 18 months than are families identified as "very low risk." In Rhode Island, 27% of the "high risk" families were, within 24 months, involved in a subsequent abuse or neglect incident in which a child required medical care or hospitalization, compared with only 1% of families assessed as "low risk."

When risk is clearly defined and objectively quantified, the choice between serving one family or another family is simplified: agency resources should be targeted to higher risk families because of the greater potential to reduce subsequent maltreatment.

TABLE 1 Rhode Island Outcomes by Risk Levels 24-Month Follow-Up		
Risk Level	**Abuse or Neglect Substantiated**	**Medical Care/ Hospitalization Required**
Low	6%	1%
Low Medium	23%	6%
Medium	39%	13%
High	63%	27%

Risk assessment instruments can help make case workers better decision makers. ***Research has generally demonstrated that simple actuarial tools can predict human behavior more accurately than even a well-trained clinical staff person (see, for instance, Meehl 1954 or Dawes, Faust, and Meehl 1989).*** In many child welfare agencies, low entry level qualifications, inexperienced workers, minimal training, and high turnover practically guarantee that clinical judgments of risk made by individual workers will vary widely in accuracy. Line staff sometimes fail to identify high risk families during abuse/neglect investigations and therefore do not engage them in service intervention, a fact that has been noted by the CRC, as well as other researchers (i.e., Johnson and L'Esperance 1984). Our own research suggests that between 15% and 25% of the "high risk" cases are <u>not</u> opened for agency services while many low risk families are carried on caseloads for months or even years. CRC studies also show that a relatively small group of "high risk" families account for a disproportionately large percentage of subsequent abuse/neglect referrals, serious maltreatment, and out-of-home child placements. This suggests that child welfare agencies may be inadvertently losing the opportunity

to prevent abuse or neglect in the families who are most at risk.

In sum, by using actuarial risk assessment, child welfare agencies can significantly improve the initial case service decisions made by individual workers. The objective is to ensure that "high risk" families are provided with services needed to protect children from future harm.

Family Needs Assessment Another important feature of the CRC case management system is the family needs assessment instrument. A companion piece to the risk assessment, it is used to evaluate the presenting problems of each family. The needs assessment instruments presented in Appendix B were designed in collaboration with staff from Michigan and Rhode Island, respectively. These assessment tools are used to systematically identify critical family problems and help plan effective service interventions. The needs assessment serves several purposes:

- **It ensures that all workers consistently consider each family's strengths and weaknesses in an objective format when assessing need for services;**

- **It provides an important case planning reference for workers and first line supervisors which eliminates long, disorganized case narratives and reduces paperwork;**

- **It serves as a mechanism for monitoring service referrals made to address identified family problems;**

- **The initial needs assessment, when followed by periodic reassessments, permits case workers and supervisors to easily assess change in family functioning and thus judge the impact of services on the case; and**

- **In the aggregate, needs assessment data provides management information on the**

problems client families face. These profiles can then be used to develop resources to meet client needs.

Reassessment The initial assessments of risk and service needs represent only the first phase of the CRC case management process. Reassessments are performed at established intervals (generally every 90 days) as long as the case is open. Case reassessment ensures that risk of maltreatment and family service needs will be considered in later stages of the service delivery process and that case decisions will be made accordingly. At each reassessment, direct service workers reevaluate the family using instruments which help them systematically assess changes in risk levels and service needs. Case progress will determine if a lower or higher service level is needed, or if the case can be closed.

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

The risk and needs assessments used to evaluate client families are not administrative add-ons, but tools designed specifically to help make case management decisions. In some agencies, the risk and needs assessment/reassessment instruments have become formal case planning documents and thus reduce the need for long case narratives and other paperwork. The time saved is available to actually serve families.

THE KEY TO EFFECTIVE MANAGEMENT

One of the most important features of the CRC model is that it provides management with computerized

information to routinely monitor and evaluate programs, assess the impact of policy, identify service needs, and determine which programs and which intervention strategies provide the best results for various types of cases. Agencies can establish clearly defined outcome objectives and use aggregate data generated by the CRC model to determine the extent to which objectives are realized. The ability to critically evaluate programs is essential to improving services to families and children.

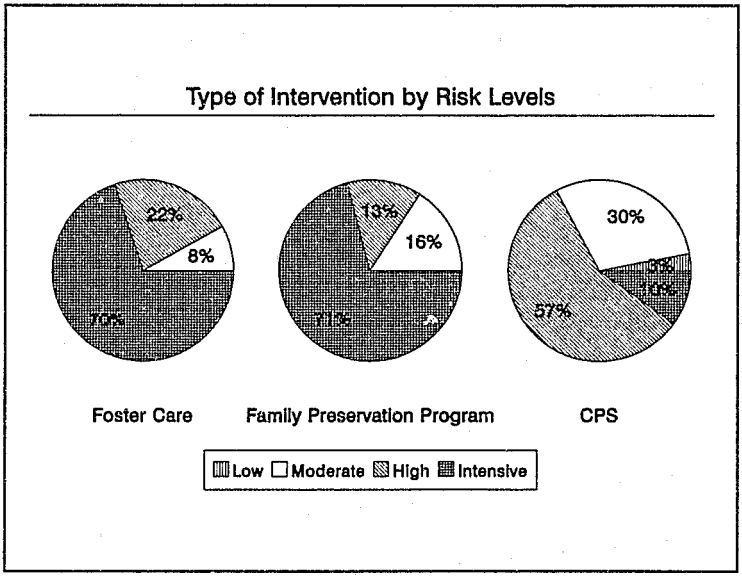
In working with Children's Protective Services in Michigan, the following set of evaluation issues were identified:

- **Determine if Structured Decision Making results in more appropriate use of services, programs;**
- **Determine if Structured Decision Making results in lower rates of subsequent maltreatment;**
- **Determine the relative effectiveness of programs and service providers;**
- **Determine the extent to which Structured Decision Making changes: 1) placement rates for foster care; 2) average length of stay in foster care; 3) rate of reintegration; and 4) rate of successful reintegration.**

One emerging issue in Child Protective Services concerns the appropriate role and the effectiveness of Family Preservation Programs. Many such programs were established as alternatives to foster care and are therefore evaluated based on their ability to reduce placement rates. ***To have a real impact on foster care placement, these programs must target children who are truly "at imminent risk of placement."*** Without structured approaches to selecting families for these programs, there is a real danger of "net widening," i.e., using these programs for families whose children are not truly at risk of placement. Data produced by a CRC system indicated this was indeed happening in one Midwestern County (see Figure 3) allowing management to take necessary corrective action. Note that 16% of all referrals

to the Family Preservation Program were rated moderate risk. Case reviews indicated these were not appropriate referrals and led to a policy stipulating that only high and intensive level cases could be referred to the Family Preservation Program.

FIGURE 3

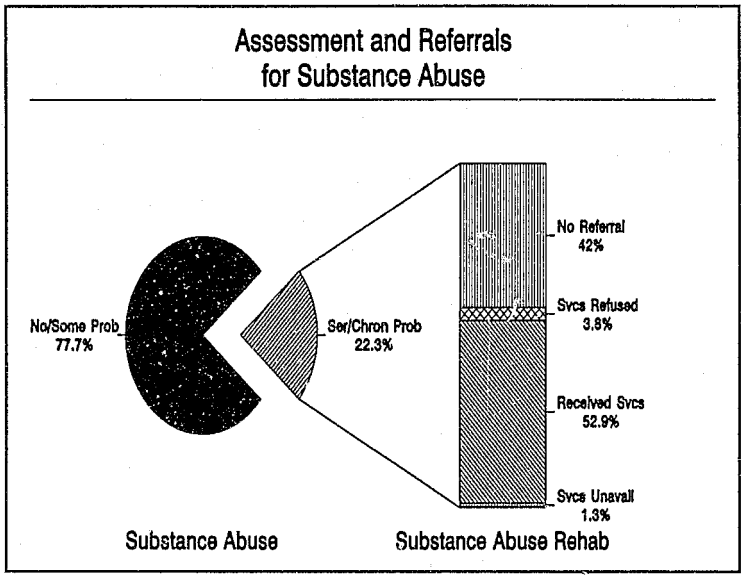


Systems developed by the CRC permit on-going monitoring of agency response to case needs as well as evaluations of programs. Figure 4 relates assessment data to referrals for services and outcomes. The first step represents an assessment of process, the second a measure of the relative effectiveness of service delivery. Much more sophisticated analyses are also possible, identifying what responses work best for various types of cases.

One of the strongest features of the CRC case management system is that assessments of risk and service needs are designed to be utilized by managerial and supervisory staff at all levels. In effect, supervisors, budget analysts, and policy makers use the same information about families (although aggregated to different levels) to manage

agency resources that workers used to make individual case decisions. The result is a case management system that integrates agency decision making from the bottom to the top and provides each agency with the ability to assess its clients, plan its service interventions, and evaluate case outcomes more effectively. Only through such an approach is it possible to know what works and what does not in child welfare services.

FIGURE 4



Agency Resource Management Efficient management of limited resources is the cornerstone of the CRC case management system. Not all families involved in child abuse or neglect incidents require or receive the same level of child welfare services. The decision to serve a family or place a child in foster care implies a significant commitment of either staff time, or purchased services, or both. There simply are not enough agency resources to optimally serve all families and this reality imposes difficult choices on direct service workers and agency managers alike. The question becomes which families should be served by the agency given limited

resources? Risk assessment provides an objective framework for making these kind of case decisions. Differential case standards provide additional flexibility in allocating resources. Many child welfare agencies treat each case the same, at least in terms of case assignment and resource allocation, regardless of the problems presented or the risk of continued abuse or neglect. Cases are assigned on a geographical or numerical basis, without regard to the degree of intervention required.

The ability to assess risk more accurately gives agencies the opportunity to target service resources more efficiently. Low risk families need not receive the same amount of agency resources (i.e., case worker time) as high risk families because they are much less likely to again maltreat their children. When differential worker contact standards based on risk are established by an agency, as they have been in Michigan, Alaska, Rhode Island, and in four large Wisconsin counties, it should be possible to make existing service resources reach farther and produce better results (see Figure 5). Another advantage of a system which classifies cases efficiently and sets clear expectations for case-related activity is the ease with which agency service resources/staff needs can be estimated. Administrators know precisely what staff/service resources will be necessary for the agency to meet its service mandate.

Workload accounting, a key piece of the CRC model, converts mandated service standards into time requirements. To establish a workload accounting system, a simple case-based time study is conducted to determine the amount of time actually needed by staff to meet service standards. By translating tasks into time requirements, various functions, such as investigations and on-going services, can be compared. This information can be used for allocating staff and for the development of budget requests which detail exactly what is required to deliver mandated services. When functions are added to the list of agency responsibilities or resources are reduced due to budget restrictions, the agency can estimate the impact and develop a set of options for policymakers. In essence, a workload-based budget is a contract for services. ***Funding bodies know exactly what level of service will be provided based on the level of***

resources allocated. As data become available on the relationship between service provision and outcomes, the potential <u>impact</u> of budget actions can be clearly identified, helping legislatures and county boards make more informed decisions regarding the use of public funds.

FIGURE 5

MICHIGAN CPS SERVICE STANDARDS

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

Figure 6 presents a simple illustration of a workload-based budget. ***It is critical that agencies understand that assigning different service levels to cases quickly loses meaning unless accompanied by a workload budgeting and resource deployment system.***

FIGURE 6

WORKLOAD BUDGETING EXAMPLE

Time Available Per Worker/Month for Case-Related Activities (calculated through personnel policies and time study): = 120 hrs/mo

Time Required for: (calculated through Time Study)		Caseload Breakdown: (1,000 on-going cases)	
Intensive Cases	= 8 hrs/mo.	20% Intensive	= 200
High	= 6 hrs/mo.	40% High	= 400
Moderate	= 4 hrs/mo.	30% Moderate	= 300
Low	= 2 hrs/mo.	10% Low	= 100
Investigations	= 12 hrs/each	Investigations	= 100

	Resource Needs: (caseload x time required)	Divide by Time Available:
Inten	200 x 8 hrs = 1600 hrs/mo	/120 hrs = 13 staff
High	400 x 6 hrs = 2400 hrs/mo	/120 hrs = 20 staff
Mod	300 x 4 hrs = 1200 hrs/mo	/120 hrs = 10 staff
Low	100 x 2 hrs = 200 hrs/mo	/120 hrs = 2 staff
Invest	100 x 12 hrs = 1200 hrs/mo	/120 hrs = 10 staff

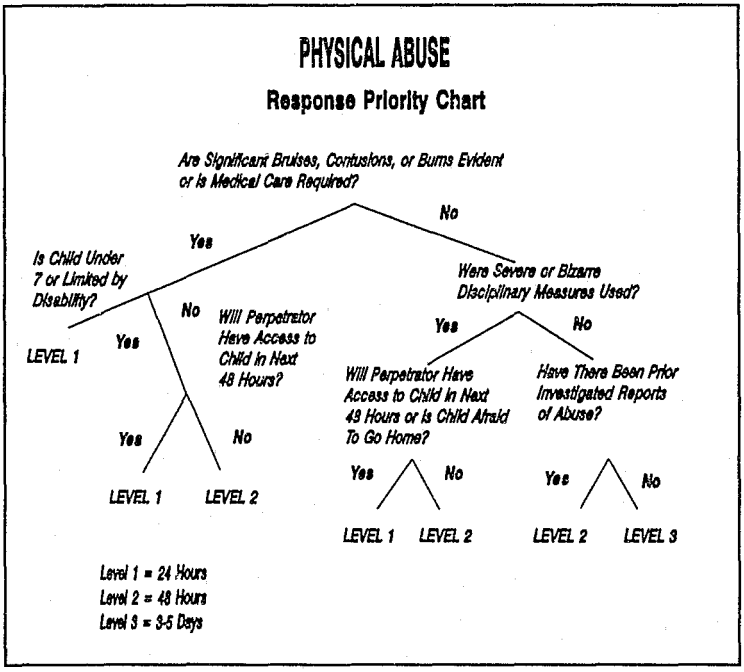
Needed to meet standards 55 staff

EXPANDING THE MODEL TO MEET LOCAL NEEDS

The principle of structuring both how decisions are made and how staff respond to assessments can be expanded into other areas of operation to improve consistency in decision making and provide better services to families. For example, CRC staff worked with a focus group of staff and supervisors in four Wisconsin counties to structure response priorities for reported incidents of abuse and neglect. The system developed (Figure 7) is easy to apply, and clearly identifies what factors are used to determine how quickly staff should respond to new referrals. The clarity of the approach not only enhances consistency among workers, but allows administrators to easily convey to key decision makers how the agency deals with referrals.

In tailoring the model to specific agency needs, CRC staff can bring systems development expertise to focus on a myriad of potential issues, including intake screening, emergency removal decisions, and termination of parental rights.

FIGURE 7



SUMMARY

The future of Child Protective Services in America depends on its ability to effectively deal with growing caseloads, increased public scrutiny, and static or diminishing resources. The number of abuse and neglect complaints received has ***tripled*** since 1980. ***Clearly, new methods are needed to deal with this crisis.*** Protective Services cannot ignore technologies which significantly improve decision making and help target resources to children and families most at risk. It is not a question of replacing professional

judgment with statistical inference. It is simply a matter of using the best information available to protect our children from harm.

Robyn Dawes, a professor at Carnegie Mellon University, addressed this issue in a recent article published in The Chronicle of Higher Education,

> *"In the last 50 years or so, the question of whether a statistical or clinical approach is superior has been the subject of extensive empirical investigation; statistical vs. clinical methods of predicting important human outcomes have been compared with each other, in what might be described as a 'contest.' The results have been uniform. Even fairly simple statistical models outperform clinical judgment. The superiority of statistical prediction holds in diverse areas, ranging from diagnosing heart attacks and predicting who will survive them, to forecasting who will succeed in careers, stay out of jail on parole, or be dismissed from police forces.*
>
> *Critics of those who infer that we should therefore use statistical methods and principles in reaching decision raise a host of objections: Perhaps the wrong experts were chosen to compare with the statistical models, or perhaps an inappropriate problem was addressed (and clinical experts would outperform statistical models at predicting something else). Perhaps we should even ignore the research results to uphold the social value that decisions about humans should not be made on the basis of statistics.*
>
> *These objections ignore the data from well over 100 studies, almost all of which show the superiority of prediction based on statistics rather than on experts' intuition. For example, undergraduate records and test scores alone predict performance in graduate school better than do the ratings of admissions committees.* ***The objections to using statistics also ignore the ethical mandate that, for important social purposes such as protecting children, decisions should be made in the best way possible. If relevant statistical information exists, use it. If it doesn't exist, collect it."*** (emphasis added)

Risk assessment, while of critical importance, is only one component of the CRC system. The CRC model is comprehensive, permitting the ***best information*** to be used at every organizational level. It links assessments to service plans, and agency standards to workload and budgeting. It provides data to workers for case decision making and data to managers for planning and program evaluation. As such, it represents a practical and efficient means for improving the plight of America's Child Protective Service systems.

As childhood poverty, youth dropout rates, and violent juvenile crime reach unacceptable heights, disadvantaged children are growing into unskilled, uneducated adults unable to help themselves or their children to the American dream. Today, over one in every five children live in poverty, a statistic that, in all probability, means that pressure on child welfare systems will only increase. The system described here can help agencies deal more effectively with one of the most tragic and perplexing problems facing our nation.

REFERENCES

Dawes, R. (1993). "Finding Guidelines for Tough Decisions," The Chronicle of Higher Education, June 9, A40.

Dawes, R., Faust, D., and Meehl, P. (1989). "Clinical Versus Actuarial Judgment," Science, 243, 1668-1674.

Johnson, W. and L'Esperance, J. (1984). "Predicting Recurrence of Child Abuse," Social Work Research and Abstracts, 20(2), 21-26.

Meehl, P. (1954). Clinical Versus Statistical Prediction: A Theoretical Analysis and a Review of the Evidence. Minneapolis, University of Minnesota Press.

APPENDIX A

Oklahoma Family Service Assessment for Abuse

			Score
A1.	Current Investigation Confirmed		
	a. Neglect only	0	
	b. Abuse	1	____
A2.	Prior CPS Referral History		
	a. Prior investigated referral for abuse	2	
	b. Any prior referral for abuse/neglect	1	
	c. None of above	-1	____
A3.	Child Characteristics (check and add for score)		
	a. ____ Female	1	
	b. ____ Mentally retarded or has history of delinquency	2	
	c. None of above	0	____
A4.	Number of Children Involved in the Abuse/Neglect Incident		
	a. One	0	
	b. Two	1	
	c. Three plus children	2	____
A5.	Household Address Changes Last 12 Months		
	a. None or one	0	
	b. Two or more	1	____
A6.	A Child in the Household Was Placed Outside the Home Prior to this Incident		
	a. No	0	
	b. Yes	1	____
A7.	Caretaker(s) have Unrealistic Expectations of the Child		
	a. No	0	
	b. Yes, primary or secondary caretaker	1	
	c. Yes, both caretakers	2	____
A8.	Caretaker(s) Use Excessive or Inappropriate Discipline		
	a. No	0	
	b. Yes, primary or secondary caretaker	1	
	c. Yes, both caretakers	3	____
A9.	Primary Caretaker has an Alcohol or Drug Abuse Problem that Contributed to the Incident		
	a. No	0	
	b. Yes, drug or alcohol use	1	
	c. Yes, both drug and alcohol use	2	____
A10.	Primary Caretaker's Ability to Provide the Child with Emotional Support and Discipline		
	a. Effective in meeting child's minimum needs	0	
	b. Not effective in some areas	1	____
A11.	Primary Caretaker has a History of Abuse or Neglect as a Child		
	a. No	0	
	b. Yes	1	____
A12.	Primary Caretaker's Relationship Problems with Other Adults		
	a. Domestic violence/severe problems	2	
	b. Harmful relationships	1	
	c. Not applicable/limited adult relationships	0	
	d. No serious problems	-1	____
A13.	Caretaker(s) are Strongly Motivated to Improve Parenting Skills		
	a. Yes, primary or secondary caretaker is strongly motivated; or no improvement necessary	-1	
	b. Neither primary nor secondary caretaker	0	____
		TOTAL SCORE	____

Michigan Family Risk Assessment for Neglect

		Score
N1.	Current Complaint is for Neglect	
	a. No 0	
	b. Yes 2	____
N2.	Number of Prior Assigned Complaints	
	a. None 0	
	b. One or More 2	____
N3.	Number of Children in the Home	
	a. Three or Fewer 0	
	b. Four or More 2	____
N4.	Number of Adults in Home at Time of Complaint	
	a. Two or More 0	
	b. One/None 3	____
N5.	Characteristics of Female Caretaker (check and add for score)	
	a. Not Applicable 0	
	b. ___ Lacks parenting skills 1	
	c. ___ Lacks self-esteem 1	
	d. ___ Apathetic or Hopeless 2	____
N6.	Caretaker(s) Socially Isolated or Withdrawn or Involved in Harmful Relationships	
	a. Neither Caretaker 0	
	b. One Caretaker 2	
	c. Both Caretakers 3	____
N7.	Female Caretaker Has a History of Alcohol or Drug Abuse	
	a. No 0	
	b. Yes 3	____
N8.	Amount of Current Household Income	
	a. Over $2,000 Per Month 0	
	b. $600 to $2,000 Per Month 1	
	c. Under $600 2	____
N9.	Perpetrator's Motivation to Change	
	a. Motivated and Realistic 0	
	b. Unmotivated 1	
	c. Motivated but Unrealistic 2	____
		TOTAL SCORE ____

Wisconsin Risk Assessment for Abuse

Score

A1. Was Abuse Alleged or Substantiated in the Current Investigation?
- a. No 0
- b. Abuse alleged but not substantiated 1
- c. Abuse substantiated ..... 2 ____

A2. Prior CA/N History
- a. Prior substantiated abuse incident 3
- b. Any prior investigation for abuse/neglect 2
- c. Any prior child welfare referral 1
- d. No CA/N history ..... 0 ____

A3. Characteristics of Children in the Household (check and add for score)
- a. ___ Any female children 1
- b. ___ Special needs or
  ___ Delinquent or status offense history 2
- c. ___ None of the above ..... 0 ____

A4. Number of Children Involved in the Abuse or Neglect Incident
- a. One child 0
- b. Two children 1
- c. Three or more children ..... 2 ____

A5. Has a Child Currently in the Household been Placed Outside the Home Prior to this Incident?
- a. No 0
- b. Yes ..... 1 ____

A6. Household Address Changed during the Last 12 Months
- a. None or one 0
- b. Two or more ..... 1 ____

A7. Does the Primary Caregiver have a History of Abuse or Neglect as a Child?
- a. No 0
- b. Yes ..... 1 ____

A8. Does the Primary Caregiver have an Alcohol or Drug Abuse Problem that Contributed to the Incident?
- a. No 0
- b. Yes, drug or alcohol use 1
- c. Yes, both drug and alcohol use ..... 2 ____

A9. Do Caregiver(s) have Unrealistic Expectations of Children?
- a. No 0
- b. Yes, the secondary caregiver only 1
- c. Yes, the primary caregiver only 2
- d. Yes, both caregivers ..... 3 ____

A10. Do Caregiver(s) Use Excessive or Inappropriate Discipline?
- a. No 0
- b. Yes, the secondary caregiver only 1
- c. Yes, the primary caregiver only 2
- d. Yes, both caregivers ..... 3 ____

A11. Primary Caregiver's Relationship Problems with Other Adults
- a. Domestic violence/severe problems 2
- b. Harmful relationships/limited adult relationships 1
- c. No serious problems evident ..... -1 ____

A12. Caregiver(s) are Strongly Motivated to Improve Parenting Skills
- a. Yes, caregiver is strongly motivated; or no improvement necessary ..... -1
- b. Neither primary nor secondary caregiver is strongly motivated to improve parenting skills ..... 1 ____

TOTAL SCORE ____

APPENDIX B

Michigan Family Assessment of Needs

S1. Emotional Stability
- a. Appropriate Response 0
- b. Both Parents or Single Parent, Some Problems 3
- c. Chronic Depression, Severely Low Esteem, Emotional Problems . . . . . 5 ____

S2. Parenting Skills
- a. Appropriate Skills 0
- b. Improvement Needed 3
- c. Destructive/Abusive Parenting . . . . . 5 ____

S3. Substance Abuse
- a. No Evidence of Problem 0
- b. One Caretaker with Some Substance Problem 2
- c. One Caretaker with Serious Problem or Both Caretakers with Some Substance Problem 3
- d. Problems resulting in Chronic Dysfunction . . . . . 5 ____

S4. Domestic Relations
- a. Supportive Relationship/Single Caretaker 0
- b. Marital Discord, Lack of Cooperation 2
- c. Serious Marital Discord/Domestic Violence . . . . . 4 ____

S5. Social Support System
- a. Adequate Support System 0
- b. Limited Support System 2
- c. No Support or Destructive Relationships . . . . . 4 ____

S6. Interpersonal Skills
- a. Appropriate Skills 0
- b. Limited or Ineffective Skills 2
- c. Hostile/Destructive . . . . . 4 ____

S7. Literacy
- a. Adequate Literacy Skills 0
- b. Marginally Literate 2
- c. Illiterate . . . . . 3 ____

S8. Intellectual Capacity
- a. Average or Above Functional Intelligence 0
- b. Some Impairment, Difficulty in Decision Making Skills 2
- c. Severe Limitation . . . . . 3 ____

S9. Employment
- a. Employed or No Need 0
- b. Unemployed but Looking 1
- c. Unemployed, not Interested . . . . . 2 ____

S10. Physical Health Issues
- a. No Problem 0
- b. Health Problem or Handicap that Affects Family 1
- c. Serious Health Problems or Handicap that Affects Ability to Provide for or Protect Child . . . . . 2 ____

S11. Resource Availability/Management
- a. Sufficient Income to Meet Needs 0
- b. On Assistance/Intermittent Income 2
- c. Financial Crisis . . . . . 3 ____

S12. Housing
- a. Adequate Housing 0
- b. Some Housing Problems, but Correctable 1
- c. No Housing, Eviction Notice . . . . . 2 ____

S13. Child Characteristics
- a. Age Appropriate, No Problems 0
- b. Minor Physical, Emotional, Intelligence Problems 1
- c. Significant Problems that put Strain on Family 2
- d. Severe Problems Resulting in Dysfunction . . . . . 3 ____

Rhode Island Caretaker Needs Assessment

Score

1. Substance Abuse
   - 0 = No evidence of caretaker problem
   - 2 = Caretaker abuse creates some problems in family OR caretaker in treatment
   - 4 = Caretaker has serious abuse problem OR both caretakers have moderate problem

   _____

2. Emotional Stability
   - 0 = No evidence or symptoms of emotional instability or psychiatric disorder
   - 2 = Caretaker has moderate problems that interfere with functioning
   - 4 = Caretaker has problems that severely limit functioning OR both have moderate problems

   _____

3. Violence
   - 0 = No evidence of threatening or assaultive behavior toward family members by caretaker
   - 2 = Isolated incidents of past violent behavior, but no injury resulted
   - 3 = Current pattern of intimidation, isolation or threats of harm
   - 4 = Repeated assaultive behavior OR any incident resulting in injury

   _____

4. Intellectual Ability
   - 0 = No evidence of limitation in caretaker intellectual functioning
   - 2 = Caretaker has somewhat limited intellectual functioning
   - 4 = Caretaker's intellectual ability severely limits ability to function

   _____

5. Health
   - 0 = Caretaker has no known health problems that affect functioning
   - 2 = Caretaker has moderate disability/illness; impairs ability to care for child(ren)
   - 4 = Serious disability/illness; severely limits ability to care for children

6. Sexual Abuse
   - 0 = Caretaker has no known deficits in parenting skills
   - 1 = Caretaker is or has been a victim of sexual abuse
   - 3 = Caretaker a perpetrator (or alleged) of sexual abuse; received sex abuse therapy
   - 4 = Caretaker a perpetrator (or alleged) of sexual abuse; has not received sex abuse therapy

   _____

7. Parenting Skills
   - 0 = Caretaker has no known deficits in parenting skills
   - 1 = Caretaker needs improvement in basic skills
   - 3 = Caretaker repeatedly displays abusive, neglectful or destructive parenting patterns

   _____

Rhode Island Caretaker Needs Assessment Continued

Score

8. Environmental
   0 = Family as adequate housing, clothing and nutrition _____
   1 = Physical environment presents potential hazards to family members' health or safety
   2 = Conditions exist in household that have caused illness or injury
   3 = Family is homeless

9. Support System
   0 = Family has available, and uses, external support system or none needed _____
   1 = Needed, but resources limited or have some negative impact or caretaker reluctant to use
   2 = Needed, but caretaker unable to access internal or external resources (skill deficits)
   3 = Needed, but resources unavailable or have major negative impact or caretaker incarcerated

10. Financial
   0 = Family income sufficient to meet needs and is adequately managed _____
   1 = Income limited (including Public Assistance), but is adequately managed
   2 = Income insufficient or not well-managed; unable to meet basic needs or responsibilities
   3 = Family is in financial crisis - little or no income

11. Education/Literacy
   0 = Caretaker has at least basic education and functional literacy skills _____
   1 = Caretaker marginally educated or literate; creates some problems
   2 = Functionally illiterate; creates major problems

12. Child(ren) Problems
   0 = Child(ren) have no known emotional, behavioral, intellectual or physical problems _____
   1 = Child(ren) have minor problems, but little impact on functioning
   2 = Child(ren) have problems in one or more areas that sometimes limit functioning
   3 = One child has severe/chronic problems that result in serious dysfunction
   6 = Children have severe/chronic problems that result in serious dysfunction

Problem Areas (check all that apply):

____ substance abuse	____ emotional stability
____ health	____ peers
____ school behavior	____ intellectual ability
____ life/social skills	____ sex abuse issues
____ assaultiveness	____ status offending
____ delinquent behavior	____ support system