



The Structured Decision Making[®] Model: An Evidenced-based Approach to Human Services



Children's Research Center

Advancing Research...Improving Outcomes

A division of the National Council on Crime and Delinquency



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It appears inescapable that workers could carry out more economical and productive interviews and arrive at more helpful decisions if they knew what to focus on and which areas would yield the most significant data.

Golan, G. (1969). How caseworkers decide: A study of the association of selected applicant factors with worker decision in admission services. *Social Services Review*, 43, 289-296.

Preface

The Children's Research Center (CRC) was established to help state and local child welfare agencies reduce child abuse and neglect by developing case management systems and conducting research that improves service delivery to children and families. During the past 20 years, much of CRC's work has focused on the development, implementation, and refinement of its Structured Decision Making® (SDM) model for child welfare agencies. The SDM® model incorporates a set of evidence-based assessment tools and decision guidelines designed to provide a higher level of consistency and validity in the assessment and decision making processes and a method for targeting limited system resources to families who are most likely to subsequently abuse or neglect their children. The SDM model is now the most widely used case management model in the United States, and research has demonstrated its effectiveness.

The value of the SDM model has also been enhanced by its strong relationship to the federal Child and Family Services Reviews (CFSR). The CFSR incorporates a set of performance standards in the areas of child safety, well-being, and permanency that all states are expected to achieve. Many of the performance indicators (e.g., recurrence of maltreatment and length of time to achieve permanency) are precisely the outcomes that a well-implemented SDM system will help attain. While the SDM model is not a cure-all for the multiple issues confronting child welfare, it can and should be an integral component of any larger strategy for attaining compliance with federal mandates.

CRC has now worked with jurisdictions in over 20 states. CRC's work in child welfare assessment and decision making started in Alaska in 1986 and by the mid-1990s had quickly spread to Michigan, New Mexico, Indiana, Georgia, Wisconsin, and Rhode Island. Over the past decade, the use of the SDM model has continued to expand. With each new project, CRC has honed its understanding of the needs of child welfare agencies and what is required to successfully implement major organizational change. Over the past several years, CRC has focused increasingly on implementation issues and has instituted several new strategies for ensuring successful transition to

the SDM model, such as enhanced supervisory training, case readings to monitor the quality of implementation, and SDM management reports that provide feedback to agency managers and supervisors. In addition, CRC has assembled a substantial research database and developed systems for monitoring service delivery; improving efficiency; and measuring the effectiveness of child welfare policies, programs, and services.

CRC is a division of the National Council on Crime and Delinquency (NCCD), which was established in 1907 to assist private and public agencies serving delinquent youth. With offices in Oakland, California, and Madison, Wisconsin, NCCD is one of the oldest non-profit research and advocacy agencies in the United States. During the last three decades, NCCD/CRC has conducted research; evaluated programs; and developed case management systems for more than 200 state, county, or federal agencies. During this time, NCCD pioneered the use of structured decision making in juvenile and criminal justice agencies. After successful completion of a risk assessment model for Alaska's delinquent population in 1986, Alaska's Social Services agency asked NCCD to work with Child Protective Services (CPS) staff to devise a system that would provide the same level of structure for CPS. This initial project began NCCD's expansion of SDM principles and practices to the child protection field.

Improving CPS systems has been a formal part of NCCD's mission since 1993, when the Board of Directors authorized the creation of CRC. Many children who are abused or neglected later become involved in delinquent and criminal behavior, ending up in substance abuse programs, training schools, jails, and prisons. To stem the cycle of crime and violence in the United States, organizations like NCCD must focus on improving services to families and children. CRC'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 not only help protect children now but will also create a better, safer society for the future.

The Need for a Better Approach to Child Welfare Decision Making

Faced with severely limited resources, most child welfare agencies are hard-pressed to respond effectively to an increasing, and increasingly complex, volume of cases. The results have included burdensome workloads; high staff turnover; children falling through cracks in the system; frequent media exposés resulting from child deaths, lawsuits, and consent decrees; increased concerns over worker and agency liability; and a continuous search for new strategies and resources to address the burgeoning problem.

The need for additional resources is obvious, but that is not the only issue. The increasing pressures have highlighted a problem that has long plagued human services agencies in general and child welfare agencies in particular: the need for more efficient, consistent, defensible, and visible decision making. CPS workers are asked to make extremely difficult decisions, yet in many agencies, workers

The problems of increasing referrals, limited resources, and liability concerns are inextricably linked with decision making issues. Agencies overwhelmed by heavy workloads need to consistently and accurately determine *which* cases should be investigated, *which* children need to be removed, and *which* families require the most intensive services. Clearly, strategic assessments are needed to help agencies and workers make decisions as efficiently and effectively as possible. Workers need the help of tools to make accurate and reliable assessments of immediate safety issues and longer-term risk. Decision making strategies are needed to help focus limited resources on those families at higher levels of risk. These decision tools must be embedded in case management systems that incorporate clearly defined service standards, mechanisms for timely reassessments, methods for measuring workload, and mechanisms for ensuring accountability and quality controls.



The structured decision making process should help agencies, supervisors and individual workers prioritize cases and areas of concern within and among cases. Ideally, this will help focus resources on those clients who need them the most.

Lisa Fontes (Child Abuse and Culture: Working with Diverse Families) pp. 81-82

have widely different levels of training and experience. Consequently, decisions regarding case openings, child removal and reunification, and other service-related issues have long been criticized as inappropriate, inconsistent, or both. In fact, research has demonstrated that decisions regarding the safety of children vary significantly from worker to worker, even among those considered to be child welfare experts (Rossi et al., 1996). As pressure to make critical decisions affecting children and families rises, so does the potential for error. Inappropriate decisions can be costly, leading to an overuse of out-of-home placements, or tragic, resulting in the injury or death of a child.

How child welfare decisions are made and how agency resources are utilized are the key issues addressed by the SDM model. While the model cannot address all the substantive issues facing the child welfare system, the current crisis cannot be overcome until the issues surrounding child welfare decision making are confronted. CRC believes that when the SDM model is properly implemented, it provides a foundation that can significantly enhance child safety, well-being, and permanency. The SDM model is based on work completed or underway in jurisdictions ranging from California to Rhode Island to Queensland, Australia (see Figure 1).

Structured Decision Making®: Enhancing Child Safety, Well-being, and Permanency

PRINCIPLES OF THE SDM® MODEL

1. **Decisions can be significantly improved when they are structured appropriately; that is, specific criteria must be considered for every case by every worker through highly structured assessment procedures.** Failure to clearly define decision making criteria and identify how workers are to apply these criteria results in inconsistencies and, sometimes, inappropriate case actions.
2. **The system must be comprehensive, helping agencies achieve their mandated goals of safety, well-being, and permanency.**
3. **Priorities given to cases must correspond directly to the results of the assessment process. Expectations of staff must be clearly defined and practice standards must be readily measurable.** Case decisions should result in providing resources to families and children who need them—the most serious and/or highest risk cases are given the highest agency priority. Moreover, if prioritization is to be translated into practice, there must be clearly identified and implemented differential service standards associated with each type of case. Service standards, differentiated by level of risk, provide a level of accountability that is often missing in human services organizations.
4. **Virtually everything an agency does, from providing services to an individual case to budgeting for treatment resources, is a response to the assessment process.** Risk and needs assessments should be directly linked to service plans. In the aggregate, assessment data will also help indicate the range and extent of service resources needed in a community. Similarly, assessment and case classification results are tied directly to agency service standards, which in turn drive staff workload and budgeting issues.

While these principles outline the basis for the SDM system, CRC recognizes that all state and county child welfare agencies are not organized to deliver services in the same way and do not always share similar service mandates. As a result, CRC’s approach to system development is a collaborative one in which agencies are engaged in a joint development effort. Each system is built on a set of principles and components that are then adapted to local practices and mandates, incorporating a great deal of input from local managers and staff. The result is a site-specific system that is “owned” by the agency and builds upon its strengths as a service organization.

FIGURE 2 Structured Decision Making® Goals and Objectives

Goals
Reduce subsequent harm to children <i>Re-referral, re-substantiation, injury, foster placement</i>
Reduce time to permanency
Objectives
Introduce structure to critical decision points
Increase consistency and validity of decisions
Target resources on families most at risk
Use aggregated assessment and decision data to inform agency-wide monitoring, planning, and budgeting

SDM® MODEL COMPONENTS

The SDM model has several basic components. At the heart of the system is a series of tools used to assess families and structure agency response at specific decision points in the life of a case, ranging from intake to reunification.

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

The model also includes two management-related components: a workload measurement and accounting system, which determines staff needs for workload demand and equitable workload distribution, and a management information component that uses aggregate family assessment data; agency response/decision data; and workload data to assist managers in planning, monitoring, budgeting, and evaluation.

SDM® TOOLS

Most important decisions in life require us to analyze, weigh, and synthesize a large body of information. Some of the most critical issues people face require an estimation of the likelihood of a future event. These include estimating

the likelihood of recidivism (gauging the probability of a parolee committing another crime) or estimating the probability of future serious illness (deciding whether to undertake preventive medical measures). However, decision making is even more complex when the essential information is unavailable or of questionable accuracy, when the decision maker has limited knowledge of the topic or problem, or when there is insufficient time to fully analyze and assimilate the relevant information. Clearly, the higher the degree of uncertainty, the greater the potential for error. In each instance, gathering and correctly analyzing *relevant* information increases the level of confidence in the decision. Nearly every discipline, ranging from medicine to meteorology, has discovered that experience in the field is not enough—statistical analysis and statistical modeling can substantially improve decision making.

Decision theory provides a framework for the development of tools and protocols that can enhance the efficacy of child welfare case decisions. The first critical step in developing a decision making protocol is to break large, complex decisions into their component parts.¹ This tenet is central to the design of the SDM model.

The SDM model uses different tools for each decision point because there are different issues that need to be addressed at each stage of the case. No single instrument can successfully capture or organize the disparate issues that must be considered at each distinct point of case



In California, the implementation of the SDM system was critical for three major reasons: 1) to establish consistency in decision making across counties and units; 2) to ensure that services are targeted to children most at risk of harm; and 3) to evaluate effectiveness through data and management reports. While other screening and risk assessment systems purport to do this, only CRC's SDM model has developed the research, tools, worker and data input, and reporting necessary for a valid and reliable system.

Marj Kelly, former Deputy Director, California Department of Social Services

processing. SDM tools and their relationship to the central mandates of child welfare, safety, well-being, and permanency, are presented below. Each section documents both the objectives of each tool and the evidence that supports its use.

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

A Research Basis for All SDM® Assessments

Different methods are used to develop SDM assessments. Some are empirically based (e.g., risk assessment), meaning that the items on the instrument are derived directly from research results. Others (e.g., safety assessment) are consensus models, while others still are a blend of research, consensus, and policy (e.g., reunification assessment). However, all SDM tools are subject to ongoing monitoring and evaluation to determine if they function as intended. Collecting and analyzing data in this manner for each of the SDM tools provides CRC and the host jurisdiction with evidence needed to confirm the efficacy of the instrument or to make necessary revisions. Ongoing evaluation of SDM tools ensures a process of continuous quality improvement and the use of assessment tools that are evidence-based.

SAFETY

Ensuring the safety of children is the core mission of child welfare agencies and is consequently a focus of the federal mandates reflected in the CFSR. Several SDM tools are designed to evaluate safety-related issues. *Each is used at different points in time, and each has a somewhat different focus.* This is to ensure that decisions are based on what information is essential at each decision point and what can be reliably gathered at that point. What can and should be considered when a referral is received is different from what can be assessed when a worker actually arrives onsite. This, in turn, is far less than what is known at the end of an investigation and development of a social history.

Together, SDM assessments constitute a formal, continuous, and iterative process of determining current and potential threats to child safety. These assessments include the response priority assessment, safety assessment, risk assessment, risk reassessment, and a reunification assessment for children in out-of-home care.

Response Priority: Responding to Allegations of Abuse/Neglect

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

The SDM intake tools clearly identify factors that determine if and how quickly staff should respond to new child abuse/neglect referrals. This results in greater consistency among workers and also permits administrators to easily convey the criteria they use to decide how the agency deals with abuse and neglect referrals. In addition, classifying and prioritizing referrals facilitates attainment of the CFSR safety indicator regarding the timeliness of investigations.

An example of a response priority decision system is shown in Figure 3. This “decision tree” approach incorporates and prioritizes critical factors and leads staff to a decision about the speed of the response. Separate decision trees are used for each allegation type.

As part of its quality improvement effort, CRC continuously evaluates the efficacy of the response priority system. Recently, using over 10,000 California referrals, CRC compared subsequent removal rates among cases that were designated for immediate response at intake (i.e., within 24 hours) with those that were determined not to be emergency situations (i.e., a ten-day response time). If the response priority tools were accurately selecting cases that needed an immediate response, the removal rate for those cases should be significantly higher than the removal rate for ten-day responses. Indeed, that was the case: the removal rate among 24-hour response cases was quadruple the rate for the ten-day response cases (13.0% vs. 3.0%).

FIGURE 3

**CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM[®] RESPONSE PRIORITY**

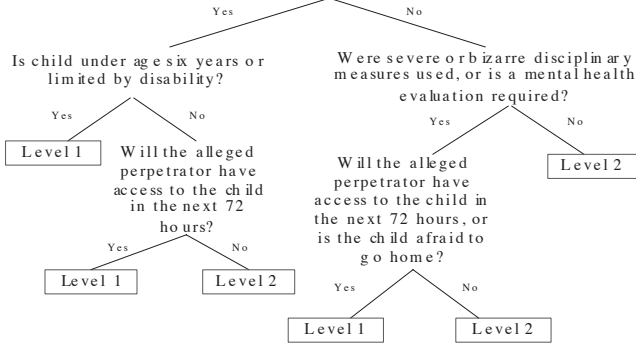
Case Name: _____ LINK #: _____ Report Time: ____:____ a.m./p.m.

Area Office: _____ Worker: _____ Report Date: ____/____/____

Current report – complete for each alleged maltreatment type

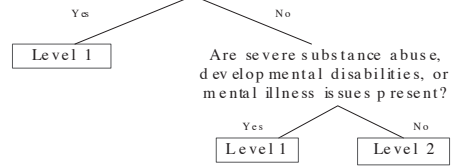
PHYSICAL/EMOTIONAL ABUSE

Are significant bruises, contusions, or burns evident, or is medical/mental health care required?



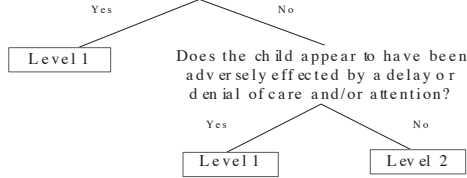
GENERAL NEGLIGENCE

Is the living situation immediately dangerous or unhealthy, and/or is any child currently left unsupervised who is under age eight years and/or limited by disability?



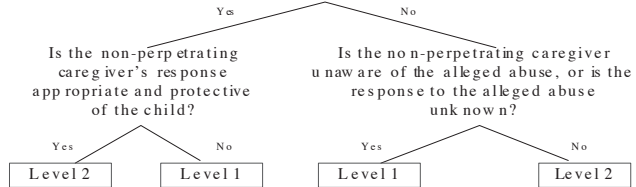
MEDICAL/EMOTIONAL/MORAL/EDUCATIONAL NEGLIGENCE

Does the child appear seriously ill or injured, or is the child in need of immediate care or attention?



SEXUAL ABUSE

Does the alleged perpetrator have access to the child, or is the child afraid to go home?



Assigned Response (select one level): Level 1 = within 24 hours
 Level 2 = within 72 hours

Policy Overrides:

Increase to Same Day whenever:

- Situations in which failure to respond immediately could result in death of, or serious injury to, a child; a report of abuse from a school, etc.

Increase to 24 hours whenever:

- Law enforcement is requesting immediate response
- Forensic considerations would be compromised by slower response
- There is reason to believe that the family may flee

Decrease to 72 hours whenever:

- Child safety requires a strategically slower response
- The child is in, and will likely remain in, an alternative safe environment for at least 72 hours
- The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period

Discretionary Override:

- Increase OR
 - Decrease response level
- Reason for Override: _____

Final Response (select one):

- Same Day
- Level 1 (24 hours):
- Level 2 (72 hours)

Hotline Worker: _____ Date: ____/____/____

(If an override results in a decreased response level)

Supervisor Approval: _____ Date: ____/____/____

These data also illustrate how “stakes” issues influence system design. Although the majority of cases where an immediate response was required did *not* have serious safety issues identified, the “facts” of the report, usually conveyed by phone, were such that an immediate response was appropriate. In essence, the “uncertainty” prevalent at this stage of information-gathering mandates the need for a conservative approach. Few issues incur a harsher public reaction than an agency’s failure to respond appropriately when notified that a child is in harm’s way.

Safety Assessment: Gauging Threats of Imminent Danger to Children

Perhaps the most critical decision facing child welfare workers is whether to leave an abused or neglected child in the home while services to reduce risk of harm are implemented. It is a difficult decision with major implications for the safety of children, their long-term psychological development, family functioning, worker liability, and the professional image of the agency. Yet, as documented in a major national study of child welfare decision making, there is no consistent agreement among child welfare workers and experts about the conditions that warrant removal from the home. Sadly, one of the key study findings was that “a family’s chances of having a child taken into custody varies widely according to the person who is assigned to investigate that case.”²

To address this concern, the SDM model incorporates a safety assessment protocol (see Figure 4) that is adapted from a model originally used in New York State. This tool has the following purposes:

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

At the first contact with the family, staff must be able to assess child safety concerns and develop and implement appropriate safety plans. The safety assessment facilitates these tasks by requiring workers to focus attention on a set of clearly defined conditions that potentially represent a threat to child safety and identify the interventions needed to control and remediate any unsafe conditions. Children are considered to be “unsafe” when *any* safety threat is present *and* the only intervention considered sufficient to protect them is removal. The safety assessment is also

completed when considering returning a child to his/her home after being removed. The purpose and structure of the SDM safety assessment is directly related to CFSR safety performance indicators including: 1) recurrence of maltreatment and 2) the provision of services to protect children in their homes.

Although there have been some attempts to broaden the role of safety assessments, available evidence indicates safety “checklists” *should be used solely to evaluate current circumstances*. The planning portion of the instrument should identify steps needed to ensure safety and well-being of the children while additional data are collected and analyzed. These tools were not designed to measure the likelihood of future harm (or “emerging danger”), and there is little data available to suggest that they do this effectively.



It is difficult to directly evaluate the efficacy of safety assessments. In general, they attempt to help workers gauge whether or not children may be harmed in the very near future (i.e., within the next 30-60 days). As a result, validation research is hampered by low rates of recurrence that occur within short timeframes. These rates are further diminished by the fact that many children judged “unsafe” are removed from their homes, often for the entire follow-up period. However, large databases from several states do provide other means for judging the efficacy of safety assessments. For example, from January 1 to June 30, 2006, California workers identified 66,300 families where there was at least one threat to child safety, but a safety plan was developed so the child could remain in the home rather than be protectively placed. Thirty days later, only 1.3% of these families required protective place-

ment, while 98.7% successfully prevented removal. Data produced by states using both safety and risk assessments also demonstrate relatively strong correlations between the two instruments. Since the risk assessments have been validated, this finding can be viewed as a measure of construct validity for safety assessments. For example, CRC has repeatedly analyzed the relationship between safety and risk by examining the extent to which families at various levels of long-term risk were *also* identified as having significant safety factors present. As would be expected, the results show that safety and risk are related: cases assessed as very high risk are about ten times more likely than low risk cases to also have had children removed from the home due to an imminent threat. While not definitive, these findings strongly suggest that SDM safety assessments are in fact addressing the issues relevant to the potential for imminent harm.

Risk Assessment: The Potential of Future Harm

With the child's immediate safety issues resolved, there is now time to evaluate the long-term likelihood of child maltreatment. This assessment will influence the decision on whether or not to open a case for services and establish the level of contact required to ensure that the child is safe.

The SDM family risk assessment is a research-based tool that estimates the likelihood that a family will abuse or neglect a child in the future.

The SDM risk assessment indices are the result of research that examined the relationship between family characteristics and child welfare case outcomes. They incorporate a range of family characteristics that are correlated with subsequent child abuse/neglect referrals, substantiation, placement, and injury. 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 tools are used to assess the future probability of abuse and neglect. Figure 5 shows the empirically based abuse and neglect risk assessment developed for California in 2003.

Because these tools are products of research on the actual experience of families previously reported to the agency, it is possible to assess risk with a reasonably high degree of accuracy. Moreover, because they are research-based, risk assessments do not have to incorporate a comprehensive list of every conceivable variable that might be related to outcomes. Instead, they are limited to a set of items that have a demonstrated relationship with actual case outcomes.³

The risk assessment concept is simple. The instrument is used to classify families into risk groups with very high, high, medium, or low probabilities of continued abuse or neglect to their children. For instance, in many of

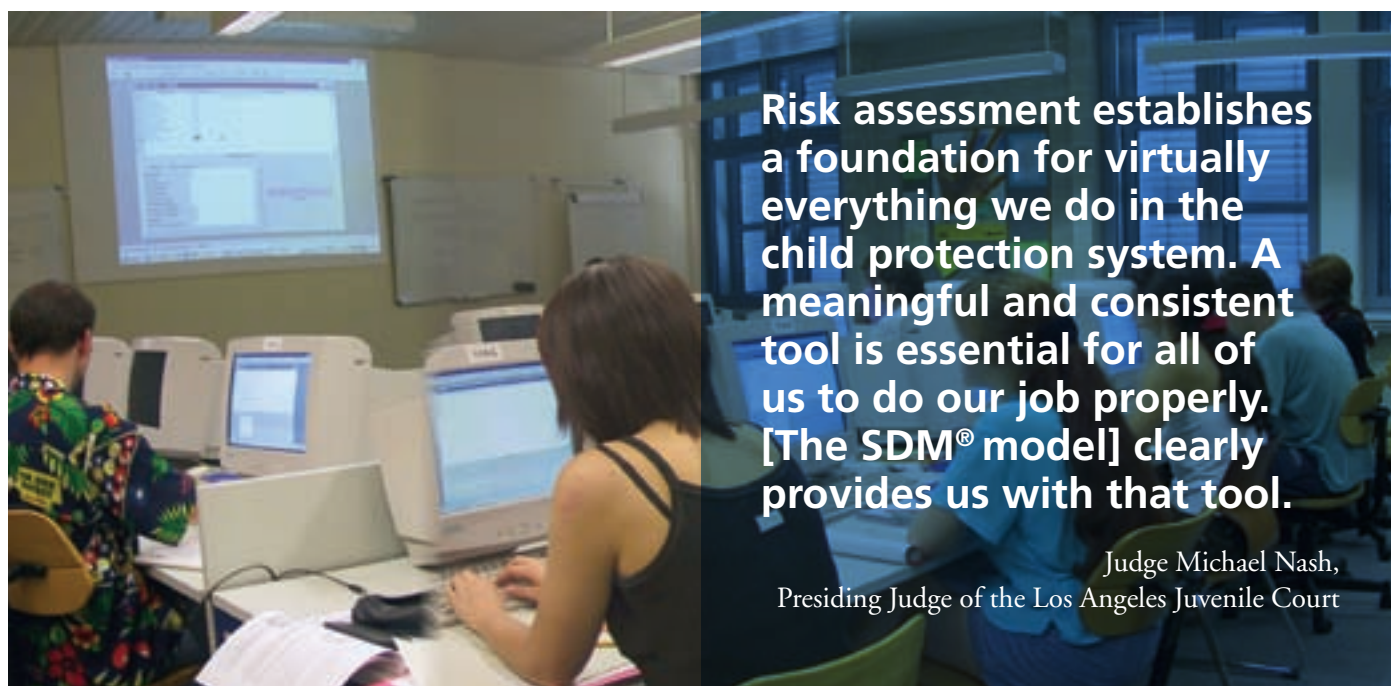


FIGURE 5

CALIFORNIA FAMILY RISK ASSESSMENT

Referral Name: _____ Referral #: _____ Date: ____/____/____

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

NEGLECT	Score	ABUSE	Score
N1. Current complaint is for neglect a. No.....0 b. Yes.....2	_____	A1. Current physical abuse complaint is substantiated a. No.....0 b. Yes.....1	_____
N2. Prior investigations (<i>assign highest score that applies</i>) a. None.....-1 b. One or more, <u>abuse</u> only.....1 c. One or two for <u>neglect</u>2 d. Three or more for <u>neglect</u>3	_____	A2. Number of prior abuse investigations (<i>number: _____</i>) a. None.....0 b. One.....1 c. Two or more.....2	_____
N3. Household has previously received CPS (<i>voluntary/court-ordered</i>) a. No.....0 b. Yes.....3	_____	A3. Household has previously received CPS (<i>voluntary/court-ordered</i>) a. No.....0 b. Yes.....2	_____
N4. Number of children involved in the CA/N incident a. One, two, or three.....0 b. Four or more.....2	_____	A4. Prior injury to a child resulting from CA/N a. No.....0 b. Yes.....2	_____
N5. Age of youngest child in the home (Age = ____) a. Two or older.....0 b. Under two.....1	_____	A5. Primary caregiver's assessment of incident (<i>score 1 if any present</i>) a. Not applicable.....0 b. One or more present (<i>check all applicable</i>).....1 ____ Blames child, and/or ____ Justifies maltreatment of a child	_____
N6. Primary caregiver provides physical care inconsistent with child needs a. No.....0 b. Yes.....1	_____	A6. Two or more incidents of domestic violence in the household in the past year a. No.....0 b. Yes.....1	_____
N7. Primary caregiver has a history of abuse or neglect as a child a. No.....0 b. Yes.....2	_____	A7. Primary caregiver characteristics (<i>score 1 if any present</i>) a. Not applicable.....0 b. One or more present (<i>check all applicable</i>).....1 ____ Provides insufficient emotional/psychological support ____ Employs excessive/inappropriate discipline ____ Domineering caregiver	_____
N8. Primary caregiver has/had a mental health problem a. None/Not applicable.....0 b. One or more apply.....1 ____ During the last 12 months AND/OR ____ Prior to the last 12 months	_____	A8. Primary caregiver has a history of abuse or neglect as a child a. No.....0 b. Yes.....1	_____
N9. Primary caregiver has/had a drug or alcohol problem a. None/Not applicable.....0 b. One or more apply.....2 ____ During the last 12 months AND/OR ____ Prior to the last 12 months	_____	A9. One or more caregiver(s) has/had an alcohol and/or drug problem a. No.....0 b. Yes (<i>check all applicable</i>).....1 During the last 12 months: [] Primary caregiver [] Secondary caregiver Prior to the last 12 months: [] Primary caregiver [] Secondary caregiver	_____
N10. Primary caregiver has criminal arrest history a. No.....0 b. Yes.....1	_____	A10. Primary caregiver has a criminal arrest history a. No.....0 b. Yes.....1	_____
N11. Characteristics of children in household (<i>score 1 if any present</i>) a. Not applicable.....0 b. One or more present (<i>check all applicable</i>).....1 ____ Developmental or physical disability ____ Medically fragile/failure to thrive ____ Positive toxicology screen at birth	_____	A11. Characteristics of children in household (<i>score 1 if any present</i>) a. Not applicable.....0 b. One or more present (<i>check all applicable</i>).....1 ____ Delinquency history ____ Developmental disability ____ Mental health/behavioral problem	_____
N12. Current housing a. Not applicable.....0 b. One or more apply.....1 ____ Physically unsafe, AND/OR ____ Family homeless	_____		
TOTAL NEGLECT RISK SCORE	_____	TOTAL ABUSE RISK SCORE	_____

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

<u>Neglect Score</u>	<u>Abuse Score</u>	<u>Scored Risk Level</u>
_____ -1 - 0	_____ 0 - 1	_____ Low
_____ 1 - 3	_____ 2 - 4	_____ Moderate
_____ 4 - 8	_____ 5 - 8	_____ High
_____ 9 +	_____ 9 +	_____ Very High

POLICY OVERRIDES. Circle yes if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.
 Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
 Yes No 2. Non-accidental injury to a child under age two years.
 Yes No 3. Severe non-accidental injury.
 Yes No 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, circle yes, increase risk by one level, and indicate reason.

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

Supervisor's Review/Approval of Discretionary Override: _____ Date: ____/____/____

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

CRC’s risk assessment studies, it has often been possible at the completion of the investigation to identify “high risk” families who have a 50.0% 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 10.0% or lower.

Figure 6 illustrates results from a 2003 risk validation study that CRC conducted in California. A random sample of over 5,600 families referred to child welfare from several California counties was included in the research. As illustrated, there is a strong relationship between risk level and both outcome measures: as the assessed risk level increases, so does the percentage of families who subsequently recidivate.

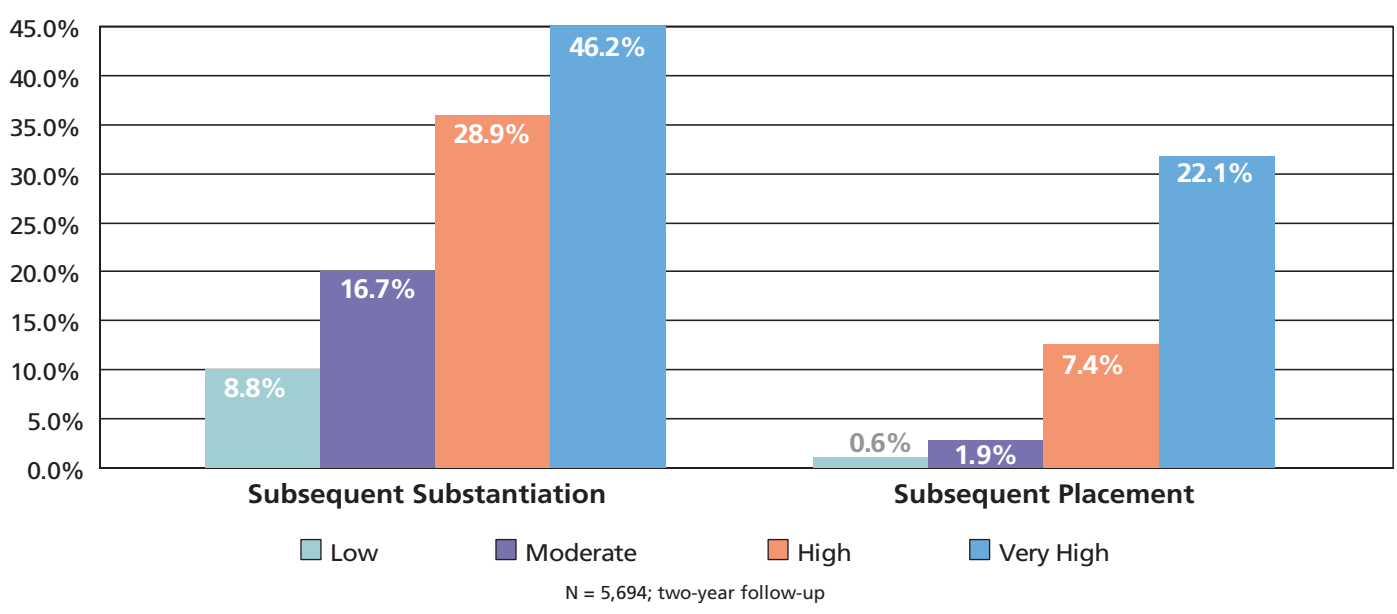
For example, the data show that among families classified as low risk, less than one in ten (8.8%) had a subsequent substantiated referral for abuse or neglect during the 24-month follow-up period. In contrast, among families classified as very high risk, almost half (46.2%) had a new substantiation during that same time period. In other words, the very high risk families were over five times more likely than the low risk families to re-abuse or re-neglect their children. Similarly, almost none of the low risk families experienced a subsequent removal, but almost one fourth of the very high risk families subsequently had a child removed. It is clear that maltreatment experienced

by children in high risk families is both more frequent and more severe.

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

In many child welfare agencies, inexperienced workers, minimal training, and high staff turnover all but guarantee that clinical judgments of risk will vary widely among workers. Line staff often fail to identify high risk families during abuse/neglect investigations and therefore do not engage them in services.⁴ CRC research shows that in some agencies using traditional assessment methods, many (in some instances, most) high risk cases are *not* opened for services, while many low risk families are carried on caseloads for years. The result is that agencies are losing the opportunity to prevent abuse in the families who are most at risk. By using actuarial risk assessment, child welfare agencies can directly address this issue and significantly improve the initial case service decisions made by individual workers.

FIGURE 6 California Risk Validation Subsequent Substantiation and Placement Rates by Risk Level (2003)



Risk Assessment and Equity

In all CRC studies to date, the developed risk systems also promote equity in decision making. Because equity is a major principle of the development process, the proportion of various races and ethnic groups assigned to each risk level is virtually identical in all jurisdictions. These results suggest that well-structured assessment tools and decision making systems can help overcome some of the racial disparities resulting from traditional practices. In fact, a recent comprehensive evaluation of the impact of SDM risk assessment on equity concluded the following:

Collectively, the findings reported here support two hypotheses: 1) the California family risk assessment (CFRA) is a fair and equitable means of assessing the likelihood of future maltreatment when used with major U.S. population subgroups – African Americans, Hispanics, and Whites; and 2) use of the CFRA will reduce disproportionate representation of minorities, including African Americans, relative to Whites in the child welfare population.⁵

Risk Assessment and CFSR Outcomes

Under federal child safety outcome requirements, states are expected to reduce the rate of recurrence (new substantiated reports) to 6.1% or less at six months from the date of the initial substantiation. To comply with these standards, it is helpful for states to be able to accurately identify families at the highest risk of maltreating a child within

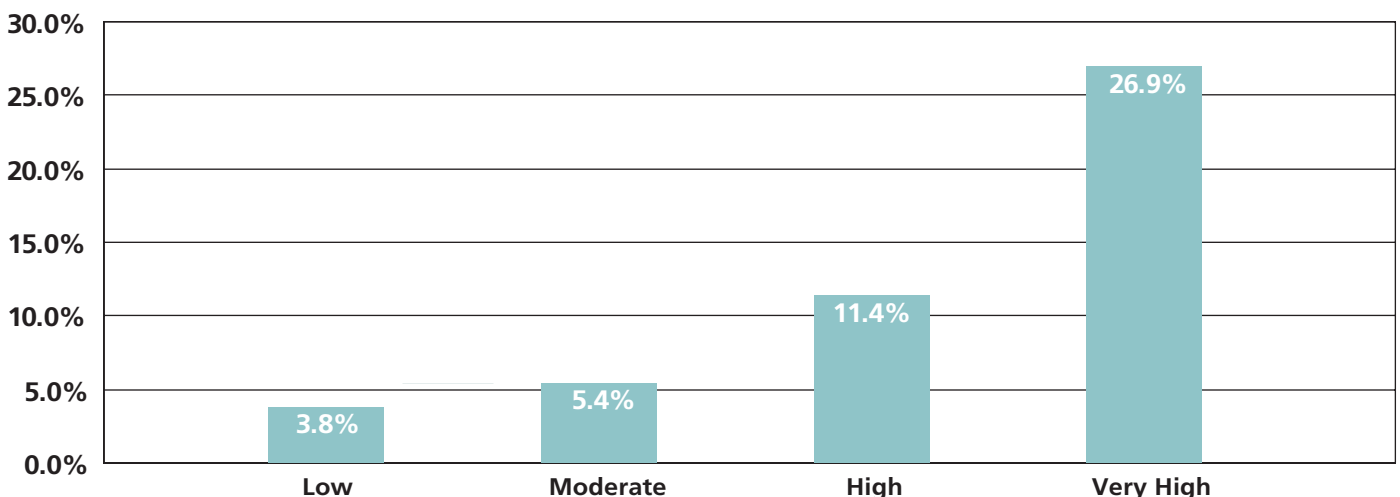
the six-month timeframe. Figure 7 illustrates that actuarial risk assessment provides such capability.⁶

In his California study, Johnson analyzed first referral cases that were substantiated but closed without services. This cohort was selected in order to avoid any possible “service effect.” Johnson found that families at the two lowest risk levels had six-month recurrence rates below the 6.1% federal threshold (without any intervention), while high and very high risk cases had recurrence rates substantially higher than 6.1%. Successful intervention with the higher risk families could therefore help agencies meet the federal standards.

Risk Reassessment: Evaluating Progress of the Service Plan

Response priority, safety, and risk assessment tools address child safety issues from various perspectives during the referral and subsequent investigation process. But for cases that are opened for services, safety and risk concerns remain an issue for the cases’ duration. Moreover, conditions change during the course of intervention: new information about the family may emerge, family composition and circumstances may change, and family members may address (or refuse to address) the underlying problems that led to the abuse or neglect. For these reasons, the SDM model incorporates a formal risk reassessment that is designed to capture any changes in the family situation that may affect the initial risk level. Ultimately, risk

FIGURE 7 Substantiated Maltreatment Recurrence within Six Months of Initial Referral in California



N = 2,033

Note: Cases analyzed were substantiated reports closed after investigation.

Source: Johnson, 2004

reassessments are part of the iterative SDM process that continuously revisits the question of child safety.

Risk reassessments are routine, structured, and intended to drive important decisions about the case. They typically occur at 90-day intervals after a case is opened. The reassessment is different from the initial risk indices in that: 1) it uses a single index (instead of two), 2) it focuses on family functioning and behavior during the period since the last assessment, and 3) it places major emphasis on the caregivers' progress in relation to the case plan. In short, it asks the question, "Based on everything we now know about this family, what is the current level of risk?" This information is then used to structure critical decisions about the case, such as whether to continue services or close the case; and if services will continue, whether to increase or decrease the intensity of supervision and services.

WELL-BEING

The federal Adoption and Safe Families Act (ASFA) specified child and family well-being as one of the three overall goals. Although considerable debate and a lack of clarity remains over exactly how to measure well-being, the legislation provided some basic guidance by indicating: 1) that families should have an enhanced capacity to address their children's needs; and 2) that children should receive adequate services to address their educational, health, and mental health needs. Clear and consistent identification of what those needs are—and the translation of those needs into an effective service plan—is the purpose of the SDM family strengths and needs assessment. The service plan is simply the response to assessment, identifying actions needed to ensure well-being.

Family Strengths and Needs Assessment: Determining Service Needs

SDM family strengths and needs assessments typically have two components—one that assesses the caregiver, and one that assesses all children in the family. The caregiver strengths and needs assessment (see Figure 8) was designed using a consensus approach in collaboration with staff from jurisdictions in California and Virginia. This and similar tools serve 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 provides a basis for prioritizing the most pressing needs and thereby helps avoid the laundry list approach to case planning.
- It provides a basis for monitoring whether appropriate service referrals are made.
- When followed by periodic reassessments, it permits caseworkers and supervisors to easily assess change in family functioning and thus monitor the impact of



services on the case.

- It provides management with aggregated information on the issues that families face. These profiles can then be used to develop resources to meet client needs.

These same purposes are served by the child strengths and needs assessment, which assesses children in areas such as emotional/behavioral, medical/physical, and educational functioning.

FIGURE 8

**VIRGINIA DEPARTMENT OF SOCIAL SERVICES: SECOND PHASE PILOT
SDM[®] FAMILY STRENGTHS AND NEEDS ASSESSMENT/REVIEW**

OASIS Case Name: _____ Case #: _____ Referral Date: ____/____/____ FIPS Code: _____
 Worker Name: _____ Supervisor: _____ Date Case Opened: ____/____/____
 Assessment/Review Date: ____/____/____ Initial _____ Review # 1 2 3 4 _____
 Primary Caretaker: _____ Secondary Caretaker: _____

		Caretaker Score	
		Primary	Secondary
SN1. Substance Use or Abuse	(Substances: alcohol, illegal drugs, inhalants, and prescription or over-the-counter drugs.)		
a.	Teaches and demonstrates healthy understanding of alcohol and drugs	+3	
b.	Alcohol or prescribed drug use or no use.....	0	
c.	Alcohol or drug abuse.....	-3	
d.	Alcohol or drug dependency	-5	
	If C or D, indicate which substances caretaker abuses: _____		
<hr/>			
SN2. Emotional Stability			
a.	Positive emotional stability	+3	
b.	No evidence or symptoms of emotional instability	0	
c.	Mild to moderate emotional instability	-3	
d.	Chronic or severe emotional instability	-5	
<hr/>			
SN3. Sexual Abuse			
a.	Teaches and demonstrates healthy understanding of sexuality and sexual boundaries	+3	
b.	No evidence that caretaker sexually abuses or fails to protect child from sexual abuse.....	0	
c.	Moderate problems related to sexuality in family; unclear sexual boundaries.....	-3	
d.	Caretaker has abused a child sexually OR has failed to protect a child from sexual abuse.....	-5	
<hr/>			
SN4. Resource Management and Basic Needs			
a.	Resources sufficient to meet basic needs and are adequately managed	+2	
b.	Resources may be limited but are adequately managed	0	
c.	Resources are insufficient or not well-managed	-2	
d.	No resources, or resources severely limited and/or mismanaged.....	-4	
<hr/>			
SN5. Parenting Skills			
a.	Strong skills	+2	
b.	Adequately parents and protects child	0	
c.	Inadequately parents and protects child	-2	
d.	Destructive or abusive parenting.....	-4	
<hr/>			
SN6. Household Relationships/Domestic Violence			
a.	Supportive.....	+2	
b.	Minor or occasional discord.....	0	
c.	Frequent discord or some domestic violence	-2	
d.	Chronic discord or severe domestic violence.....	-3	
<hr/>			
SN7. Caretaker Abuse or Neglect History			
a.	Abuse or neglect as a child, demonstrates good coping ability	+2	
b.	No abuse or neglect as a child.....	0	
c.	Minor problems related to abuse or neglect as a child	-2	
d.	Serious problems related to abuse or neglect as a child	-3	
<hr/>			
SN8. Social or Community Support System			
a.	Strong support system.....	+1	
b.	Adequate support system	0	
c.	Limited or somewhat negative support system	-1	
d.	No support system or negative support system	-3	
<hr/>			
SN9. Physical Health			
a.	Preventive health care is practiced.....	+1	
b.	Health issues do not affect family functioning.....	0	
c.	Health concerns or disabilities affect family functioning.....	-1	
d.	Serious health concerns or disabilities result in inability to care for child	-2	
<hr/>			
SN10. Communication Skills			
a.	Strong skills	+1	
b.	Functional skills.....	0	
c.	Limited skills	-1	
d.	Severely limited skills.....	-2	

Caretaker: Priority Needs

1. _____
 2. _____
 3. _____

Caretaker: Priority Strengths

1. _____
 2. _____
 3. _____

PERMANENCY

In addition to child safety and well-being, the ASFA emphasizes the importance of expediting permanency for children who have been placed in foster care. The legislation shortened the timeframes for making permanency decisions in order to avoid children languishing in out-of-home care. It also required courts and child welfare agencies to conduct more thorough reviews of the permanency goal and the permanency plan at each review hearing. The foster care component of the SDM model—which relies on the principles of standardized assessment and structured decision making—was designed to help states effectively translate federal policies regarding permanency into practice.

Reunification Assessment: Returning Children Home

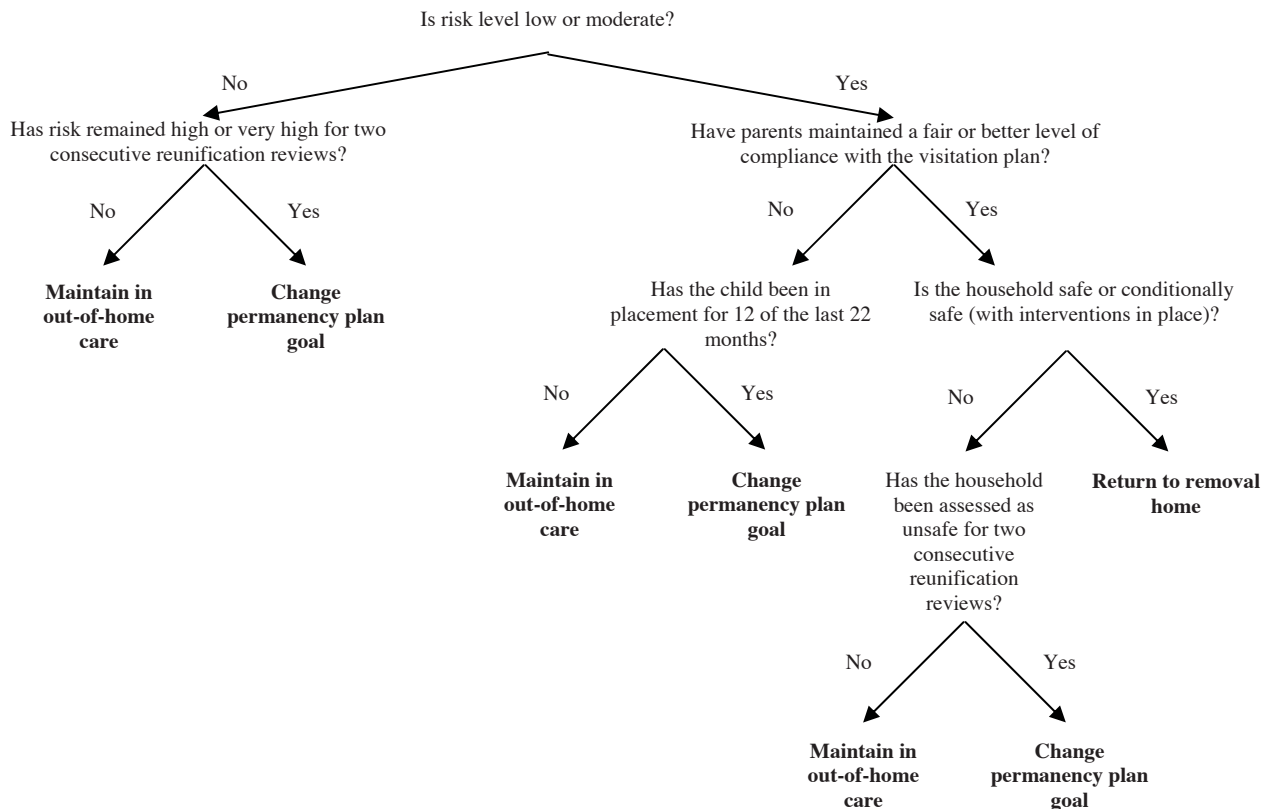
The SDM reunification assessment establishes presumptive decision guidelines for children in care based on the risk of future maltreatment, the safety of the home environment, and demonstrated parental interest and involvement in the lives of their children. It is a “best practice” guide

that facilitates implementation of the federal legislation while leading to more consistent and appropriate decision making. While every agency will need to modify this component of the model based on its policies and terminology, the overall logic of the system is universally applicable. The system presumes the following:

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

In the foster care model, the *initial* risk level is established using the research-based risk assessment. The risk *reassessment* assumes that risk is reduced when the family has made significant progress toward treatment goals. The reassessment scoring system generally precludes consider-

FIGURE 9 Placement/Permanency Plan Guidelines



ation of reunification if there had been *any new substantiations* of maltreatment for any child in the household since the previous assessment.

The reunification model consists of four assessment components:

- A structured risk reassessment.
- A structured evaluation of the quality and quantity of parent/child visitation.
- A reunification safety assessment.
- Structured guidelines for returning the children home or changing the permanency planning goal.

As shown in Figure 9, the results of the structured assessments are jointly considered to guide decisions about returning a child to the home or changes to the permanency plan. This is presented as an example. In practice, CRC staff work with each agency to develop a protocol that incorporates criteria reflective of key local policies and regulations.

Evaluation results have demonstrated that the use of the structured reunification assessment helps a larger percentage of children achieve permanency within 15 months⁷ when compared with traditional methods of making permanency decisions. An addendum also reported that children who were returned home as recommended by the SDM system were less likely to reenter foster care during a one-year follow-up period.⁸

INTEGRATING THE SDM® MODEL WITH CASE PRACTICE

Unquestionably, using reliable and valid decision tools is fundamental to effective agency practice. CRC recognizes that it is also important to incorporate tools into quality case practice. SDM tools are not designed as interview guides; rather, they are a culmination of the assessment process and help to both focus the direction of inquiry and organize the information collected, leading to a likely plan of action. The quality of the information gathered increases as workers use effective interviewing skills and as they are able to engage the family in the assessment and planning process.

For example, a worker using an SDM risk assessment would meet the family using good, culturally appropriate engagement skills. He/she would ask the family to tell their story in their own words. He/she would ask about both what is working well and what struggles the family

faces. Throughout, the worker is sorting the information into the various risk items. Aware of any gaps in knowledge, the worker asks increasingly focused questions. Collateral interviews may be necessary to gather different perspectives. SDM tools can and should be used in conjunction with the family to the greatest extent possible.

By design, SDM assessments do not MAKE decisions. The recommended result of an SDM assessment should be tested against family perspective and worker clinical judgment. When all are aligned, the direction is clear. When there are differences, the SDM model provides a framework for dialogue until there is resolution. That resolution may be revising responses to items based on better understanding of the facts; helping the family to reach a more accurate awareness of the issues they face; or as a last resort, determining that child safety requires court intervention.

THE MANAGEMENT COMPONENTS OF THE SDM® MODEL

In addition to providing greater consistency in decision making and more efficient use of resources, the SDM model includes three components designed to facilitate management and administration of child welfare agencies. These components (resource requirement identification, workload measurement, and management information reports) help maximize the utility of the SDM model.

Identifying Resource Requirements

Not all families involved in child abuse or neglect incidents require the same level of child welfare services. Yet in terms of case assignment and resource allocation, many child welfare agencies treat each case the same. Hence, services are sometimes provided to families who will not benefit



from them, while other higher risk families do not receive the resources needed to adequately protect children. This is inefficient and frequently counterproductive.

SDM assessments can help maximize the use of limited resources. This is accomplished through the use of case opening guidelines and by employing differential service standards for opened cases.

Case opening guidelines inform decisions about whether or not to open a case for ongoing in-home services. They are based on actual outcomes for families at various levels of risk. Low risk families are unlikely to re-abuse or re-neglect their children whether or not the agency intervenes. Therefore, it makes little sense to open these cases for ongoing services. On the other hand, high risk families are much more likely to return to the system, and services are needed to reduce the risk of maltreatment. By focusing on high and very high risk cases, the agency targets its resources on the families who need them most and consequently reduces the likelihood of subsequent abuse and neglect.

An example of the utility of focusing resources on high risk cases is illustrated by data from a management report for California counties. The report involved a large cohort of cases that were investigated and had a risk assessment completed. Some of the cases were opened for services, while many others were not. This provided the opportunity to examine the impact of child welfare services by

comparing the outcomes of the cases that were served with those that were not, while controlling for level of risk. The results illustrated in Figure 10 are striking. They show that providing services to low and moderate risk cases had no impact on reducing subsequent harm (i.e., the low risk cases that were opened for services were re-referred at a rate [3.6%] very similar to cases that had not been opened [2.6%]). In contrast, providing services to high and very high risk cases had a dramatic impact—subsequent referrals were reduced by almost half. For example, among the very high risk cases, 15.6% of families who did not receive services were re-referred within two years, as opposed to fewer than 9% of those who did receive services. This suggests that child welfare interventions can have an impact—when they are targeted to high risk cases.

An example of risk-based case opening guidelines is shown in Figure 11, where the presumption is that low and moderate risk cases will not be opened for services, but high and very high risk cases will be.

A second mechanism for targeting resources is the use of differential service standards. Instead of seeing all cases at the same level of frequency (e.g., once per month), risk-based standards tie the frequency of contact to the family's level of risk. The rationale for this approach is the same as that used in the case opening guidelines. Low risk families—if they have cases opened in the first place—do not need to receive the same amount of agency resources (i.e., caseworker time) as high risk families because they are

FIGURE 10 New Substantiated Allegations of Maltreatment Within Six Months of a Substantiated Allegation January 1 – June 30, 2006

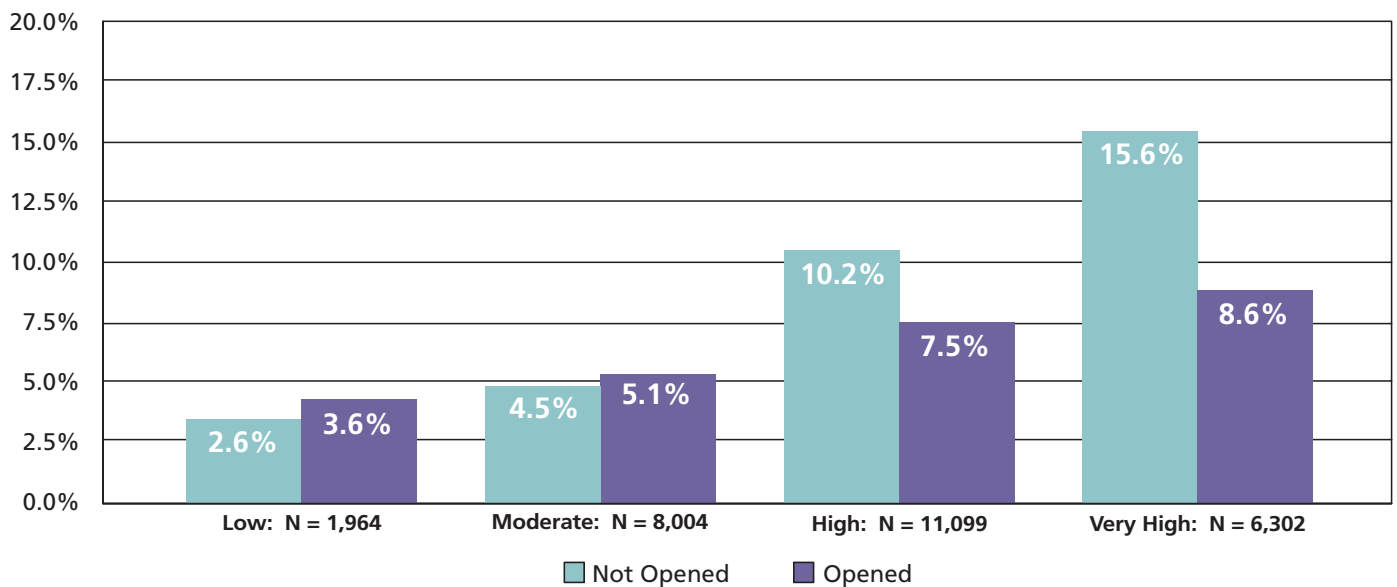


FIGURE 11 Risk-based Case Open/Close Guidelines

RISK LEVEL	RECOMMENDATION
Low	Close *
Moderate	Close *
High	Open
Very High	Open

* When unresolved safety concerns are still present at the end of the investigation, the case should receive ongoing services regardless of the risk level.

FIGURE 12 Service Level for In-home Cases Minimum Contact Standards

RISK LEVEL	
Low	<ul style="list-style-type: none"> • One face-to-face contact per month by the CPS worker with the client • One collateral contact per month by the worker on behalf of the client
Moderate	<ul style="list-style-type: none"> • Two face-to-face contact per month by the CPS worker with the client • Two collateral contacts per month by the worker on behalf of the client
High	<ul style="list-style-type: none"> • Three face-to-face contact per month by the CPS worker with the client • Three collateral contacts per month by the worker on behalf of the client
Very High	<ul style="list-style-type: none"> • Four face-to-face contact per month by the CPS worker with the client • Four collateral contacts per month by the worker on behalf of the client

much less likely to maltreat their children again. On the other hand, high risk families should be contacted more frequently than they have been under traditional standards. When an agency establishes differential worker contact standards based on risk, it becomes possible to make existing service resources reach farther and produce better results. Figure 12 shows how the Michigan Family Service Agency has defined and differentiated service standards by case type. Similar standards have been implemented in many other agencies.

Workload Measurement

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

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

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

A workload-based budget, in essence, is a contract for services. Funding bodies know exactly what level of service will be provided based on the level of staff resources

FIGURE 13 Determination of Workload Demand and Staff Needed

CASE TYPE	NUMBER OF CASES PER MONTH	TIME REQUIRED PER CASE, PER MONTH TO MEET STANDARDS	TIME REQUIRED PER MONTH BY CASE TYPE
Abuse/Neglect Intakes	700	1.0 Hours	700 Hours
Investigations	350	6.5 Hours	2,275 Hours
ONGOING CASES			
Low	100	3.3 Hours	330 Hours
Medium	250	4.2 Hours	1,050 Hours
High	150	6.6 Hours	990 Hours
Foster Care Cases	100	9.0 Hours	900 Hours
TOTAL WORKLOAD DEMAND			6,245 Hours/Month
WORKER TIME AVAILABLE PER MONTH ¹			120.6 Hours
TOTAL NUMBER OF STAFF NEEDED ²			51.8

¹ Time available to handle cases. Reflects reductions from salaried hours due to vacation, sick days, training, and administrative tasks.

² Calculated by dividing workload demand by time available per worker.

allocated. The effect of budget reductions on client service will be readily apparent, as will the effect of enhanced resources.

Figure 13 provides an example of a workload-based budget.

Management Information Reports: Data for Planning, Monitoring, and Evaluation

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

As shown in Figure 14, aggregated risk information can, for example, document changes in the nature of the client population. This (example) graph reveals substantial increases over a five-year period in the proportion of substantiated cases identified as high and very high risk.

This information clearly demonstrates new challenges facing the agency and documents changes in workload. Similarly, Figure 15 shows how managers can use aggregate needs assessment data to identify the most prevalent needs in the client population. This information can then be compared to available resources in the community to determine resource shortfalls and support funding requests.

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

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

FIGURE 14 Changes in Initial Risk Levels 1993 – 1998 (Example)

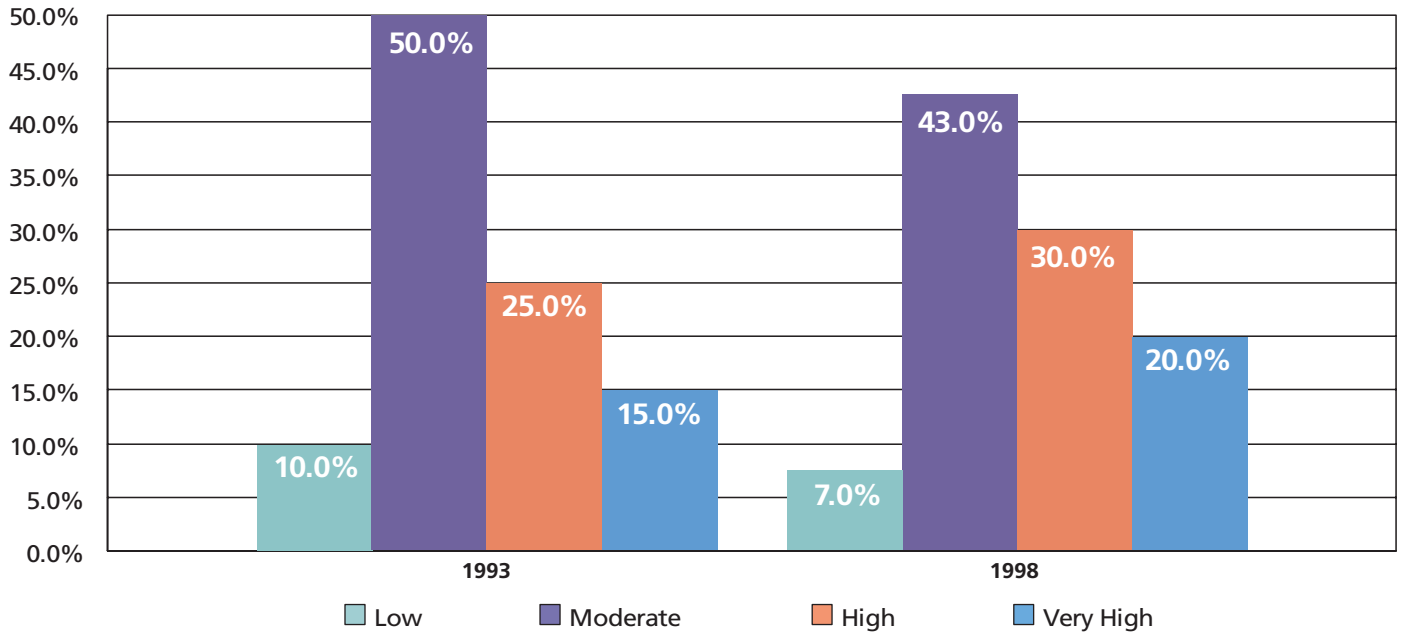
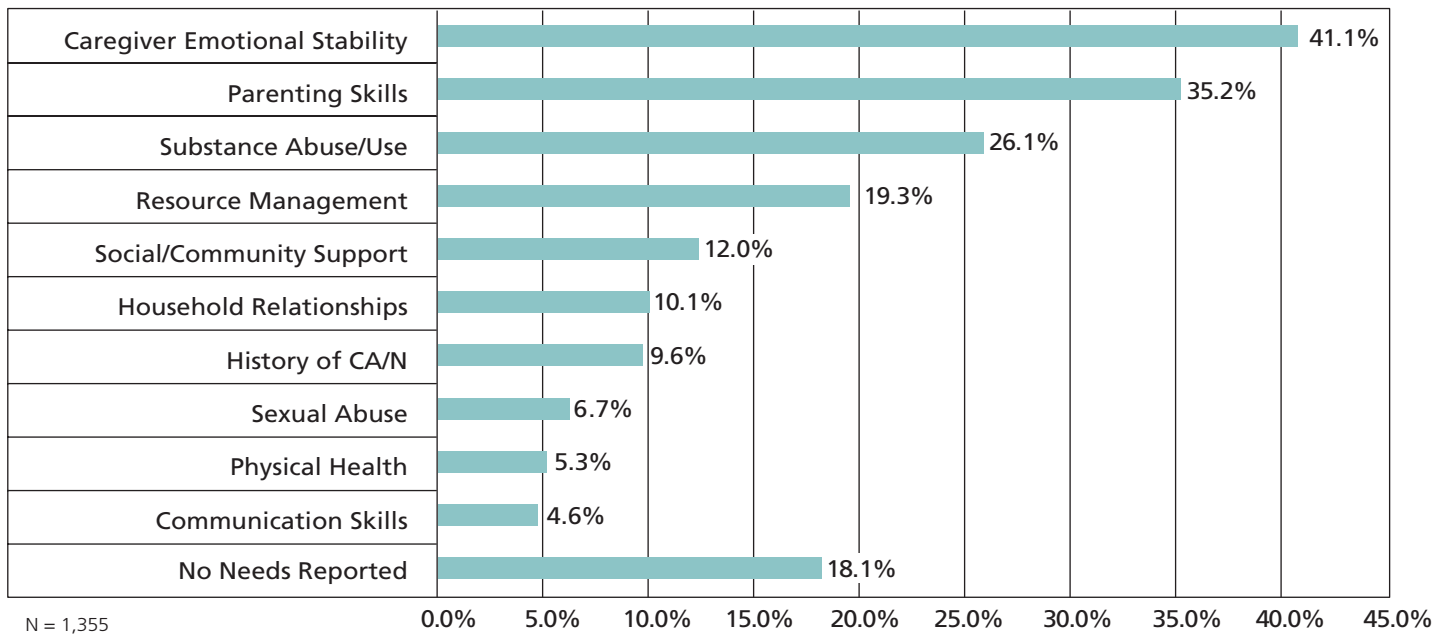


FIGURE 15 SDM® Family Strengths and Needs Assessment Results Priority Family Needs



NEW DEVELOPMENTS

Over the past two decades, the SDM model has been constantly evolving, both as a result of new research and in response to agencies' requests for assistance in developing structured approaches in areas not previously incorporated into the model. That evolution has continued in recent years as the SDM model has added new components to its structured decision making approaches in other human services organizations.

Assessments of Foster and Relative Care Providers

As part of its focus on child safety, well-being, and permanency, CRC has developed an SDM assessment model for foster and relative care providers. Following completion of a study that examined the characteristics of stable and disrupted foster placements, CRC partnered with nine California counties and the California Department of Social Services to develop a model designed to: 1) promote safety, stability, and well-being for children in out-of-home care and 2) provide workers with the critical pieces of information necessary to identify the best placement option for children and what types of support foster and relative care providers may need to be successful. The assessment components focus on identifying a provider's ability and willingness to meet children's needs and identifying the nature and level of support needed by the provider to increase placement stability and child well-being.

Early Intervention with High Risk TANF Families

A recent study of over 1,000 Temporary Assistance to Needy Families (TANF) recipients¹⁰ found that nearly two

out of three families experienced at least one CPS investigation, and one in four of the families had at least one child placed in out-of-home care. The link between the need for financial support and child abuse has led to a joint project involving CRC; Orange, Madera, Merced, and San Luis Obispo counties in California; and Norfolk, Virginia. The intent is to implement SDM tools that identify TANF recipients who are at increased risk of becoming involved in child maltreatment incidents. Through the SDM TANF program, workers are able to target support services to families in order to reduce the likelihood of child maltreatment. Addressing contributing factors of child maltreatment may also address the same issues families experience as social barriers to self-sufficiency (e.g., mental health, domestic violence, parenting issues, substance abuse, etc.).

SDM® in Adult Protective Services

Elder and dependent adult abuse and neglect is a growing concern. As the population ages, it is expected that the numbers of maltreatment allegations will increase. Cases are increasingly complex and challenging, and Adult Protective Services (APS) program resources are often extremely limited. APS still lags behind child protection in funding, research, and public awareness. Because of this, there are fewer tools and research studies available in APS to assist caseworkers in responding to and intervening in reports of abuse.

To address this need, in 2005, CRC and Riverside County, California, initiated a joint project to design, implement, and evaluate an SDM system for APS that includes intake screening, response priority, and safety assessment tools.

Maintaining Integrity

It is clear that the relative success of any new system is primarily dependent on emphasis given to implementation and accountability issues. This requires ongoing monitoring of mandated activities to ensure that standards are met and that children and families are served in a timely, consistent manner.

CRC assists child welfare agencies with monitoring and evaluation in a variety of ways. First, CRC has created a highly efficient web-based quality assurance system available to agencies. This system, SafeMeasures®, tracks and reports key performance and outcome measures and makes real-time aggregate reports continuously available to managers and supervisors. These include reports on all the federal outcome measures associated with the CFSR. Data are “mined” from the agency’s SACWIS, so no additional data entry is required. This system allows staff to “drill down” to specific caseloads and individual cases directly from the graphical presentation of aggregate data. Figures

16 and 17 present examples of SafeMeasures aggregate reports that are currently available to many California counties.

CRC also provides training and technical assistance to agency supervisors for in-depth case readings, focusing on the link between SDM assessments, effective case planning, and service provision. This training has helped numerous agencies translate the goals and objectives of the SDM model into practice and improve the case management skills of CPS workers.

Finally, CRC provides many agencies with semi-annual reports that summarize key information generated by the SDM system. These reports highlight accomplishments, identify trends, and report on areas of concern for each agency. As such, they help managers stay attuned to issues and support evidence-based practice.

FIGURE 16 Outcome Measure Time to Reunification in 12 Months

Of all children who were reunified in a given month, how long had they been in care?

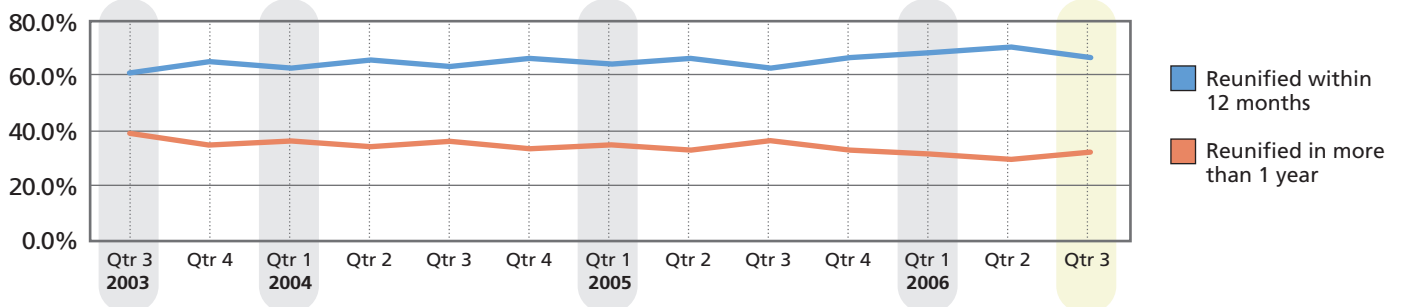
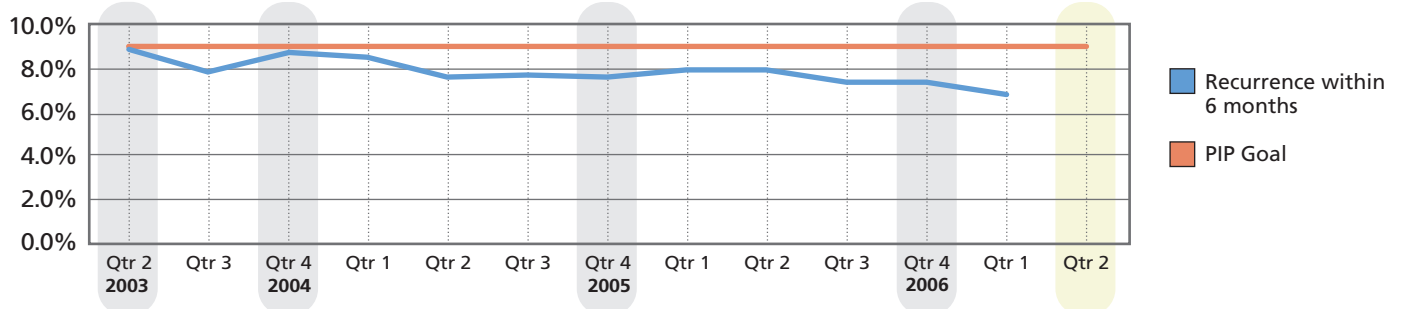


FIGURE 17 Outcome Measure Recurrence within Six Months

What percent of children with a substantiation of abuse or neglect had another substantiated report within a six-month period?



Evaluating the SDM® Model

The SDM model has been embraced by a large number of child welfare agencies in the United States and abroad. The appeal of the SDM model is based partially on the fact that it has undergone several research and evaluation studies. Key questions asked include:

- Are case decisions in fact more *consistent* across staff?
- Does the SDM model help staff make *better* decisions?
- Does the model actually help reduce the incidence of subsequent abuse and neglect?

Some results have been presented earlier; the results of other evaluations that addressed these questions are presented below.

COMPARATIVE RELIABILITY AND VALIDITY

A variety of risk assessments have been developed and adopted by child welfare agencies. However, until recently, these assessments, whether consensus-based or empirically based, had not been rigorously evaluated. To remedy this, the Office of Child Abuse and Neglect (OCAN) selected CRC (overseen by an independent advisory board of national experts) to conduct a comparative evaluation of the reliability and validity of three different risk models.¹⁰ These included two consensus models—the Washington Risk Assessment Matrix and the Fresno Family Assessment Factor Analysis (which was used in California prior to their adoption of the SDM system) and the empirically based Michigan Family Risk Assessment.

Risk Assessment Reliability

The first phase of the study assessed the reliability of the three risk models by measuring the extent to which *different* workers assigned the *same* risk level to the *same* family. The study methodology involved a total of 80 randomly selected cases that were assessed by four case readers who had been trained on the Washington scale, four who had been trained on the Fresno instrument, and four others who had been trained on the Michigan SDM model.¹¹ Both simple comparisons of the percentage of cases on which raters agreed and a statistical measure of reliability, Cohen's Kappa, demonstrated that the reliability of the Michigan system was significantly higher than the level of reliability attained by the “expert” or “consensus-based” approaches to risk assessment.

In 85.0% of all cases, at least three of the four raters using the Michigan tool agreed on the risk level assigned to a case. Reliability of the consensus-based instruments, however, was well below what is considered adequate. For both the Fresno and Washington tools, at least three of the four raters agreed on a risk level in only about 50.0% of all cases assessed. The Cohen's Kappa test of reliability indicated the Michigan scale was reliable, while the Washington and Fresno scales were not.

Risk Assessment Validity

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

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

To assess the validity of the three risk instruments, CRC compared results from a cohort of 1,400 cases investigated for abuse and neglect allegations in the fall of 1995. Following the investigations, each family was tracked for 18 months. Figure 18 presents the **mean** number of investigations and substantiations per case at each risk level. Clearly, the Michigan system did a superior job identifying families with low, moderate, and high proclivities for maltreating children. With the Michigan risk assessment, the higher the assessed level of risk, the greater the number of subsequent investigations and substantiations. With the consensus-based assessments, this expected relationship between risk and outcomes did not exist.

EVALUATION OF THE MICHIGAN SDM® SYSTEM

Between 1989 and 1992, CRC and Michigan child welfare staff worked together to design an SDM system¹² consisting of risk and needs assessments, case planning tools, and reassessments, as well as differentiated service

FIGURE 18 Mean Number of New Investigations and Substantiations

Reported during an 18-month follow-up period by risk level.

	Fresno Tool		Michigan Tool		Washington Tool	
	Investigations	Substantiations	Investigations	Substantiations	Investigations	Substantiations
Low	.53	.22	.25	.09	.39	.18
Moderate	.66	.28	.54	.21	.67	.27
High	.59	.22	.87	.43	.64	.28
Base Rate	.58	.24	.59	.25	.60	.25

standards. System implementation began in 13 pilot counties during 1992.

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

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

Case Closing Decisions

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

Changes in Service Provision

Program participation in the SDM counties occurred at significantly higher levels than in the comparison counties.

This was particularly true for high and intensive risk families. For example, high risk families in the SDM counties were more likely than the high risk non-SDM families to become involved in parenting skills training, substance abuse treatment, family counseling, and mental health services (see Figure 19).

Outcomes

The evaluation also examined whether changes such as those noted above resulted in a better overall system of child protection. The principal question is whether implementation of the SDM system translated into lower rates of maltreatment in Michigan. Figure 20 compares overall results for cases from counties using the SDM model with comparison counties. For each outcome measure, families in the SDM counties had better outcomes than other families. The greatest difference was found in rates of new substantiations, where SDM families had a rate less than half that observed for the comparison group (6.2% vs. 13.2%).

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

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

FIGURE 19 Michigan SDM® Evaluation Results Percent of High Risk Cases That Received Specific Services

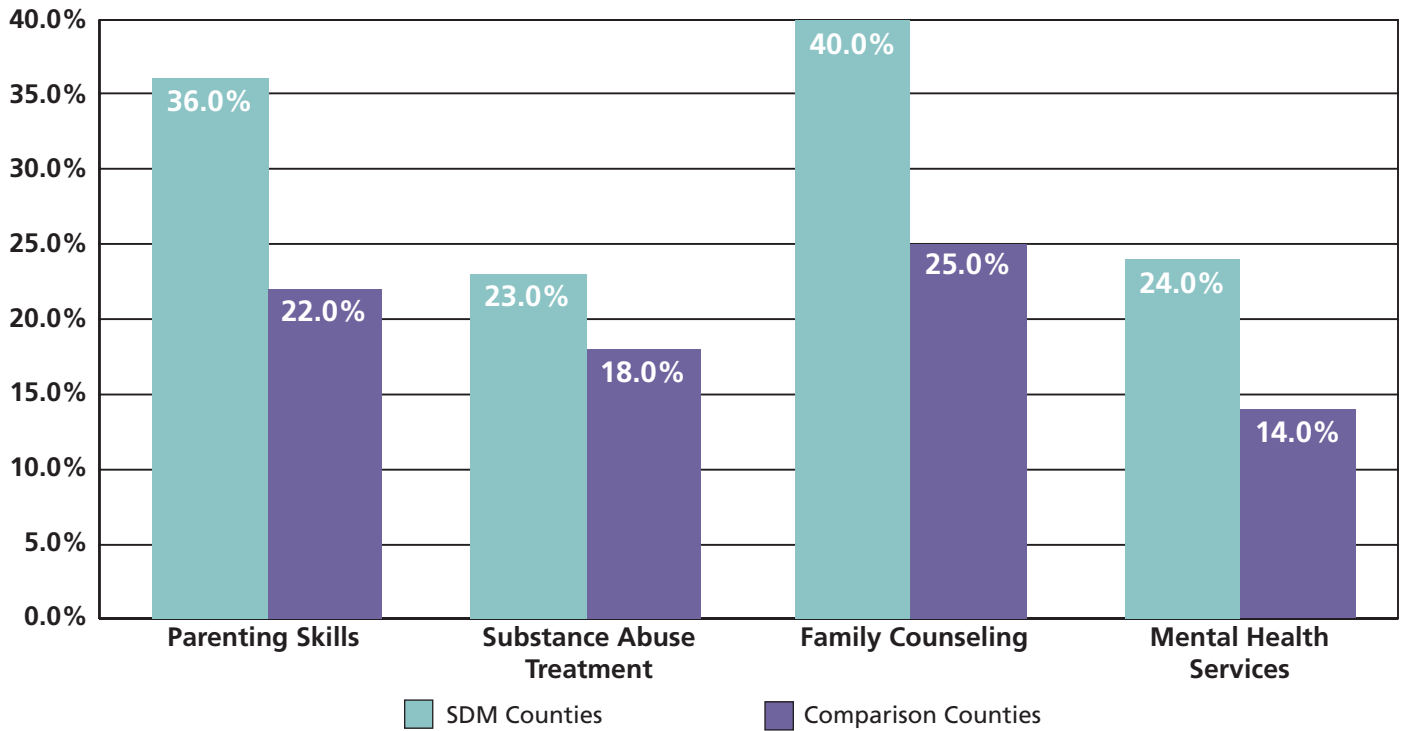
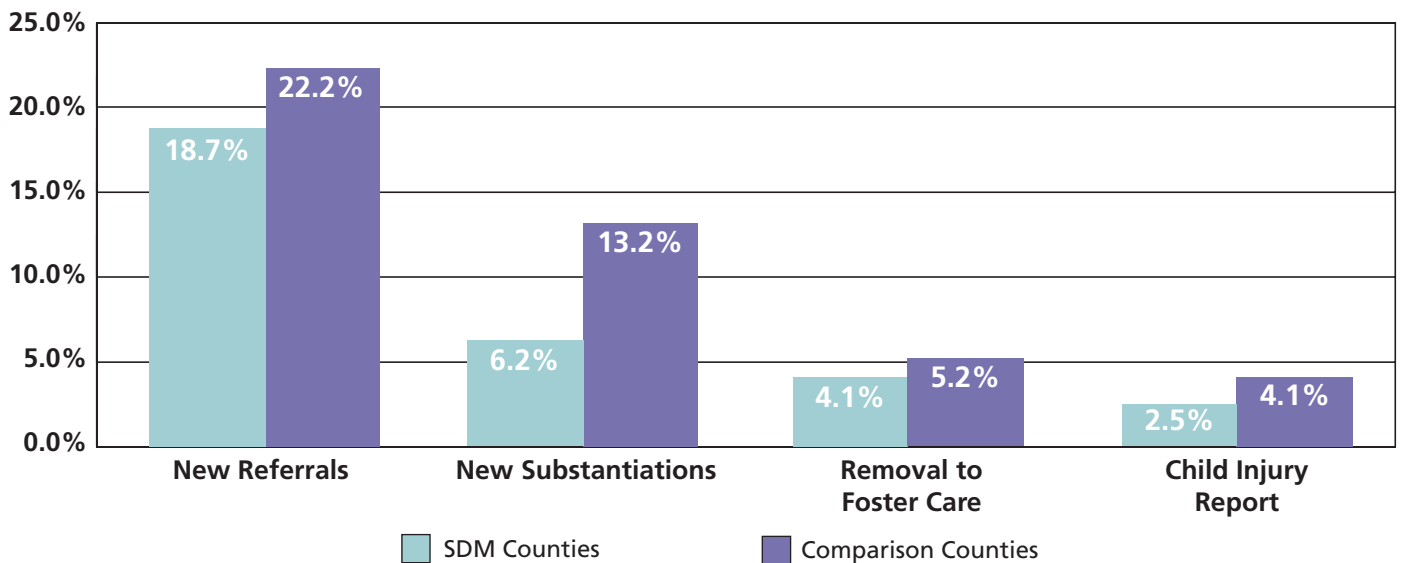


FIGURE 20 Michigan SDM® Evaluation Results Outcomes for CPS Cases — 12-month Follow-up



Foster Care Outcomes

There is powerful evidence—based on a second Michigan evaluation—that bringing structure to reunification decisions can help states improve their performance with permanency outcomes.

A few years after implementing the other components of the SDM model, Michigan’s Family Service Agency began

implementation of the SDM reunification assessment. The goal of the ten-county pilot project was to expedite permanency for children entering foster care who had a goal of return home. The evaluation of the pilot project: 1) used a matched group of counties¹⁴ for comparison purposes that continued to make reunification decisions as usual, 2) involved approximately 2,000 children in foster care, and 3) used the percentage of children who achieved perma-

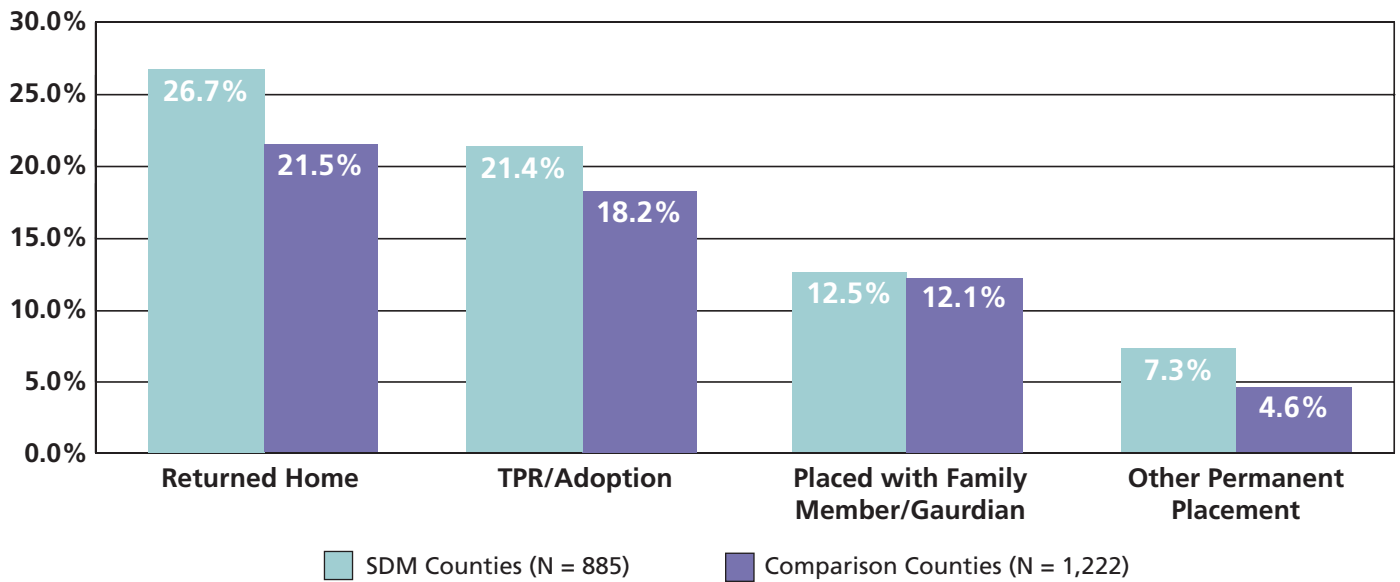
nency within 15 months after their entry into foster care as the primary outcome measure.

The evaluation results showed that in the counties using the SDM model, more children achieved permanency within 15 months (68.0% vs. 56.0% — not shown), and more children achieved permanency in each outcome category (return home, adoption, etc.). See Figure 21.¹⁵

In addition, a subsequent component of the evaluation focused on the children in both groups who had

been returned home. These children were tracked for an additional 12 months to determine the extent to which those reunifications were successful. Once again, the counties using the SDM model were more successful than those relying on traditional approaches. After one year, just 7.0% of the children reunified in SDM counties had reentered foster care, while the corresponding figure for the comparison counties was 11.0%.¹⁶ Not only did the SDM counties send more children home, but it also appears that they did a better job of determining which children should be reunified.

FIGURE 21 Michigan Post-SDM® Implementation Permanency Type 15 Months After Entering Foster Care



Summary

Adding structure to CPS decision making procedures *and* routinely monitoring and evaluating these procedures can result in a decision model that substantially improves safety, well-being, and permanency.

As Rycus and Hughes point out, many attempts to produce assessments in child welfare have mixed concepts, invented

idiosyncratic terminology, and confused rather than clarified issues facing social workers.¹⁷ The following recommendations summarize what CRC has learned from more than 30 years of risk assessment development, involvement in the North American Resource Centre on Child Welfare colloquy on risk assessment, and through work with dozens of agencies to implement SDM systems.

1. Decision protocols should be simple. Criteria considered at each decision point should be explicit and easily articulated to staff, the judiciary, and the community.
2. Decision tools should consist only of criteria that relate specifically to the decision at hand and can be assessed with some degree of reliability at the point in time when each decision is made.
3. Decision tools should lead *directly* to presumptive decisions. This requires the structure of an additive index; a decision tree; or at a minimum, clear rules on the role of each factor in reaching each decision.
4. Overrides to tools should be allowed, but reasons for overrides should be documented, approved by a supervisor, and monitored to determine their role in the case management process.
5. Decision tools, regardless of their origin (research-based, consensus-based, or clinical-based) should be tested for reliability, equity, and efficacy. Evidence regarding the effectiveness of each decision tool should be routinely collected, analyzed, and reported back to staff and administrators.
6. Finally, it is essential that the child welfare field recognizes that it is not enough to simply identify factors with a demonstrated relationship to risk and allow these factors to be applied in different ways by different staff members at each decision point. A high level of *structure* is required to ensure that staff make consistent and appropriate decisions to expedite the safety and well-being of children in the care of the child welfare system.

If researchers, training experts, and policy makers work together to promote valid, reliable, and equitable decision protocols, child welfare systems will reap enormous benefits. The potential to make evidence-based practice a reality has never been greater. Good decision models, good social work, and innovative approaches to involving families and the communities in the process are not in competition. Each is key to ensuring the safety, well-being, and permanency of children; all of these components must be subject to routine continuous quality assurance and evaluation. Quite simply, this should constitute an ethical mandate for all involved in protecting children from abuse and neglect.

Endnotes

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- ¹⁰ Baird, C., Wagner, D., Healy, T., & Johnson, K. (1999). Risk assessment in child protective services: Consensus and actuarial model reliability. *Child Welfare*, 78(6), 723-748.
- ¹¹ The study took place in four different sites to ensure broad geographic and ethnic representation: Alameda County, California; Dade County, Florida; Jackson County, Missouri; and four counties in Michigan (Macomb, Muskegon, Ottawa, and Wayne). Twenty cases were selected from each of the four sites. There were three people in each site—each trained on a different risk instrument—who completed the risk assessments. Each site team scored the 20 cases from its site and the cases from each of the other sites.
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- ¹⁷ Rycus, J. S., & Hughes, R. C. (2003). Issues in risk assessment in child protective services: Policy white paper. Columbus, OH: North American Resource Centre for Child Welfare. See also Rycus, J. S., & Hughes, R. C. (2007). Issues in risk assessment in child protective services. *Journal of Public Child Welfare*, 1(1), 85-116.



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