

Using Comprehensive Family Assessments  
to Improve Child Welfare Outcomes  
Ramsey County Community Human Services &  
University of Minnesota School of Social Work  
St. Paul, Minnesota

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# Comprehensive Family Assessment Posttest Study

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Submitted by

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## Introduction

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In 1994, the Children’s Bureau (CB) created a Federally-based program designed to assess performance outcomes of State child welfare agencies, in an effort to ensure safety, permanency and well-being of children and families receiving child welfare services (Children’s Bureau, 2008). The first round of Child and Family Services Reviews (CFSRs) that took place in 2001, revealed many areas throughout the country where child welfare systems were in need of significant improvement. One area that received a great deal of attention was that State agencies were found to focus primarily on initial risk and safety assessments and did not engage in comprehensive assessments that identified, in a more holistic fashion, the strengths and needs of families. Reviewers noted that, in fact, without capturing comprehensive information about each family, the safety, permanency and well-being needs of children and families were not being met. As a result of these findings, the Children’s Bureau developed the *Comprehensive Family Assessment Guidelines for Child Welfare* (2005) to serve as a resource for States to follow in implementing practice changes.

The Children’s Bureau awarded five federally-funded grants in order to design, implement, and evaluate practice changes, in accordance with the Comprehensive Family Assessment Guidelines. The foundation for a Comprehensive Family Assessment – a holistic view of the family – begins with the first contact with the family and is then built upon until the case is closed. Synthesizing information from the *Comprehensive Family Assessment Guidelines* created by the Children’s Bureau in 2005, the most essential components of a CFA include the following: family involvement including frequency and quality of visits; ongoing case planning and CFA updates; the identification of needs and strengths of *all* family members thorough documentation, incorporation of outside information and/or assessments, and connections to appropriate services in relation to needs. Minnesota’s Ramsey County Community Human Services Department (RCCHSD) was one of the five grantees chosen to participate in this initiative. In 2007, RCCHD partnered with the University of Minnesota’s School of Social Work in the College of Education and Human Development (UMN) to evaluate current RCCHSD child protection assessment processes as well as a newly-designed practice model that more fully incorporated the Comprehensive

Family Assessment (CFA) Guidelines in RCCHSD Intake and in Case Management services. These initiatives built upon work that RCCHSD had already been doing in the area of anti-racism initiatives and family centered assessment.

Phase 1 of the evaluation of the Comprehensive Family Assessment Project was focused on understanding how workers were assessing and providing case management services to families who were involved with child protection (CP) services in Ramsey County through family centered assessment. The *Comprehensive Family Assessment: Intake Baseline Study* report and addenda outline findings of the evaluation of Intake (Family Investigation and Family Assessment [Alternative Response]) RCCHSD Child Protection using case record review data, worker and supervisor focus group data, and information gathered from families that received intake services. (Kim et al., 2012; Kim, LaLiberte, Heldt, Piescher & Snyder, 2012; Piescher, Snyder, Nguyen, LaLiberte, & Wells, 2010) The *Comprehensive Family Assessment: Program Baseline Study* report and addenda outline findings of the evaluation of Program (or on-going case management services) RCCHSD Child Protection using case record review, worker and supervisor focus group data, time study data, and information gathered from families that received case management services (Harrison, Piescher, LaLiberte, Snyder & Wells, 2009; Piescher, LaLiberte, Merritt, Snyder & Wells, 2009; Wells et al., 2009). Baseline findings were used to aid in the continued development and evaluation of the RCCHSD Comprehensive Family Assessment model. The intent of the practice model was that the resulting thorough, specific, and holistic assessment would lead to greater client engagement as well as more targeted and cost-effective services that improve family and child well-being (RCCHSD, n.d).

RCCHSD adapted the original Children's Bureau *Comprehensive Family Assessment Guidelines for Child Welfare*, to include a focus on *both* intake and ongoing case management services. RCCHSD believed the basic point of the practice model – a focus on a holistic assessment of children and the family – would provide an important template for reviewing and revising intake and assessment practices from a family's first entry into the system throughout ongoing service provision. The practice model that was created is congruent with the CFSR requirements, and provides guidance throughout the intake and case management process. The focus in Intake was aimed at improving the initial assessments as a way of beginning the information-gathering process with a family that is

holistic, rather than focusing solely on a presenting problem. The focus in Case Management was aimed at understanding and responding to the underlying causes of the issue that brought the family to the attention of child protection through holistic assessment, behaviorally-based case planning, and targeted service provision. Further, RCCHSD sought to improve documentation, incorporate findings from CFSR reviews, and ensure consistency between assessments in Intake and Case Management, in order to further integrate the two, therefore creating a more seamless system for children and families.

Phase 2 of the Comprehensive Family Assessment Evaluation was designed to assess the implementation of the CFA practice model in Ramsey County's Child Protection case management units. The Formative Evaluation report (Kim, Piescher & LaLiberte, 2010) highlights the strengths and challenges of the implementation of the CFA practice model based on Ramsey County's Worker Guide (March 24, 2009 version). The purpose of the formative evaluation was to clarify program goals and identify those elements of the implementation of the intervention that were successful and those elements that were in need of improvement (Weston, McAlpine & Bordonaro, 1995) and/or further training. The Formative Evaluation consisted of three components: a fidelity study of child protection case management workers' implementation of the CFA practice model (interviews and case record reviews); interviews with case aides; and a supervisor observation study. Findings of the Formative Evaluation were utilized to refine practice procedures and training opportunities for Ramsey County staff.

Phase 3 of the evaluation was designed to compare changes in both practice and child and family outcomes associated with CFA practice implementation at Ramsey County. The current report outlines findings of the evaluation of Intake (Family Investigation and Family Assessment) and Case Management Child Protection using case record review and focus group data. Posttest data are presented below and compared to earlier data obtained during the baseline intake and program studies. Additional reports developed during Phase 3 include *Comprehensive Family Assessment Posttest Supervisor Study* and *How Workers Think About and Utilize Culture in Child Welfare Practice* (Piescher, Bidwell, LaLiberte & Snyder, 2012; Piescher, Heldt, LaLiberte & Snyder, 2013).

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## Methods

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### **Instrument Development**

Case record review instruments were developed to capture relevant information from randomly selected cases in Ramsey County. The instruments were developed to reflect the federal CFSR case record reading instruments and to identify, where practical, the ten elements of the federally recommended format for CFAs. The measures were operationalized and included the requirements for applicability found in the CFSR instruction to reviewers (U.S. Department of Health and Human Services, 2008). The items were developed to be as objective as possible, but in a small number of items it was necessary to rely on some degree of case reviewer judgment. For example, reviewers were asked to determine whether worker visits were sufficient in ensuring the safety, permanency, and well-being of the child. (If the answer was “no,” the reviewer would explain this finding qualitatively in order to understand the individual nuance of each case.)

### **Sampling Process**

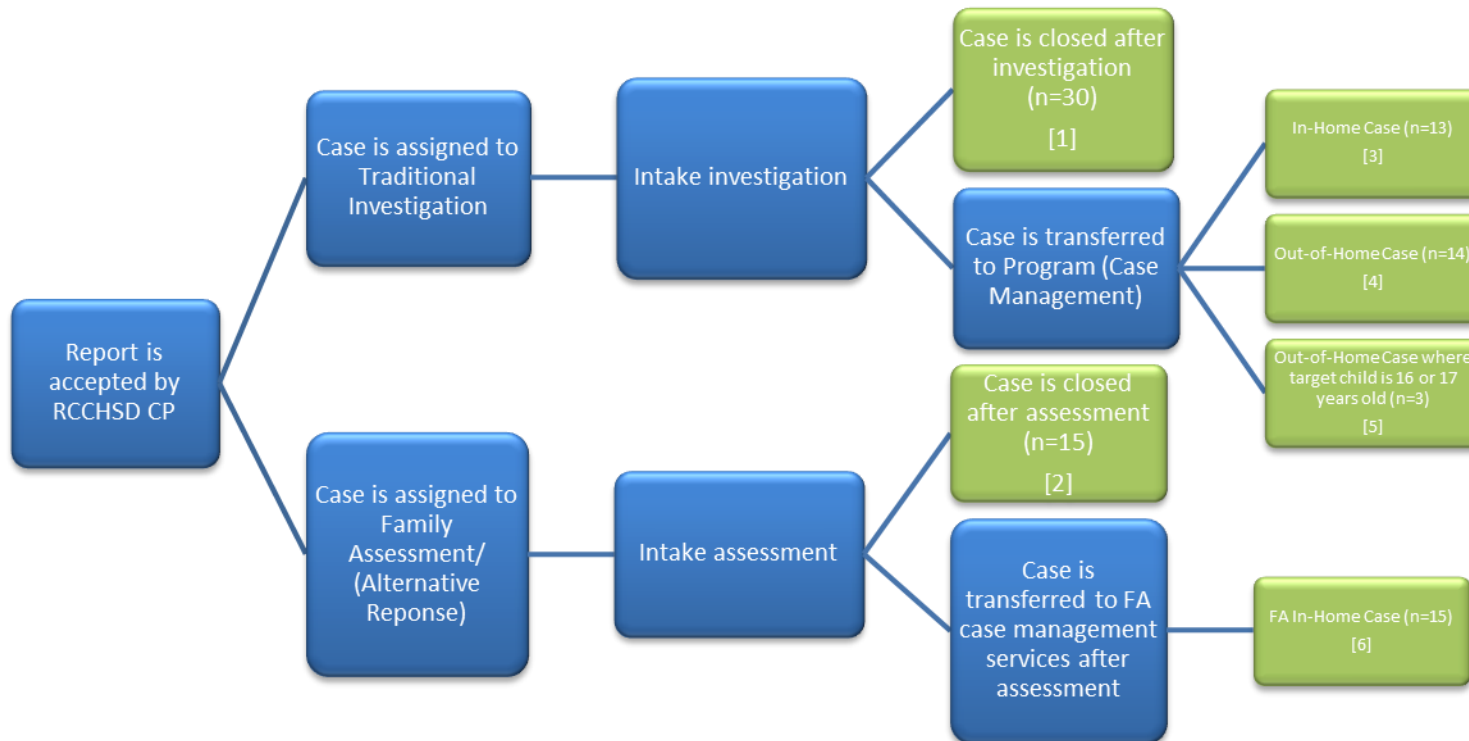
The sampling plan for the case record reviews (CRRs) was based on guidelines from the federal CFSR reviews (U.S. Department of Health and Human Services, 2008). Records were selected from the Social Services Information Systems (SSIS) based in the RCCHSD Child Protection (CP) division according to case type. To ensure that the sample was representative of both Family Investigation (FI) and Family Assessment (FA) cases, a stratified random sampling method was used. Family Assessment/ Alternative Response (FA) is a voluntary service offered to families who are reported under the child protection statute but whose situation does not meet the threshold for a traditional child protection investigation. State law indicates a Family Assessment response is preferred practice, except in situations that include alleged egregious harm (as determined at the time of receipt of the report), sexual abuse and/or maltreatment in a child daycare or foster care home (Minnesota Department of Human Services, 2009). Determinations of maltreatment are not made in Family Assessment cases.

Consequently, 60 Family Investigation cases and 30 Family Assessment cases were selected from the sampling frame, for a total of 90 cases. The sampled cases fit into six

separate tracks. (See Figure 1 below.) Track [1] included 30 cases that were assigned to FI, received an intake investigation and were then closed. Track [2] included 15 cases that were assigned to FA, received an intake assessment and were then closed. Track [3] included 13 cases that were assigned to FI, received an intake investigation and then were transferred to in-home case management services. Track [4] included 14 cases that were assigned to FI, received an intake investigation and then were transferred to out-of-home case management services. Track [5] included three cases (where the target child was 16 or 17 years old) that were assigned to FI, received an intake investigation and then were transferred to out-of-home case management services. Track [6] included 15 cases that were assigned to FA, received an intake assessment and were then transferred to in-home case management services.



Figure 1. Flowchart indicating project sampling frame and service tracks



The sampling frame included 253 Family Investigation cases (representing 577 children and 811 allegations) and 168 Family Assessment cases (representing 402 children and 240 allegations). All traditional intake and case management cases (tracks 1, 3, 4, and 5) were opened in Intake on or after October 1, 2010. All Family Assessment (Alternative Response) cases (tracks 2 & 6) were opened in Intake on or after April 1, 2011.

Due to the way that cases were identified within the SSIS system, there were a number of cases that, upon case record review, were rejected and replaced with alternate, randomly sampled cases. For FI “out of home” cases there was one case that was rejected because the child was never placed outside of the home, and was instead transferred from the biological mother’s household to the biological father’s household. For FI “in home” cases there were six cases that were rejected because they were placed outside of the home at some point after the case was opened. For FI “intake only” cases, 13 were rejected all-together; eleven cases were rejected because they were already receiving child protection case management services and a new allegation made it appear to the computer system as a new intake case and two other cases were rejected because they were deemed inappropriate for child protection services and were closed within one day (and prior to the first meeting with the family). For FA cases, five were rejected because they were transferred to FI services after the case was opened.

To determine whether the final baseline sample represented the larger sampling frame from which it was drawn, demographic characteristics of children included in the sample were compared with demographic characteristics of children included in the larger sampling frame. Results of this comparison revealed that the sample was generally representative of the frame from which it was drawn. (See Table 1.)

**Table 1: Demographic Characteristics of Sample (n=90) and Sampling Frame (N=847)**

	Race							Allegation			
	Hispanic	White	Black or African Am.	Am. Indian/ Alaskan Native	Asian / Pac. Island	Multi- Racial	Unable to Det.	Neg.	Phys. Abuse	Sex. Abuse	Med. Neg.
<b>Sampling Frame</b>	11.6%	27.5%	40.7%	4.4%	14.9%	11.3%	1.2%	65.9%	22.5%	10.8%	0.8%
<b>Sample</b>	18.3%	35.6%	42.2%	1.1%	7.8%	13.3%	0.0%	64.0%	20.2%	9.8%	6.0%
FA	16.7%	50%	40%	0.0%	10%	0.0%	0.0%	65.1%	31.4%	1.2%	2.3%
FI	20.0%	28.3%	43.3%	1.7%	6.7%	20%	0.0%	62.1%	10.5%	17.9%	9.5%

Analyses of the demographic characteristics revealed that the proportions of African American children and children of multiple races in the sample were comparative to those in the larger sampling frame. However, the sample appeared to be comprised of a slightly higher proportion of Hispanic and White children and a lower proportion of Asian/Pacific Islander children than was the sampling frame. This difference may be explained by slight differences in the method of coding race utilized in the sample as compared to that used in the sampling frame. Sampling frame racial categories came from one data entry point (i.e., SSIS “child race” option) in the SSIS system whereas racial categories of the sample relied on multiple data points (e.g., child, mother, or father race in case notes or SSIS “child race” code). No large differences in the proportions of allegations of general neglect, physical abuse, or sexual abuse were evident between the sample and the larger sampling frame. However, there was a slightly larger proportion of allegations of medical neglect in the sample than was found in the sampling frame.

Of the 90 Intake cases reviewed, the average period of time that a case was open in Intake was 39 days (SD = 24.6), but there was a wide range of four to 166 days. On average, Family Investigations (FI) and Family Assessment (FA) cases were open for approximately the same amount of time (39 days vs. 38 days, respectively), but there was much greater variability within FI cases (with a range of four to 166 days open for FI and a range of four to 61 days open for FA cases) mainly due to the presence of one case that was open in FI for 166 days. When this one case was removed from the analysis, the high end of the range decreased to 97 days and the average number of days open in intake for FI cases dropped

from 39 to 37 days ( $SD = 23.7$ ). An independent-samples t-test was conducted to compare the average amount of time a case was open in intake for the current (posttest) sample to the original baseline sample. There was no significant difference in days open for the post-test sample ( $M=37.49$ ,  $SD=20.67$ ) and for the baseline sample ( $M=39.29$ ,  $SD=23.65$ );  $t(207)=-.572$ ,  $p=.57$ . **These results suggest that the length of time that cases remained open during the intake period (ranging from four to 97 days) has not changed between the *Intake Baseline Study* and the current study.**

Of the 45 Case Management cases reviewed, the average period of time that a case was open in case management was 236 days ( $SD = 104.6$ ) for FI cases and 111 days ( $SD = 57.2$ ) for FA cases. Cases were open for a wide range of time (much like Intake cases), with some FI and FA cases remaining open for as little as 87 (FI) or 45 (FA) days or as long as 487 (FI) or 258 (FA) days. Differences in the average amount of time cases were open was likely a reflection of implementation date, as FI began implementing CFA practice approximately one year prior to FA. An independent-samples t-test was conducted to compare the average amount of time a case was open in case management for the current (posttest) sample to the original baseline sample for FI cases. (Due to a restructuring of FA case management during the evaluation, no baseline data is available for FA case comparisons.) There was a significant difference in days open for the post-test sample ( $M=236.01$ ,  $SD=104.61$ ) and for the baseline sample ( $M=295.98$ ,  $SD=143.40$ );  $t(88)=2.25$ ,  $p=.03$ . **These results suggest that the length of time that FI cases remained open during the case management period has significantly decreased (by approximately 60 days) between the baseline and posttest study.**

### Case Record Reviews

Extensive training was conducted with case record reviewers prior to the collection of data used in the current study. Instrumentation was reviewed in a detailed fashion, with all reviewers also completing a thorough review of background reading, including the *Child and Family Service Reviews Procedures Manual* (2006), the *Comprehensive Family Assessment Guidelines for Child Welfare* (Children's Bureau, 2005), and a review of federal and state definitions relevant to case record reviews (safety assessments, risk assessments, family strength and needs assessments - all of which were available to case record

reviewers in a manual). Following two sessions of item-by-item instrumentation review by two senior researchers, a sample case was selected and a review completed as a means of testing the utility of the instrument. The sample case was then used to train three case record reviewers on using the instrument in both the paper and electronic formats. Each reviewer received approximately 45 hours of initial training (not including completing background reading), followed by approximately 15 hours of on-going group training and additional individual training on a question-by-question basis over a period of 10 weeks.

During training, each reviewer co-read one FI case management case (approximately 16 hours of co-case reading) before beginning independent case record reviews. Reliability among readers was checked using interclass correlations and discrepancies among reviewers were discussed during on-going training sessions in order to develop a set of decision rules to guide future case record reviews. Inter observer agreement for the initial training case was .96 ( $p=.000$ ), CI = .96-.97. Inter observation agreement for the subsequent reliability case (traditional intake) was .95 ( $p=.000$ ), CI = .95-.96. These results indicate a high level of agreement between the three reviewers used in the current study.

### **Data Analysis**

The CFSR items deemed particularly important in analyzing CFA were items 1, 3-4, 14-15, and 17 through 23. These items included: safety and risk assessments; maintaining children's connections to community, extended family, friends, etc.; placements with relatives; comprehensive assessments; family involvement in case planning; patterns of worker visits; and connection of services related to a child's physical health, mental health, and education needs.

Analyses (including crosstabs, frequencies, t-tests and case summaries) were conducted using the Statistical Product and Service Solution (SPSS) software version 21. Following initial analyses of the posttest data, results were compared to appropriate baseline study results in order to identify trends and statistically significant changes that occurred between baseline case record review (prior to CFA practice implementation) and posttest case record review (following CFA practice implementation).

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## Results

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### **Safety and Risk Assessment**

#### *Overview*

The evaluation of child safety and risk are integral components of the Comprehensive Family Assessment model in order to secure the protection of each child within the home. *Safety, risk, and comprehensive assessments* are three independent procedures with unique guidelines as specified by the CFSR. The assessment of risk and safety should be completed during investigation (or assessment, in FA cases) for *all* cases, while a safety plan should only be put into place in cases with an apparent risk of harm or safety threat. Ongoing assessments should be conducted as the case moves into child protection case management regardless of whether the family is served in the FI or FA track. The current study includes analyses of assessment data based on these CFSR guidelines with one exception. While the CFSR evaluates safety for *all* children in the household, the current study largely focused on the safety assessment for the subject child (youngest alleged victim) only.

As written in the CFSR, there are a number of questions that refer to a specific subset of clients, such as those who are at risk of immediate harm. In addition, the family composition varies for each child served; for example, a parent may not be available at the time of case opening or the father's whereabouts are unknown. Therefore, the number of clients to whom any question refers will vary by question. Where this is the case, the numbers will be provided in the text or tables.

#### *Timeliness*

Timeliness of initiating investigations of reports of child maltreatment is imperative to ensuring children's safety, especially in cases in which children are reported to be in imminent danger. State policy requires an immediate response – face-to-face contact with the child and primary caregiver within 24 hours of the report – to reports of maltreatment alleging substantial child endangerment, or daily attempts until contact is made. For all other reports, face-to-face contact with the child and primary caregiver are required to occur within five days of the report, or attempts must be made every five days until contact is made. Workers in the current study documented timely face-to-face visits with children

who were alleged victims of maltreatment in 93% of the cases. When examined separately, workers met their timelines in 90% of FI cases and 100% of FA cases. Between 90% and 100% compliance for FI and FA is considered a strength according to CFSR. Of the cases in which workers were not able to conduct a face-to-face visit in the appropriate timeframe, all but one (FI case) had documented attempts to contact the child and caregiver (or collateral contact when the child and caregiver could not be reached) within the appropriate timeframe. In comparison, in the *Intake Baseline Study*, timely face-to-face contact was documented in 73% of the cases. Comparison of the two samples (baseline and post-test), therefore, reveals 27% improvement in meeting State requirements. A Pearson chi-square test reveals that the difference between baseline and post-test results was statistically significant ( $\chi^2(1, N=210) = 13.88, p=.000$ ). **Results of the current study indicate that RCCSHD followed policies regarding timeliness of investigations in approximately 90% of FI cases and 100% of FA cases, surpassing previous CFSR reports and indicating significantly improved compliance since the Initial *Intake Baseline Study*.**

#### *Risk Assessments, Safety Assessments, and Safety Plans*

The Minnesota Department of Human Services (DHS) places a high priority on the completion of risk and safety assessments, and the subsequent development of safety plans for all cases with risk of immediate harm (i.e., those cases with a safety threat present). Risk and safety assessments form the foundation for developing a thorough, comprehensive assessment of all family members and, together with safety plans, ensure the protection of children within the home. In the RCCSHD CFA practice model, information learned during risk and safety assessments (whether initial or on-going) is built upon in the family functional assessment (or the assessment of the underlying causes of behaviors that put the child at risk of immediate or future harm), which then informs development of the case plan.

Of the Intake cases reviewed approximately 98% (97% FI and 100% FA) included a completed safety assessment within 45 days of case opening (this marks a 1% improvement over the *Intake Baseline Study* results) with only two cases where workers did not document a safety assessment when there should have been one. Of those two cases, one received a safety assessment after the initial 45 day period and the other did not.

There were 15 cases (17% of the entire sample) in which the worker described a risk of immediate harm to children (13 cases in FI and 2 cases in FA); of those cases, 13 (87%) had a safety plan on file. The two cases that documented a risk of immediate harm to children and had no safety plan on file were from FI. Additionally, there was one case (in FI), where reviewers were unable to determine whether there was an identified risk of immediate harm to children; no safety plan was documented in that case. **Results of the current study indicated that RCCHSD followed policies regarding safety assessments in Intake 98% of the time. This is a 1% improvement from the *Intake Baseline Study*. Despite this success, workers are still occasionally creating safety plans for cases where there is an absence of safety threats. This practice has improved since the *Intake Baseline Study*, with a reduction from 28% to 12% for both FI and FA.**

Conducting ongoing risk and safety assessments throughout the life of the case further guarantees protection for children and continues to inform other on-going assessments and case planning processes. In order to measure the use of on-going risk assessments, case record reviewers documented whether a worker completed a risk assessment both within the first 60 days and after 60 days of commencement of case management services (for all cases, regardless of whether a safety threat was present) as well as when there was a change in the family's situation during these same two time periods. Completion of risk assessments prior to case closure was also assessed. In order to measure the use of on-going safety assessments, case record reviewers documented whether a worker completed a safety assessment both within the first 60 days and after 60 days of commencement of case management services (for those cases that noted the presence of a risk of harm, or safety threat) as well as prior to case closure. In addition, when safety threats were present, the development of safety plans as well as the detail included in safety plans was assessed. Details of these assessments can be found in Table 2.

In regard to conducting on-going risk assessments when risk of harm or a safety threat was indicated, little change was seen early on in the case management process (within 60 days of case opening) between baseline and posttest for FI cases. Just over a third of all FI cases (36%) received an ongoing risk assessment during that time period and less than half (47%) received an on-going risk assessment in that time period when the family's situation changed. However, utilization of on-going risk assessments was high for



FI cases after 60 days of case management receipt. Over 90% of all FI cases received a revised risk assessment after 60 days of case management service receipt. In contrast to FI, FA cases consistently received on-going risk assessments throughout the case management process. Utilization of safety assessments followed the same pattern as risk assessments, with only half of FI cases that indicated a threat to the child's safety receiving a revised safety assessment within 60 days but *all* cases receiving revised safety assessments thereafter. Because threats to a child's safety were not evident in the majority of FA cases, only the use of revised safety assessment after 60 days could be measured; in this instance the use reached 100%. Safety plans, on the other hand, were revised consistently throughout the case management process for both FI and FA cases though numbers were somewhat higher for FA than FI cases.

The goal in this area is to consistently connect risk and safety assessments to safety plans or working agreements (and therefore on-going assessments, case plans, and services) for all families. **Significant increases in the use of ongoing risk and safety assessments as well as safety plans were found when comparing baseline FI case management to posttest FI case management cases.** However, because of small sample sizes sometimes quite large increases between baseline and posttest (for FI cases) did not reach a level of statistical significance. **Yet, there remains an opportunity for improvement in the on-going risk and safety assessment processes for FI cases early on during case management service delivery. Although FA data does not allow for comparisons for this response track over time, the evaluation of on-going risk and safety assessment and use of safety plans is currently an areas of strength for FA. On-going risk and safety assessment and safety planning utilization is higher for FA than FI; and, utilization in FA is consistently high.**

**Table 2. Use of risk assessments, safety assessments, and safety plans in Case Management**

		Case Management			
		All	FI	FA	
		Posttest (n=45)	Baseline (n=60)	Posttest (n=30)	Posttest (n=15)
<b>Risk Assessment</b>					
	Completed within 60 days (n=43, 43, 28, 15)	77%	35%	36%	87%
	Completed when there was a change in the family's situation (within 60 days) (n=20, --, 15, 5)	60%	---	47%	100%
	Completed after 60 days (n=37, 30, 26, 11)	95%	63%	93%**	100%
	Completed when there was a change in the family's situation (after 60 days) (n=26, --, 22, 4)	100%	---	100%	100%
	Completed prior to case closing (n=30, 24, 17, 13)	97%	88%	94%	100%
<b>Safety Assessment</b>					
	Completed within 60 days (n=4, 15, 4, and 0)	50%	47%	50%	N/A
	Completed after 60 days (n=6, 10, 5, and 1)	100%	40%	100%*	100%
	Completed prior to case closing (n=1, 1, 1, 0)	100%	100%	100%	N/A
<b>Safety Plan</b>					
	Completed within 60 days (n=4, 15, 4, and 0)	100%	33%	100%*	N/A
	Completed after 60 days (n=6, 10, 5, and 1)	67%	30%	80%	0%
	Described safety threat (n=43, 36, 28, 15)	100%	75%	100%**	100%
	Included all risks to safety (n=43, 36, 28, 15)	93%	19%	89%**	100%
	Contained realistic evaluation of threats (n=43, 36, 28, 15)	85%	67%	83%	100%
	Contained realistic evaluation of protective factors (n=43, 36, 28, 15)	77%	54%	75%	100%

**Note.** Corresponding sample sizes for Posttest all, Baseline FI, Posttest FI, and Posttest FA are given in ( ) respectively in each row. Questions about on-going risk assessment were added to the posttest assessment; therefore data regarding ongoing risk assessment when a change in the family's situation are evident is not available. Also, at certain time points there were FA cases in which a threat to the child's safety was not evident; at these time points "N/A" is used. \* $p < .05$  \*\* $p < .01$

*Safety: Plans, Services, and Family Member Involvement*

Parent involvement and appropriate child involvement is an important aspect of safety and risk assessment, and is essential to meaningful case planning (Children's Bureau, 2007). **Encouragingly, when available, both mothers and fathers were involved in safety planning in a majority of cases; this marks a slight improvement since the baseline studies. Child involvement in Intake safety planning remains lower than parent involvement, but with significant improvements since the *Intake Baseline Study*; however, children were involved in a majority of cases that completed a safety plan in Case Management.** For example, safety planning in Intake involved *available mothers* 100% of the time (for both FI and FA Intake cases, an improvement of almost 9% overall), *available fathers* 93% of the time (92% for FI cases and 100% for FA cases, an improvement of 9% overall), and children of at least school age 88% of the time (100% in FI cases and 50% in FA cases, an improvement of 151% overall). Safety planning in Case Management involved *available mothers* 92% of the time (92% for FI and 100% for FA cases, the same rate as was found in the *Program Baseline Study*), *available fathers* 67% of the time (63% for FI cases and 100% for FA cases, an improvement of 15% in FI), and children of at least school age 90% of the time (89% in FI cases and 100% in FA cases, an improvement of 780% in FI). Although mother and father involvement showed improvement since baseline studies, Fisher's exact test indicates a non-significant difference for mothers and fathers between the two time points. However, involvement of children in the safety planning has increased significantly ( $p=.001$ , FET for Intake and  $p=.000$ , FET for Case Management) from baseline studies to the current study.

**Ramsey County performed strongly in connecting families to services that were congruent with their assessed needs in terms of safety, risk, and prevention of placement, across FI and FA cases.** In the current study, case records were reviewed in order to identify the types of services that were being provided to each child and family and whether or not those services were appropriate in targeting identified safety threats and/or risk of placement. There were 22 Intake cases where there were identified safety threats and/or risk of placement. Of these 22 cases, 18 cases (82%) received at least one service (through RCCHD or a community partner) that was specifically targeted to the identified safety threats and/or risk of placement. This represents a significant

improvement of 811% over baseline, where only 9% of applicable cases received services targeting identified safety threats or risk of placement ( $\chi^2(1,N=44) = 26.33, p=.000$ ). Combined, there were a total of 63 different services received among the 18 cases (with a range of one to six services received per case) with 94% of the overall services received specifically targeting identified safety threats and/or risk of placement. There were 15 Case Management (FI) cases where there were identified safety threats and/or risk of placement. Of these 15 cases, 13 cases (88%) received at least one service that was specifically targeted to the identified safety threats and/or risk of placement. This represents an improvement of 24% from service provision at baseline, where only 71% of applicable cases received services targeting identified safety threats or risk of placement ( $\chi^2(1,N=90) = 1.30, p=.253$ ). Combined, there were a total of 115 different services received among the 13 cases (with a range of three to 12 services received per case) with 97% of the overall services received specifically targeting identified safety threats and/or risk of placement.

### *Permanency*

Once a safety threat is detected via a safety assessment and the worker determines that it is not possible to ameliorate the safety threat using an in-home safety plan, establishing an environment of permanency and stability for a child placed out-of-home is crucial. The CFSR includes two Permanency Outcomes which are relevant to Ramsey County's performance in this area: 1) children have permanency and stability in their living situations, and 2) continuity of family relationships and connections are preserved. **The current study found that these permanency outcomes are an area of strength for Ramsey County.**

The current study found several areas of strength regarding Ramsey County's performance on CFSR permanency goals. Only 17 of the 90 cases reviewed in the current study were considered placement or out-of-home cases. (There were 14 out of 120 cases in the *Intake Baseline Study* and 35 out of 60 in the Baseline Case Management Study). The current study revealed that **of the 17 out-of-home cases, two (representing 12% of the out-of-home cases) had a placement occurring within 12 months of a prior placement. Both of these cases (as well as 87% of cases that didn't include reentry**

**into placement) received services that clearly targeted the prevention of placement; in these cases workers met with other professionals to coordinate case planning and engaged the family in services. The proportion of cases that re-entered represents no change from baseline, but clearly the service coordination and provision to prevent placement is an area of a strength for Ramsey County.** In the current study, there was one additional FI case that had a risk of placement within the first 60 days of case management; this case also received services targeted toward preventing placement. The result was that the child remained in the home, with safety threats managed by a safety plan.

**Current data about Permanency Outcome 2 reveal that (in most cases) attempts were made to maintain a child's connection to family during placement via inquiries to relatives. In fact, 69% of cases received an inquiry prior to placement and 88% of cases received a relative inquiry after placement.** This is in stark contrast to baseline findings, which revealed that only 21% of cases received an inquiry prior to placement and 77% received a relative inquiry after placement. This is a significant improvement from baseline to posttest, representing a 228% increase in relative inquiries prior to placement ( $\chi^2(1,N=42) = 10.10, p=.001$ ) and a (non-significant) 14% increase in relative inquiries after placement ( $\chi^2(1,N=42) = 0.91, p=.341$ ). **Approximately half (53%) of all children were placed with a relative (as compared to 57% at baseline) and all but two (78%) appeared to be stable (as compared to 80% at baseline).**

National CFSR standards mandate child protection make tribal inquiries in 100% of cases involving a Native American child. Of the 90 cases reviewed, 93% included documentation that an inquiry about tribal membership was conducted in Intake (90% for FI cases and 100% for FA cases). These numbers remain similar to the *Intake Baseline Study* – however FA cases rose from 95% inquiry to 100% inquiry. Of note – of the six FI cases where there was no apparent inquiry into tribal status, three were international families from Africa and Asia, one was African American, and two were Caucasian American. Of the 17 out-of-home cases, 77% included documentation in Case Management that an inquiry about tribal membership was conducted. This represents a 22% improvement over baseline, though the difference is non-significant ( $\chi^2(1,N=42) = 0.96$ ,

$p=.326$ ). **Preserving connections to tribes can be considered an area of strength for Ramsey County.**

### **Comprehensive Family Assessment**

Comprehensive family assessments (CFAs) allow workers to move beyond the incident that brought the family to child protection and focus instead on the patterns of parental behavior over time in a broader context of strengths and needs. While safety and risk assessments serve a vital purpose throughout the case planning process, they are not comprehensive. For the purpose of this study, “comprehensive” means that “the assessment incorporates information collected through other assessments and addresses broader needs of the child and family that are affecting a child’s safety, permanency, and well-being” (Children’s Bureau, 2005). Because CFAs require the establishment of a partnership with the family and collaboration with community partners, it is not possible to conduct a complete comprehensive family assessment in Intake. Rather, the beginnings of assessing the family from a holistic view (rather than focusing solely on the presenting problem) take place within these first 45 days. Comprehensive Family Assessments are fully completed during the case management process. Thus, the following analyses used the abovementioned criteria as well as the *Comprehensive Family Assessment Guidelines* (Schene, 2005) to detail the extent to which workers were able to engage in comprehensive family assessment practice throughout the life of the case.

**Almost all posttest cases included a comprehensive family assessment of at least one family member.** (See Table 3.) **ALL Intake cases included a *partial or full initial assessment* of at least one family member, and 96% of all Case Management cases included a *partial or full assessment* of at least one family member.** An *initial assessment* (for Intake, or *full assessment* when referring to assessments occurring in Case Management) is defined as a comprehensive family assessment that is written up by the worker in a way that it is possible to reference all facets of the assessment in the case record, while a *partial assessment* is referenced in the case record (usually not presented as a single entry) that references most, but not all, facets of the initial (or full) assessment. This is a significant, and substantial, change from baseline findings. There were two FI Case

Management cases that did not include a comprehensive assessment of at least one family member; in these cases the worker relied on the initial comprehensive assessment conducted in Intake.

**Table 3. Comprehensiveness of Assessments in Intake and Case Management Cases of at Least One Family Member**

	Intake				Case Management		
	FI		FA		FI	FA	
	Pretest n=60	Posttest n=60	Pretest n=60	Posttest n=30	Pretest n=60	Posttest n=30	Posttest n=15
Full	0%	87%**	0%	100%**	10%	67%**	80%
Partial	100%	13%	100%	0%	78%	27%	20%
None	0%	0%	0%	0%	12%	6%	0%

Note. \* $p < .05$ , \*\* $p < .01$  when comparing rates of full comprehensive assessments over time from baseline to posttest.

### *Family Involvement*

A thorough comprehensive family assessment includes the involvement of all available family members, including the subject child, mother, father, and siblings, and foster families (if applicable). The current study evaluated family involvement by examining: 1) the completion of need assessments for each family member; 2) the frequency and quality of worker visits with each family member, as well as 3) the involvement of family members in the case planning process. Recognizing that each family has unique attributes, the researchers accounted for the unique member make-up of each family unit and only included the parent(s) that were available for services during the time of case opening. “Availability” was defined as the person having contact with the worker or the worker knowing where the person was at least at some point in the case. Table 4 presents differences in availability of family members from baseline studies to the current study based on this definition. **Although differences in availability did not reach a level of statistical significance, larger proportions of fathers were available following CFA implementation in FA Intake cases and FI Case Management cases than were available prior to CFA implementation. Availability of other family members remained rather consistent.**

Table 4. Availability of Family Members

	Intake						Case Management			
	All Cases		FI		FA		All Cases	FI		FA
	Pretest n=120	Posttest n=90	Pretest n=60	Posttest n=60	Pretest n=60	Posttest n=30	Posttest n=45	Pretest n=60	Posttest n=30	Posttest n=15
Mom	95%	97%	100%	98%	90%	93%	100%	92%	100%	100%
Dad	63%	69%	70%	62%	55%	83%	71%	42%	67%	80%
Child	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sibling	74%	71%	70%	75%	78%	73%	78%	67%	77%	80%



**Utilization of Comprehensive Family Assessments for individual family members significantly increased between the initial baseline study and the current study for both Intake and Case Management.** Results of the current analysis revealed that **available mothers (biological, adoptive or step-mothers), target children, and siblings were more often assessed than available fathers (biological, adoptive or step-fathers).** Additionally, when assessed, **available mothers, target children, and siblings were more often *fully* assessed than were available fathers** (see Tables 5 and 6.)

**Mothers were given a full, initial comprehensive assessment more frequently than any other family member, with fathers receiving the fewest full, initial comprehensive assessments. (See Table 5.) Even with the increase in the number of available fathers (or father substitutes – meaning adoptive or step fathers) between the *Intake Baseline Study* and the current study, the number of fathers receiving a full or partial initial assessment declined by 18%.** A Pearson chi-square test revealed that the difference between the percent of father full or partial initial comprehensive assessments obtained during the *Intake Baseline Study* and the current study was statistically significant ( $\chi^2(1, N=124) = 4.82, p=.028$ ). Target children during the current study more often received full initial comprehensive assessments in comparison to their *Intake Baseline Study* counterparts, who received a partial initial comprehensive assessment more often than a full initial assessment. Combining FI and FA samples, of the target children who received an initial assessment, 81% received a full initial comprehensive assessment. In the *Intake Baseline Study*, by comparison, of the target children who received an initial assessment, a full initial assessment took place only 41% of the time. A Pearson chi-square test reveals that the difference between the percent of full vs. partial initial comprehensive assessments obtained during the *Intake Baseline Study* and the current study was statistically significant ( $\chi^2(1, N=199) = 31.96, p=.000$ ). In the current study, siblings were more likely to receive partial, initial comprehensive assessments rather than full, initial assessments. Fathers and siblings were most often omitted from the comprehensive assessment process compared to mothers and target children, even when they were available to the worker.

**Table 5: Comprehensive Assessments of Available Family Members in Intake**

	Full Initial Assessment		Partial Initial Assessment		No Assessment	
	FI	FA	FI	FA	FI	FA
<b>Fathers baseline</b> (n=35 FI, n=26 FA)	31%	39%	51%	39%	18%	22%
<b>Fathers posttest</b> (n=37 FI, n=25 FA)	38%	44%	19%	28%	43%*	28%
<b>Mothers baseline</b> (n=60 FI, n=53 FA)	38%	66%	62%	32%	0%	2%
<b>Mothers posttest</b> (n=59 FI, n=28 FA)	76%**	93%*	22%	7%	2%	0%
<b>Children baseline</b> (n=60 FI, n=59 FA)	37%	42%	60%	53%	3%	5%
<b>Children posttest</b> (n=60 FI, n=30 FA)	68%**	90%**	27%	7%	5%	3%
<b>Other children in home baseline</b> (n=42 FI, n=47 FA)	17%	29%	64%	52%	19%	19%
<b>Other children in home posttest</b> (n=45 FI, n=22 FA)	53%**	50%	31%	36%	16%	14%

*Note.* \* $p < .05$ , \*\* $p < .01$  when comparing rates of full comprehensive assessments or the lack of a comprehensive assessment over time from baseline to posttest. A pre-test was not conducted for FA cases.

During case management, mothers were again given a full comprehensive assessment more frequently than any other family member, with fathers again receiving the fewest full comprehensive assessments. (See Table 6.) Mothers in the current study more often received a partial or full comprehensive assessment than their baseline counterparts ( $\chi^2(1, N=85) = 7.54, p=.006$ ). However, unlike in Intake, the use of comprehensive assessments for available fathers *increased* between the *Program Baseline Study* and the current study even though the increase was not statistically significant ( $\chi^2(1, N=72) = 1.30, p=.254$ ). As in Intake, target children in Case Management in the current study more often received full comprehensive assessments in comparison to their

*Program Baseline Study* counterparts, who received a partial comprehensive assessment more often than a full assessment. Unlike Intake, siblings were more likely to receive full comprehensive assessments rather than partial assessments. Fathers and siblings were most often omitted from the comprehensive assessment process compared to mothers and target children, even when they were available to the worker.

**Table 6: Comprehensive Assessments of Available Family Members in Case Management**

	Full Assessment		Partial Assessment		No Assessment	
	FI	FA	FI	FA	FI	FA
<b>Fathers baseline</b> (n=25 FI)	0%	--	18%	--	82%	--
<b>Fathers posttest</b> (n=20 FI, n=12 FA)	18%	46%	18%	8%	75%	64%
<b>Mothers baseline</b> (n=55 FI)	5%	--	50%	--	45%	--
<b>Mothers posttest</b> (n=30 FI, n=15 FA)	64%**	79%	21%	14%	14%**	7%
<b>Children baseline</b> (n=60 FI)	6%	--	47%	--	47%	--
<b>Children posttest</b> (n=30 FI, n=15 FA)	56%**	71%	26%	29%	18%**	0%
<b>Other children in home baseline</b> (n=40 FI)	5%	--	42%	--	53%	--
<b>Other children in home posttest</b> (n=23 FI, n=12 FA)	52%**	84%	19%	8%	29%	8%

*Note.* \*  $p < .05$ , \*\*  $p < .01$  when comparing rates of full comprehensive assessments or the lack of a comprehensive assessment over time from baseline to posttest.

**Overall utilization of comprehensive family assessments was generally higher in FA than FI for both Intake and Case Management. Increases in utilization and completeness of comprehensive assessments were seen across Intake and Case Management. However, only 14% of Intake cases and 47% of Case Management**

**cases included an initial/full (as appropriate) comprehensive assessment on all available family members.**

#### *Frequency and Quality of Family Visits*

According to the *CFA Guidelines*, “engagement and building relationships are of central importance in gathering meaningful information from families, children, and youth” (Children’s Bureau, 2005). Ensuring that families have enhanced capacity to provide for their children’s needs is partly achieved through this relationship building over time. Assessments must be updated throughout a case as family circumstances change and workers gather new information about existing needs. For this reason, the CFSR guidelines include the frequency and quality of worker visits over time as an important aspect of the assessment process. A visit is defined as a face-to-face contact between the caseworker and family member.

Since children who are maltreated experience a variety of stressors that impact their development, initial comprehensive assessments with youth should focus on gathering information that will assist in deciding what actions are needed to keep the child safe and to establish permanency. This is accomplished partly through the identification of strengths and needs in relation to physical health, academic achievement, and emotional functioning (USDHHS ACF, 2007). In order to sufficiently and accurately gather this complex information, evaluating the *quality* of each face-to-face visit is key. In determining whether a contact is a “quality” visit, the reviewer considered a number of factors, including duration and location of the visit (as required by Minnesota Department of Human Services, 2005). Most importantly, the reviewer evaluated whether the visits were sufficient to address issues pertaining to the safety, permanency, and well-being of the child as well as to promote achievement of case goals.

Using the sufficiency guidelines mentioned above to determine the “strength” of visitation, **the current data reflect “strength” results with 91% of all target children (across FI and FA Intake) having sufficiently frequent visits and 87% of the quality of all visits appearing to be sufficient to ensure the safety, permanency, and well-being of the child and promote achievement of case goals. Across FI and FA Intake cases, there was an improvement of approximately 10% for frequency of visits and approximately 21% for the quality of visits from the *Intake Baseline Study* to the**

**current study.** Although trends of these analyses are leading in the right direction, chi-square analyses indicate that the change between the *Intake Baseline Study* and the current study was non-significant for sufficiency of visits with the target child. (See Table 7 below for further details regarding sufficiency of visit frequency and quality by intake type.)

Additionally, the frequency and quality of visits between the caseworker and the parents were also reviewed to determine whether or not they appeared to be sufficient in ensuring the safety, permanency, and well-being of the child. **The frequency and quality of visits between the caseworker and available parents (in order to ensure safety, permanency, and well-being of the child) is an area that continues to need improvement for Intake cases (with the exception of mothers receiving FA services). Overall, FA cases continue to show higher sufficiency than FI cases, but no significant improvements were made between the *Intake Baseline Study* and the current study. In fact, worker visits seem to be slightly less sufficient overall, compared to the *Intake Baseline Study* sample. Additionally, the frequency and quality of mother visits continues to be significantly higher than for father visits.**

Overall (across FI and FA Intake cases), there were slight (non-significant) changes in the sufficiency of visits with mothers to ensure safety, permanency, and well-being of the child between the *Intake Baseline Study* and the current study. For the frequency of visits with mothers, there was a 1% improvement and for the quality of visits, there was a 4% decrease in sufficiency. For fathers there was a decrease of 10% in frequency of visits and a 16% decrease in the quality of visits (both statistically non-significant changes) between the *Baseline Intake Study* and the current study. As shown in Table 7 below, the sufficiency of visits with available mothers and fathers to ensure safety, permanency, and well-being of the child was higher among FA cases than FI cases. Results of Fisher's Exact test indicate significant differences between FA and FI cases for both frequency ( $p=.007$ , FET) and quality ( $p=.008$ , FET) of visits. Additionally, the sufficiency of mother visits to ensure safety, permanency, and well-being of the child across FI and FA, both in frequency ( $p=.000$ , FET) and quality ( $p=.000$ , FET) were significantly higher than for father visits.

**Table 7: Sufficient Visits with Children and Available Parents in Intake**

	Sufficient Frequency		Sufficient Quality	
	FI	FA	FI	FA
<b>Children baseline</b> (n=60 FI, n=59 FA)	82%	83%	65%	78%
<b>Children posttest</b> (n=60 FI, n=30 FA)	88%	97%	82%	97%
<b>Fathers baseline</b> (n=35 FI, n=26 FA)	77%	92%	62%	81%
<b>Fathers posttest</b> (n=37 FI, n=25 FA)	60%	92%	49%	72%
<b>Mothers baseline</b> (n=60 FI, n=53 FA)	77%	93%	68%	87%
<b>Mothers posttest</b> (n=59 FI, n=27 FA)	78%	100%	66%	89%

Again using the sufficiency guidelines mentioned above to determine the “strength” of visitation, the current study found that **monthly contact with the children was the most typical visitation pattern; this pattern occurred for 85% of all children receiving case management services and represents a 43% increase (in visitation for FI case management cases) from the *Program Baseline Study*.** (See Table 8.) The current data reflect “strength” results with **82% of all target children (across FI and FA Case Management) having sufficiently frequent visits and 78% of the quality of all visits appearing to be sufficient to ensure the safety, permanency, and well-being of the child and promote achievement of case goals. Across FI and FA Case Management cases, there was an improvement of approximately 1% for frequency of visits and approximately 21% for the quality of visits from the *Program Baseline Study* to the current study.** Although trends of these analyses are leading in the right direction, chi-square analyses indicate that the change between the *Program Baseline Study* and the current study was non-significant for sufficiency of visits with the target child.

The frequency and quality of visits between the caseworker and the parents were also reviewed to determine whether or not they appeared to be sufficient in ensuring the safety, permanency, and well-being of the child. As it was for children, the typical visitation

pattern for almost three quarters (73%) of all mothers and half (50%) of all fathers was monthly. This represents a 26% increase for mothers and a 233% increase for fathers, though not statistically significant. **The frequency and quality of visits between the caseworker and available parents (in order to ensure safety, permanency, and well-being of the child) is an area that has shown modest improvement over the *Program Baseline Study*. The current study reveals that 84% of all mothers and 50% of all fathers (across FI and FA Case Management) having sufficiently frequent visits and 71% of the quality of all mothers' visits and 41% of the quality of all fathers' visits appearing to be sufficient to ensure the safety, permanency, and well-being of the child and promote achievement of case goals. In FI Case Management cases, this represents a 13% increase for mothers and a 25% increase for fathers in frequency, and an 11% increase for mothers and a 25% increase for fathers in quality (though increases were not statistically significant). Overall, FA cases continue to show higher sufficiency than FI cases. Additionally, the frequency and quality of mother visits continues to be significantly higher than for father visits.**

**Table 8: Sufficient Visits with Children and Available Parents in Case Management**

	Sufficient Frequency		Sufficient Quality		Monthly Visitation	
	FI	FA	FI	FA	FI	FA
<b>Children baseline</b> (n=60 FI, n=59 FA)	72%	--	58%	--	58%	--
<b>Children posttest</b> (n=30 FI, n=15 FA)	73%	100%	70%	93%	83%*	87%
<b>Fathers baseline</b> (n=25 FI, n=26 FA)	28%	--	20%	--	12%	--
<b>Fathers posttest</b> (n=20 FI, n=12 FA)	35%	75%	25%	67%	40%*	67%
<b>Mothers baseline</b> (n=55 FI, n=53 FA)	67%	--	56%	--	62%	--
<b>Mothers posttest</b> (n=30 FI, n=15 FA)	76%	100%	62%	87%	76%	67%

*Note.* \*  $p < .05$ , \*\*  $p < .01$  when comparing rates of visits with family members over time from baseline to posttest. A pre-test was not conducted for FA cases.

**Clearly, results of the current study indicate moderate to substantial growth in utilizing comprehensive family assessments and involving family members in the assessment process. Areas that need continued improvement for Ramsey County include initiating more comprehensive assessment across *all* family members, but especially for fathers and siblings, who often did not receive an initial comprehensive assessment, when available.** Due to inconsistent gathering of information across family members, there was great variability in the inclusion of all family members in the comprehensive assessment process (ranging from 13% to 68% of cases, depending on case type). **Additionally, the frequency and quality of visitation with all family members, with special attention to fathers is an area for continued improvement.** Case file documentation indicated that visitation was either not sufficient or unclear as to whether or not the quality of visits with parents was sufficient to ensure the safety, permanency, and well-being of children approximately half of all cases in which fathers were available and a quarter of cases in which mothers were available; improved documentation of visitation may improve these numbers. Although modest gains were demonstrated in the current study, these gains did not rise to a level of statistical significance. **An area that showed improvement is the comprehensiveness of assessments. When workers are completing comprehensive assessments, they are more often completing full initial assessments than partial initial assessments; this is in stark contrast to baseline studies. Additionally, the frequency and quality of visits with mothers was found to be sufficient in ensuring safety, permanency, and well-being of children in almost all FA cases, indicating a strength to be modeled for visits with other family members in both FA and FI cases.**

### *Case Planning and Assessment*

The purpose of a comprehensive family assessment is to develop a plan that addresses factors affecting a child's well-being and guides the family towards improved functioning. The assessment, along with the case plan, must comprehensively consider the family's history, current situation, and the impact of maltreatment on future family development. This information can only be gathered accurately through the regular case plan involvement of all family members (Children's Bureau, 2005). The current study



assessed case plan involvement in the most recent case plan of individual family members. **Case plans were found for all cases receiving Case Management services, with most plans being developed after opening in Case Management (96%). Across FI and FA cases, mothers were most often involved in case planning (95%), followed by target children (63%), and then fathers (48%).** Of the 30 cases served by FI Case Management, 29 (97%) had a case plan on file that was developed after case opening in Case Management; the remaining case had a plan on file that was developed in Intake. Available mothers were involved in 96% of all case plans (25 of 26), available fathers involved in 42% (8 of 19) of case plans, and the target child in 56% (5 of 9) of case plans. Involvement of family members in case planning increased for mothers (previously 82%) and target children (previously 32%) as compared to the *Program Baseline Study* but decreased for fathers (previously 60%). Of the 15 cases served by FA Case management, 14 (93%) had a case plan on file that was developed after case opening in Case Management; the remaining case had a plan on file that was developed in Intake. Available mothers were involved in 93% of all case plans (14 of 15), available fathers involved in 58% (7 of 12) of case plans, and the target child in 71% (5 of 7) of case plans. For cases in which ongoing case planning was applicable (FI n=23, FA n=6), 78% (74% for FI and 83% for FA) received an informal or formal update after the first 60 days of case management.

### *Identifying Family and Community Strengths*

The focus of a comprehensive assessment is not only the presenting issue at a specific time, but a thorough “big picture” view of the needs and strengths of a family unit. As outlined by the *CFA Guidelines*, “the family strengths and protective factors are assessed in order to identify resources that can support the family’s abilities to meet its needs and better protect the children” (Children’s Bureau, 2005). While the CFSR does not tackle this issue for Ramsey County, a national review of child protection services found that family assessments often failed to identify family strengths that could be built upon (United States Children’s Bureau, 2007).

The current data reveal that for the majority of time, workers adequately assessed strengths. **Family strengths were mentioned or appeared complete in 98% of all Intake and Case Management cases (97% for FI and 100% for FA cases). Strengths**

**were more often assessed within the first 45 days of receiving the case in Intake and after 60 days of receiving the case in Case Management. Strengths appeared in case notes (for Case Management) and/or in Structured Decision Making (SDM) assessments (for Intake) most often.** (See Table 9 below for details about where workers were documenting family strengths.)

**Table 9: Documentation of family strengths**

	Intake				Case Management		
	FI		FA		FI		FA
	Pretest n=60	Posttest n=60	Pretest n=60	Posttest n=30	Pretest n=60	Posttest n=30	Posttest n=15
<b>No documentation</b>							
Within 45/60 days	0%	2%	2%	3%	65%	17%	0%
After 60 days	--	--	--	--	35%	0%	0%
<b>In strengths and needs assessment form or in a contracted assessment only</b>							
Within 45/60 days	22%	70%	13%	80%	0%	10%	13%
After 60 days	--	--	--	--	17%	23%	67%
<b>In case notes and/or intake narrative only</b>							
Within 45/60 days	15%	20%	8%	7%	33%	56%	47%
After 60 days	--	--	--	--	33%	14%	33%
<b>In both strengths and needs assessment form/contracted assessment and in case notes and/or intake narrative</b>							
Within 45/60 days	63%	8%	77%	10%	2%	17%	40%
After 60 days	--	--	--	--	15%	63%	0%

*Note.* A pre-test was not conducted in FA. Documentation of family strengths is presented within the first 45 days of Intake; Documentation of family strengths is presented within the first 60 days of Case Management as well as after the first 60 days of Case Management.

**Workers assessed strengths of the target child and mothers in almost all cases but were less successful in assessing fathers' strengths.** (See Tables 10 and 11 below.) **Community strengths were noted least often and were more likely to be noted in Case Management than in Intake** ( $\chi^2(1,N=90) = 3.878, p=.049$  for FI;  $\chi^2(1,N=45) = 4.865, p=.027$  for FA). **Significant improvements in assessing child strengths were demonstrated in Intake (representing a 16% improvement over baseline) and Case Management (representing a 29% improvement over baseline). Significant**

**improvements in assessing community strengths were also seen in Case Management, representing a 192% improvement over baseline.**

**Table 10: Assessment of Family Member and Community Strengths in Intake**

	Mentioned or Appeared Complete		None Documented	
	FI	FA	FI	FA
<b>Child Strengths baseline</b> (n=60 FI, n=60 FA)	97%	80%	3%	20%
<b>Child Strengths posttest</b> (n=60 FI, n=30 FA)	93%	93%*	7%	7%
<b>Fathers Strengths baseline</b> (n=36 FI, n=26 FA)	72%	73%	28%	27%
<b>Fathers Strengths posttest</b> (n=37 FI, n=24 FA)	62%	83%	38%	17%
<b>Mothers Strengths baseline</b> (n=60 FI, n=53 FA)	88%	96%	12%	4%
<b>Mothers Strengths posttest</b> (n=59 FI, n=28 FA)	95%	100%	5%	0%
<b>Community Strengths baseline</b> (n=60 FI, n=60 FA)	68%	67%	32%	33%
<b>Community Strengths posttest</b> (n=60 FI, n=30 FA)	52%	73%	48%	27%

*Note.* \* $p < .05$ , \*\* $p < .01$  when comparing rates of assessments of strengths over time from baseline to posttest.

**Table 11. Assessment of Family Member and Community Strengths in Case Management**

	Mentioned or Appeared Complete		None Documented	
	FI	FA	FI	FA
<b>Children baseline</b> (n=60 FI, n=59 FA)	72%	--	28%	--
<b>Children posttest</b> (n=30 FI, n=15 FA)	93%*	100%	7%	0%
<b>Fathers baseline</b> (n=25 FI, n=26 FA)	52%	--	48%	--
<b>Fathers posttest</b> (n=20 FI, n=12 FA)	60%	83%	40%	17%
<b>Mothers baseline</b> (n=55 FI, n=53 FA)	76%	--	24%	--
<b>Mothers posttest</b> (n=30 FI, n=15 FA)	90%	100%	10%	0%
<b>Community Strengths baseline</b> (n=60 FI, n=60 FA)	25%	--	75%	--
<b>Community Strengths posttest</b> (n=30 FI, n=15 FA)	73%**	100%	27%	100%

Note. \* $p < .05$ , \*\* $p < .01$  when comparing rates of assessments of strengths over time from baseline to posttest.

### *Appropriate Services in Connection to Family Needs*

In order to guarantee appropriate services for a family, a worker must use the comprehensive assessment to simultaneously evaluate the strengths and needs of all family members. Typically, “families involved with agency child protection have multiple needs and require a range of assessments and follow up services” (Minnesota Department of Human Services, 2005). The current study examined each family member’s needs as well as reasons why needs were not identified by the worker as needs or addressed by services. The study defined “need” as either a problem that should be addressed by services (e.g. alcohol dependency) or a necessity for services (e.g. individual therapy or transportation).

**Looking first at children in the family, data show that FI and FA Intake workers between the *Intake Baseline Study* and the current study made significant improvements in addressing the needs and ensuring the provision of services to meet identified needs. Additionally, FA Intake workers continued to excel in this area, as their identification of needs and provision of services to meet child needs was significantly higher than FI cases. See Tables 12 and 13 for information presented separately for FI and FA cases. Overall (FI and FA cases combined), when children had specific needs, workers identified those needs in 82% of cases, an improvement of 37%**

since the *Intake Baseline Study*. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study was statistically significant ( $\chi^2(1, N=101) = 5.89, p=.015$ ). Of the children who were identified by the worker as having needs, 73% of the services received addressed the identified needs, an improvement of 235%. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study was statistically significant ( $\chi^2(1, N=84) = 20.88, p=.000$ ). Fisher's Exact Test also indicated that FA workers were more likely than FI workers to both identify and ensure the provision of services around child needs ( $p=.003$  and  $p=.004$  respectively, FET).

**Identification of needs and ensuring the provision of services to meet identified needs for available mothers remained generally unchanged between the *Intake Baseline Study* and the current study. However, FA Intake workers continued to excel in this area, as their identification of needs and provision of services to meet mothers' needs was significantly higher than FI cases.** Overall (FI and FA cases combined), when mothers had specific needs, workers identified those needs in 77% of cases, a decrease of 1% since the *Intake Baseline Study*. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study was not statistically significant ( $\chi^2(1, N=190) = 0.007, p=.933$ ). Of the mothers who were identified by the worker as having needs, 68% of the services received addressed the identified needs, an improvement of 10%. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study was not statistically significant ( $\chi^2(1, N=190) = 0.825, p=.364$ ). Fisher's Exact Test indicated that FA workers were more likely than FI workers to identify ( $p=.03$ ) but not ensure the provision of services ( $p=.09$ ) around mothers' needs. However, a Pearson chi-square test revealed that the increase in the provision of services to address mothers' needs between the *Intake Baseline Study* and the current study was statistically significant ( $\chi^2(1, N=190) = 4.727, p=.030$ ).

**Identification of needs and ensuring the provision of services to meet identified needs for available fathers remained generally unchanged between the *Intake Baseline Study* and the current study. However, FA Intake workers continued to excel in this area, as their identification of needs and provision of services to meet fathers' needs was significantly higher than FI cases.** Overall (FI and FA cases combined), when fathers had specific needs, workers identified those needs in 74% of

cases, a decrease of 5% since the *Intake Baseline Study*. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study was not statistically significant ( $\chi^2(1,N=112) = 0.309, p=.578$ ). Of the fathers who were identified by the worker as having needs, 72% of the services received addressed the identified needs, the same proportion as baseline. Fisher's Exact Test indicated that FA workers were more likely than FI workers to identify ( $p=.015$ ) but not ensure the provision of services ( $p=.229$ ) around fathers' needs.

**Table 12: Identification of needs in Intake**

	All known needs were clearly identified as needs		All known needs not identified as needs		Unclear if needs identified as needs	
	FI	FA	FI	FA	FI	FA
<b>Child Needs baseline (n=26 FI, n=21 FA)</b>	35%	91%	19%	5%	46%	5%
<b>Child Needs posttest (n=32 FI, n=22 FA)</b>	69%**	100%	16%	0%	16%**	0%
<b>Fathers Needs baseline (n=31 FI, n=24 FA)</b>	68%	92%	32%	8%	0%	0%
<b>Fathers Needs posttest (n=34 FI, n=23 FA)</b>	62%	91%	38%	9%	0%	0%
<b>Mothers Needs baseline (n=53 FI, n=52 FA)</b>	64%	92%	36%	8%	0%	0%
<b>Mothers Needs posttest (n=58 FI, n=27 FA)</b>	69%	93%	31%	7%	0%	0%

Note. \*  $p < .05$ , \*\*  $p < .01$  when comparing rates over time from baseline to posttest.

**Table 13: Needs Addressed by services in Intake**

	All known needs were clearly addressed		All known needs not addressed		Unclear if needs addressed	
	FI	FA	FI	FA	FI	FA
<b>Child Needs baseline (n=16 FI, n=16 FA)</b>	38%	44%	63%	50%	0%	6%
<b>Child Needs posttest (n=31 FI, n=21 FA)</b>	58%	95%**	23%**	5%**	19%	0%
<b>Fathers Needs baseline (n=31 FI, n= 22 FA)</b>	71%	73%	29%	27%	0%	0%
<b>Fathers Needs posttest (n=34 FI, n=23 FA)</b>	65%	83%	35%	17%	0%	0%
<b>Mothers Needs baseline (n=54 FI, n=51 FA)</b>	67%	57%	33%	43%	0%	0%
<b>Mothers Needs posttest (n=58 FI, n=27 FA)</b>	62%	82%*	38%	19%*	0%	0%

Note. \*  $p < .05$ , \*\*  $p < .01$  when comparing rates over time from baseline to posttest.

**While promising patterns were found regarding identification of need and provision of services to address needs for Intake, the same was not true for Case Management (CM). Because data was not collected for FA cases at baseline, comparisons over time cannot be made for FA cases. Looking first at children in the family, data show that FI CM workers between the Baseline Case Management Study and the current study did not make significant improvements in addressing the needs and ensuring the provision of services to meet identified needs. However, FA CM workers continued to excel in this area, as their identification of needs and provision of services to meet child needs was higher than FI cases. See Tables 14 and 15 for information presented separately for FI and FA cases. Overall (FI and FA cases combined), when children had specific needs, workers identified those needs in 76% of cases. Of the children who were identified by the worker as having needs, 62% of the services received addressed the identified needs. However, FI cases saw a reduction in both the identification of need (by 10%) and the provision of services to address identified needs (by 31%) between the Baseline Case Management Study and the current study. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study for FI cases was not statistically significant for identification of needs and the provision of services to address identified needs ( $\chi^2(1,N=70) = 0.373, p=.541$  and  $\chi^2(1,N=70) = 3.568, p=.059$ , respectively). However, Fisher's Exact Test indicated that FA workers were more likely than FI workers to identify but not ensure the provision of services around child needs ( $p=.033$  and  $p=.140$  respectively, FET).**

**Identification of needs and ensuring the provision of services to meet identified needs for available mothers followed similar patterns as were seen in the identification of needs and provision of services to children in CM. Overall (FI and FA cases combined), when mothers had specific needs, workers identified those needs in 74% of cases. Of the available mothers who were identified by the worker as having needs, 71% of the services received addressed the identified needs. However, FI cases saw a reduction in both the identification of need (by 24%) and the provision of services to address identified needs (by 22%) between the Baseline Case Management Study and the current study. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study for FI cases was statistically significant for identification of needs but**

not the provision of services to address identified needs ( $\chi^2(1,N=82) = 5.163, p=.023$  and  $\chi^2(1,N=82) = 2.957, p=.086$ , respectively). Fisher's Exact Test indicated that FA workers were neither more statistically likely than FI workers to identify nor ensure the provision of services around mothers' needs ( $p=.071$  and  $p=.277$  respectively, FET).

**Identification of needs and ensuring the provision of services to meet identified needs for available fathers also followed similar patterns as were seen in the identification of needs and provision of services to children and mothers in CM.**

Overall (FI and FA cases combined), when available fathers had specific needs, workers identified those needs in 67% of cases. Of the available fathers who were identified by the worker as having needs, 61% of the services received addressed the identified needs. However, FI cases saw a reduction in both the identification of need (by 51%) and the provision of services to address identified needs (by 52%) between the Baseline Case Management Study and the current study. A Pearson chi-square test revealed the difference between the *Intake Baseline Study* and the current study for FI cases was statistically significant for both identification of needs and the provision of services to address identified needs ( $\chi^2(1,N=52) = 9.253, p=.002$  and  $\chi^2(1,N=50) = 11.355, p=.000$ , respectively). However, Fisher's Exact Test indicated that FA workers were more likely than FI workers to identify and ensure the provision of services around fathers' needs ( $p=.000$  and  $p=.008$  respectively, FET).

**Table 14: Identification of needs in Case Management**

	All known needs were clearly identified as needs		All known needs not identified as needs		Unclear if needs identified as needs	
	FI	FA	FI	FA	FI	FA
<b>Child Needs baseline (n=47 FI)</b>	72%	--	15%	--	13%	--
<b>Child Needs posttest (n=23 FI, n=11 FA)</b>	65%	100%	26%	0%	9%	0%
<b>Fathers Needs baseline (n=32 FI)</b>	81%	--	19%	--	0%	--
<b>Fathers Needs posttest (n=20 FI, n=23 FA)</b>	40%*	92%	60%*	8%	0%	0%
<b>Mothers Needs baseline (n=53 FI)</b>	87%	--	13%	--	0%	--
<b>Mothers Needs posttest (n=29 FI, n=14 FA)</b>	66%*	93%	35%*	7%	0%	0%

Note. \*  $p < .05$ , \*\*  $p < .01$  when comparing rates over time from baseline to posttest.



**Table 15: Needs Addressed by services in Case Management**

	All known needs were clearly addressed		All known needs not addressed		Unclear if needs addressed	
	FI	FA	FI	FA	FI	FA
<b>Child Needs baseline (n=44 FI)</b>	75%	--	14%	--	11%	--
<b>Child Needs posttest (n=23 FI, n=11 FA)</b>	52%	82%	17%	0%	26%	18%
<b>Fathers Needs baseline (n=31 FI)</b>	87%	--	13%	--	0%	--
<b>Fathers Needs posttest (n=19 FI, n=12 FA)</b>	42%**	92%	58%**	8%	0%	0%
<b>Mothers Needs baseline (n=54 FI)</b>	82%	--	18%	--	0%	--
<b>Mothers Needs posttest (n=28 FI, n=14 FA)</b>	64%	85%	36%	14%	0%	0%

Note. \*  $p < .05$ , \*\*  $p < .01$  when comparing rates over time from baseline to posttest.

After the national CFSR review by the Administration for Children and Families, the Children’s Bureau highlighted the importance of targeting specific areas of children’s needs to improve service connection, specifically education, physical health, and mental health of the child. Out of 90 cases reviewed in Intake, six target children (two from FI and four from FA) were identified as having problems with school. Of these six children, five received appropriate services (two FI cases and three FA cases) to meet their educational needs, with one FA case (that was open for a total of four days) where it was unclear from the documentation whether or not school academic problems were addressed by services. **In the current study, Intake FI cases exceeded the 90% threshold required to meet substantial conformity in the CFSR. FA cases fell below the 90% threshold set by the CFSR, however, it was due solely to one case that was open in Intake for a total of four days. Results indicate improved performance in this area from the *Intake Baseline Study*, where all cases fell below the 90% threshold.** Out of 45 cases reviewed in Case Management, seven target children (four from FI and three from FA) were identified as having problems with school. Of these seven children, six (86%) received appropriate services (four FI cases and two FA cases) to meet their educational needs. **In the current study, Case Management FI cases exceeded the 90% threshold required to meet substantial conformity in the CFSR. FA cases fell below the 90% threshold set**

**by the CFSR. Results indicate improved performance in this area from the *Intake Baseline Study*, where this need was met in only 63% of cases.**

**In the current study, there were a small number of cases identified as having physical and mental health needs in Intake (see Table 16 for types and frequency) and Case Management (see Table 17 for types and frequency).** This may relate to the way the target children were selected for the purposes of review, as the youngest victim in each case was selected and often health and mental health needs become more apparent with age and entry into school. The mean age of the target child in the current study was 7.19 years, with approximately 69% of the sample falling below the age of 10 years and 22% below the age of two. However, these numbers may also indicate a need to examine the way in which intake workers are gathering child physical and mental health information. **The most common health needs identified in the current study were behavioral problems and child general mental health. However, when identified as needs, services to address these needs were provided only 60-83% of the time in Intake and 60-100% of the time in Case Management (see Tables 16 and 17 for more information).**

**Table 16: Specific child physical and mental health needs addressed during Intake**

	Yes		Unclear		No	
	FI	FA	FI	FA	FI	FA
Child Medical Problem baseline (FI n=4; FA n=1)/120	100%	100%	0%	0%	0%	0%
Child Medical Problem posttest (FI n=1; FA n=2)/90	100%	100%	0%	0%	0%	0%
Child Physical Disability baseline (FI n=1; FA n=0)/120	100%	N/A	0%	N/A	0%	N/A
Child Physical Disability posttest (FI n=0; FA n=0)/90	N/A	N/A	N/A	N/A	N/A	N/A
Child alcohol abuse addressed baseline (FI n=2; FA n=2)/120	0%	50%	50%	0%	50%	50%
Child alcohol abuse addressed posttest (FI n=0; FA n=0)/90	N/A	N/A	N/A	N/A	N/A	N/A
Child other drug abuse addressed baseline (FI n=2; FA n=3)/120	50%	33%	50%	0%	0%	66%
Child other drug abuse addressed posttest (FI n=0; FA n=3)/90	N/A	34%	N/A	33%	N/A	33%
Child cognitive status addressed baseline (FI n=3; FA n=1)/120	0%	0%	100%	0%	0%	100%
Child cognitive status addressed posttest (FI n=1; FA n=0)/90	100%	N/A	0%	N/A	0%	N/A
Child behavioral problem addressed baseline (FI n=15; FA n=11)/120	53%	64%	33%	18%	13%	18%
Child behavioral problem addressed posttest (FI n=7; FA n=9)/90	71%	78%	0%	11%	29%	11%
Child mental health addressed baseline (FI n=12; FA n=9)/120	67%	78%	25%	0%	8%	22%
Child mental health addressed posttest (FI n=5; FA n=6)/90	60%	83%	0%	0%	40%	17%
Child criminal activities addressed baseline (FI n=1; FA n=2)/120	0%	0%	100%	50%	0%	50%
Child criminal activities addressed posttest (FI n=0; FA n=0)/90	N/A	N/A	N/A	N/A	N/A	N/A
Child witnessing domestic violence addressed baseline (FI n=6; FA n=2)/120	17%	0%	33%	0%	50%	100%
Child witnessing domestic violence addressed posttest (FI n=1; FA n=0)/90	100%	N/A	0%	N/A	0%	N/A
Child perpetrating domestic violence addressed baseline (FI n=1; FA n=3)/120	100%	67%	0%	0%	0%	33%
Child perpetrating domestic violence addressed posttest (FI n=0; FA n=0)/90	N/A	N/A	N/A	N/A	N/A	N/A

**Table 17: Specific child physical and mental health needs addressed during Case Management**

	Yes		Unclear		No	
	FI	FA	FI	FA	FI	FA
Child Medical Problem (FI n=3; FA n=1)/45	67%	100%	0%	0%	33%	0%
Child Physical Disability (FI n=1; FA n=0)/45	100%	N/A	0%	N/A	0%	N/A
Child alcohol abuse addressed (FI n=0; FA n=0)/45	N/A	N/A	N/A	N/A	N/A	N/A
Child other drug abuse addressed (FI n=0; FA n=2)/45	N/A	50%	N/A	50%	N/A	0%
Child cognitive status addressed (FI n=0; FA n=0)/45	N/A	N/A	N/A	N/A	N/A	N/A
Child behavioral problem addressed (FI n=8; FA n=6)/45	100%	83%	0%	0%	0%	17%
Child mental health addressed (FI n=5; FA n=6)/45	60%	100%	20%	0%	20%	0%
Child criminal activities addressed (FI n=1; FA n=0)/45	0%	N/A	100%	N/A	0%	N/A
Child witnessing domestic violence addressed (FI n=0; FA n=0)/45	N/A	N/A	N/A	N/A	N/A	N/A
Child perpetrating domestic violence addressed (FI n=0; FA n=0)/45	N/A	N/A	N/A	N/A	N/A	N/A

*Note.* These questions were not asked at baseline for case management cases. Therefore only results at posttest are available for case management.

After evaluating whether services were connected to specific needs, it was also important to examine the connection between the type of assessment and the services delivered, as well as more general service trends for all family members. **First, it is important to note that for Intake cases where there was either a safety threat or a risk of placement, 100% of the services provided were appropriate to child risk of immediate harm or risk of placement. Examination of all services received in Intake (regardless of safety and placement risk) revealed an uneven distribution of services across family members with target children receiving the highest number of services (32%) and fathers receiving the fewest number of services (3%).** Across the 90 cases reviewed, there were a total of 155 services provided. Of the services provided to target children (n=49), out of home placement (27%), transportation (20%), mental health services (16%) and individual counseling (12%) were most frequently provided. Families, as a unit received a total of 59 services, primarily in the form of child protection case management (46%), emergency cash assistance (20%) and “other” unspecified services

(14%). Mothers received a total of 28 services, most often in the form of transportation (21%), chemical dependency services (21%), individual counseling (14%) and emergency cash assistance (14%). Fathers rarely received services (n=5); of the four services, transportation, chemical dependency services and “other” unspecified services were received.

**For Case Management cases where there was either a safety threat or a risk of placement, 100% of the services provided were appropriate to child risk of immediate harm or risk of placement. Examination of all services received in Case Management (regardless of safety and placement risk) revealed an uneven distribution of services across family members with mothers receiving the highest number of services (27%) and fathers and siblings receiving the fewest number of services (8%).** Across the 45 cases reviewed, there were a total of 248 services provided (three additional services were provided to caretakers other than mothers and fathers). Of the services provided to target children (n=62), out of home placement (19%), mental health services (16%), transportation (15%), individual counseling (10%), and child protection case management (10%) were most frequently provided. Families, as a unit received a total of 79 services, primarily in the form of child protection case management (44%), emergency cash assistance (18%) and transportation (14%). Mothers received a total of 67 services, most often in the form of employment services (16%), chemical dependency services (16%), mental health services (10%), transportation (10%), and emergency cash assistance (10%). Fathers rarely received services (n=19); services were divided among chemical dependency, family-based counseling, employment, legal, mental health, transportation, and other services.

It is important that the provision of service responds to the “big picture” of a family beyond safety and risk. To evaluate this, case reviewers looked at how workers connected the family with services in response to the safety plan, risk assessment, and other assessments beyond risk and safety. Data from the current study showed that workers used slightly different tactics to connect families to services in response to safety plans, placement prevention, or assessments other than risk and safety. **Intake workers most commonly provided information about services, arranged services for families, coordinated services, and engaged families in services, independent of where the**

**service need originated. However, Intake workers were more action-oriented in connecting families to services in cases in which the services were in response to the safety plan or another assessment. (See Table 18 for complete findings.)**

**Table 18: Worker actions to connect family to services in Intake**

	For Safety Plan		To Prevent Placement		In Response to Other Assessment	
	FI (n=13)	FA (n=3)	FI (n=21)	FA (n=0)	FI (n=22)	FA (n=15)
baseline	FI (n=13)	FA (n=3)	FI (n=21)	FA (n=0)	FI (n=22)	FA (n=15)
posttest	FI (n=12)	FA (n=3)	FI (n=12)	FA (n=0)	FI (n=25)	FA (n=21)
Provided information about services (baseline)	67%	22%	22%	N/A	53%	44%
Provided information about services (posttest)	54%	100%	47%	N/A	72%	95%
Made a referral to services (baseline)	0%	6%	0%	N/A	7%	17%
Made a referral to services (posttest)	42%	100%	20%	N/A	56%	43%
Arranged services or contacted provider (baseline)	35%	33%	33%	N/A	43%	20%
Arranged services or contacted provider (posttest)	67%	100%	38%	N/A	46%	67%
Provided concrete services (baseline)	10%	6%	13%	N/A	17%	23%
Provided concrete services (posttest)	75%	67%	40%	N/A	42%	62%
Coordinated services (baseline)	15%	17%	25%	N/A	8%	17%
Coordinated services (posttest)	67%	67%	33%	N/A	48%	43%
Met with other agencies (baseline)	0%	11%	0%	N/A	7%	10%
Met with other agencies (posttest)	67%	33%	27%	N/A	32%	48%
Negotiated with landlords (baseline)	0%	0%	0%	N/A	0%	7%
Negotiated with landlords (posttest)	8%	100%	7%	N/A	4%	10%
Staffed meetings with providers (baseline)	0%	0%	0%	N/A	0%	5%
Staffed meetings with providers (posttest)	25%	100%	7%	N/A	12%	14%
Engaged family in services (baseline)	65%	18%	38%	N/A	33%	12%
Engaged family in services (posttest)	75%	100%	67%	N/A	60%	81%

Patterns of service provision in case management mirrored those found in Intake. **Case management workers most commonly provided information about services, arranged services for families, provided concrete services, and engaged families in services, independent of where the service need originated. However (as was true in Intake), Case Management workers were more action-oriented in connecting families to services in cases in which the services were in response to the safety plan.** (See Table 19 for complete findings.)

**Table 19: Worker actions to connect family to services in Case Management**

	For Safety Plan		To Prevent Placement		In Response to Other Assessment	
baseline	FI (n=43)	FA (n=0)	FI (n=36)	FA (n=0)	FI (n=48)	FA (n=0)
posttest	FI (n=10)	FA (n=2)	FI (n=12)	FA (n=0)	FI (n=18)	FA (n=13)
Provided information about services (baseline)	93%	--	89%	--	85%	--
Provided information about services (posttest)	50%	100%	39%	--	72%	100%
Made a referral to services (baseline)	--	--	--	--	--	--
Made a referral to services (posttest)	50%	100%	23%	--	67%	62%
Arranged services or contacted provider (baseline)	71%	--	58%	--	60%	--
Arranged services or contacted provider (posttest)	70%	100%	31%	--	39%	69%
Provided concrete services (baseline)	81%	--	67%	--	44%	--
Provided concrete services (posttest)	80%	100%	39%	--	41%	62%
Coordinated services (baseline)	49%	--	47%	--	27%	--
Coordinated services (posttest)	70%	50%	31%	--	44%	46%
Met with other agencies (baseline)	54%	--	47%	--	38%	--
Met with other agencies (posttest)	70%	50%	23%	--	28%	46%
Negotiated with landlords (baseline)	--	--	--	--	--	--
Negotiated with landlords (posttest)	10%	0%	8%	--	6%	8%
Staffed meetings with providers (baseline)	54%	--	39%	--	31%	--
Staffed meetings with providers (posttest)	20%	0%	0%	--	11%	23%
Engaged family in services (baseline)	95%	--	86%	--	58%	--
Engaged family in services (posttest)	70%	100%	62%	--	61%	85%

*Note.* Not all questions were asked at baseline. In these cases -- is used to denote information not available at baseline.



### *Incorporation of Additional Information*

In some cases, the initial interviews of a comprehensive family assessment indicate a need to gather specialized assessments for certain family members, including mental, physical, and neurological status, among others. Oftentimes caseworkers contract with agencies that provide these assessments, and it is vital that “a regular process of communication must exist between child welfare and other service providers on the changing conditions within the family” (Children’s Bureau, 2005). A CFA must incorporate these assessments in evaluating family need as a basis for intervention strategies that guarantee safety, permanency, and well-being of the children. **Current data show that specialized assessments appeared complete in 60% of FI Intake cases (an improvement of 71% since baseline) and 83% of FA Intake cases (an improvement of 730% since baseline).** A Pearson chi-square test revealed that the difference between baseline and post-test results was statistically significant for both FI ( $\chi^2(1,N=120) = 7.52, p=.006$ ) and FA cases ( $\chi^2(1,N=90) = 47.63, p=.000$ ). In addition, 28% of FI cases and 17% of FA cases mentioned a specialized assessment but it was not completed during Intake (these results are similar to the *Intake Baseline Study* results). Current data also revealed that specialized assessments appeared complete in 47% of FI Case Management cases (an improvement of 217% since baseline) and 73% of FA Case Management cases. An additional 50% of FI Case Management cases and 27% of FA Case Management cases mentioned specialized assessments, but not appear to be complete. **Thus, 97% of all TI Case Management and ALL FA Case Management cases incorporated information from at least one specialized assessment. Results of the current study show that specialized assessments have improved significantly since the *Intake Baseline Study*.**

**Encouragingly, workers attempted to increase communication between Ramsey County and contracted service providers during both Intake and Case Management.** Workers met with other agencies about a safety plan in 75% of FI Intake cases that had a safety plan and 62% of cases that had a risk of placement in FI Intake. This is a significant increase from baseline ( $\chi^2(1,N=37) = 23.31, p=.000$  for safety planning and  $\chi^2(1,N=29) = 8.98, p=.003$  for preventing placement). Workers met with other agencies about a safety plan in 75% of FI Case Management cases that had a safety plan and 43% of

cases that had a risk of placement; this did not happen at all at baseline. This represents a 39% increase in communication about safety planning ( $\chi^2(1, N=52) = 3.47, p=.062$ ) but a slight (9%) decrease in communication about preventing placement ( $\chi^2(1, N=64) = 0.41, p=.524$ ).

### *Cultural Competency*

Child welfare and the entire social work profession have set a precedent in designing culturally competent services and using a cultural lens. The field recognizes that culture – including race, ethnicity, rituals, and traditions – can offer a powerful source of healing for clients. In creating comprehensive family assessment guidelines, the Children’s Bureau also stressed the importance of considering “the family’s cultural, ethnic, and linguistic factors in assessing strengths and needs” (United States Children’s Bureau, 2007). Although Ramsey County has been working toward providing culturally competent services since 2001, the recent adoption and refinement of culturally-focused practice (still in process at the time of case record reading and not entirely captured in this assessment) into CFA allows workers a more concrete way of engaging families through culture.

The current study found that **culturally competent practice is still an area that needs improvement. The majority of cases receiving Intake services – for both FI and FA – included no description of the family’s environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances** (see Table 20). Only about 15% of FI cases included at least some mention of the family’s environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances, while approximately 30% of all FA cases included any mention of these descriptions. **While FA made statistically significant improvements in addressing cultural competency since the *Intake Baseline Study*, FI fared significantly worse during this round of review. Despite improvements in FA, this continues to be an area that requires more specific practice guidelines in order to ensure that initial assessments are culturally relevant, especially in FI cases.**

**Table 20: Assessment of contextual strengths and hindrances in Intake**

	Appeared Complete		Mentioned		Not Mentioned	
	FI	FA	FI	FA	FI	FA
Contextual strengths (baseline n=60 FI, n=60 FA)	10%	3%	33%	2%	57%	95%
Contextual strengths (posttest n=60 FI, n=30 FA)	2%	17%*	13%	13%	85%**	70%**
Potential contextual hindrances (baseline n=60 FI, n=60 FA)	12%	3%	30%	7%	58%	90%
Potential contextual hindrances (posttest n=60 FI, n=30 FA)	2%*	17%*	8%	10%	90%**	73%*

*Note.* \*  $p < .05$ , \*\*  $p < .01$  when comparing rates of assessments of strengths and hindrances over time from baseline to posttest for appeared complete and not mentioned responses.

**The current study found that cultural competence in Case Management is also an area in need of further development. The majority of cases receiving Case Management services – for both FI and FA – included no description of the family’s environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances (see Table 21). Only about 23% of FI cases included at least some mention of the family’s environmental, cultural, ethnic, or linguistic contextual strengths (16% of FI cases included potential hindrances in this area), while 27% of all FA cases included any mention of these strengths (20% of FA cases included potential hindrances in this area). Assessment of contextual strengths and potential hindrances (or lack thereof) did not improve since baseline.**

**Table 21: Assessment of contextual strengths and hindrances in Case Management**

	Appeared Complete		Mentioned		Not Mentioned	
	FI	FA	FI	FA	FI	FA
Contextual strengths (baseline n=60 FI)	0%	--	20%	--	80%	--
Contextual strengths (posttest n=30 FI, n=15 FA)	3%	7%	20%	20%	77%	73%
Potential contextual hindrances (baseline n=60 FI)	0%	--	22%	--	78%	--
Potential contextual hindrances (posttest n=30 FI, n=15 FA)	3%	7%	13%	13%	83%	80%

*Note.* \*  $p < .05$ , \*\*  $p < .01$  when comparing rates of assessments of strengths and hindrances over time from baseline to posttest for appeared complete and not mentioned responses.

In addition to assessing contextual strengths and potential hindrances, case reviewers also noted whether the case record reflected a negative or judgmental attitude

by the worker regarding the client or the client's ability or willingness to follow through with any plans or services. **Fortunately, very few Intake cases appeared to display a negative or judgmental attitude.** The current study revealed that 8% of FI Intake cases and 3% of FA Intake cases displayed this attitude, as compared to 2% of baseline FI Intake cases and 3% of baseline FA Intake cases. The slight increase in judgmental attitude found in FI Intake is non-significant ( $\chi^2(1,N=120) = 2.81, p=.094$ ). **Trends in Case Management were similar to those found in Intake; however a larger proportion of FI Case Management cases revealed a judgmental attitude.** The current study revealed that 23% of FI Case Management but *NO* FA Case Management cases displayed this attitude, as compared to 8% of baseline FI Case Management cases. The increase in judgmental attitude found in FI Case Management is significant ( $\chi^2(1,N=90) = 3.89, p=.049$ ).

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## Conclusion

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The findings of this study offer key insights regarding how practice at Ramsey County has changed in association with the development and implementation of Comprehensive Family Assessment across Child Protection units. Ramsey County began the CFA project in 2007 with relatively strong practices that supported the well-being of the children and families they served. However, practice was inconsistent across the agency and there were also areas in need of improvement in the domains of safety, permanency, and well-being. Results of the current study reveal improved practice and client outcomes across a number of different indicators with particular areas in need of continued focus.

First, study findings suggest that current practice supports greater engagement and comprehensive assessment of children. Findings show that workers are visiting children in a more timely fashion than prior to CFA implementation and that visits with children are of quality. A greater proportion of children are receiving comprehensive assessments – starting in Intake and continuing into Case Management - than they were during Family-Centered Assessment practice (FCA – practice used in Ramsey County prior to CFA implementation). Children are engaged in case planning with a greater frequency as well. Children's needs have been identified and addressed with services at a greater rate than prior to CFA implementation (with the exception of FI Case Management). In fact, children receive the highest number of services than any other family member. In addition, improvements in permanency outcomes

have also been evident – including increased relative inquiries both before and after a child is placed out of home.

Outcomes of mothers are similar to those of the children described above. Workers regularly visited available mothers, and the quality of visits was generally sufficient to ensure the safety, permanency, and well-being of the child and promote case goals. Mothers' receipt of comprehensive assessments has increased significantly since CFA implementation. In fact, mothers received comprehensive assessments more frequently than any other available family member. Identification of needs and delivery of services for mothers has remained relatively stable over time; the majority of mothers' needs have been identified and addressed with services. Small, but non-significant increases in identification of needs and provision of services to address needs were evident in all service areas except FI Case Management. In this area, identification of need and provision of services declined over time. Mothers have been engaged throughout the life of the case, including in assessments, safety planning, and case planning.

Outcomes of fathers are less favorable. Although Ramsey County has been able to identify more fathers than prior to CFA implementation, fathers' involvement in the case has not followed suit. It appears as though fathers are engaged early on in the case but that engagement decreases thereafter. For example, the majority of fathers are involved in safety planning early on in the cases. However, as the case progresses engagement decreases. Only 35% of available fathers in FI Case Management received sufficiently frequent visits and 25% received sufficient quality of visits (as compared to 76% and 62%, respectively, of mothers) over the life of the case. And, although parents are receiving more comprehensive assessments than they were at baseline (both mothers *and* fathers), 72% of fathers did not receive any comprehensive assessment at posttest. In fact, fathers received a comprehensive assessment the least frequent of any other family member. And, not surprisingly, the identification of fathers' needs and provision of services to address those needs is also an area for continued improvement.

Some of the decreases in father outcomes may be due to changes in the availability of family members over time. Ramsey County implemented new father finding and engagement policies in concert with CFA practice. The result of these new policies was an increase in available fathers – from 63% to 69% in Intake and from 42% to 67% in FI Case Management (80% of cases in FA Case Management included fathers). Thus fathers who previously were unavailable at baseline (and therefore were not factored into evaluations) became available at

posttest; these newly available fathers may have been more difficult to engage throughout the life of the case, which then negatively biased the results of this study.

Assessment practices (in general) within Ramsey County Child Protection have dramatically improved. Findings revealed that workers consistently conducted safety and risk assessments (both initial and ongoing) and provided services appropriate to safety, risk, and prevention of placement for families. In addition, in the vast majority of cases at least one member of the family receives a *full* comprehensive assessment. The challenge that remains for Ramsey County is to reach all family members (most notably absent are fathers and siblings) for *full* comprehensive assessments. Specialized assessments are increasingly being used and integrated into service planning and decision-making. However, including culture in the assessment and decision-making process continues to be an area for growth for Ramsey County; only 15-30% of all cases mentioned the family's environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances and approximately half of the cases mentioned community strengths. As Ramsey County refines its assessment tools and documentation standards, it is anticipated that dramatic changes in the inclusion of culture will be evident.

Differences between worker practices and child and family outcomes were evident not only across indicators (as described above), but also between FI and FA response tracks. These differences were seen in utilization of comprehensive assessments, frequency and quality of visits with parents, documenting of family members' strengths and needs, and provision of services to meet family members' needs. Practice and client outcomes were consistently better in FA cases than FI cases. There are likely a number of reasons for these differences – ranging from differences in court-involvement (or the lack thereof) to differences in risk level and intensity of the case to other factors at the unit, agency, practice, or policy level. However, it is important to consider opportunities for harnessing the strengths seen in FA (and FI) and build on those in future revisions of the practice approach.

Continued areas for growth and consideration of practice include engagement of fathers, utilization of culture, and service provision. As Ramsey County continues to work to improve practices across the agency, it will be important to address the following questions:

1. Newly implemented father identification policies are assisting workers in finding available fathers to inform assessment and decision-making. However, engagement of

- fathers throughout the life of the case remains a challenge. What practices or policies could be added or revised to continue to support growth in this area?
2. Ramsey County has recently (since data was collected for this study) revised its assessment tools and documentation standards to more explicitly focus on culture. In addition, continued training has been required of workers in the areas of trauma and culture. How can the County continue to support workers' use of culture in assessment and decision-making? And, how can the County continue to support supervisors in their work with front-line workers in the use of culture in assessment and decision-making?
  3. Ramsey County's CFA practice ties comprehensive assessment to the behavior(s) that resulted in the child being unsafe or at-risk. Service provision is then tied back to these behaviors via the functional assessment. Service provision, therefore, is most often tied to safety and risk. Considering whether and/or how to connect families to services that are not directly related to safety and/or risk is something the County will need to contemplate. (This is a question for the larger child welfare field and the Children's Bureau as well.)

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## References

- Children's Bureau, National Resource Center for Family-Centered Practice and Permanency Planning. (2005). *Comprehensive family assessment guidelines for child welfare*. Washington, DC: Patricia Schene.
- Children's Bureau. (2007). *Using Comprehensive Family Assessments to Improve Child Welfare Outcomes: Program Announcement* (Award No. HHS-2007-ACF-ACYF-CA-0023). Washington, DC: Joan E. Ohi.
- Children's Bureau. (2008). *Child and Family Services Reviews: Fact Sheet*. Retrieved November 8, 2008, from <http://www.acf.hhs.gov/programs/cb/cwmonitoring/recruit/cfsfactsheet.htm>
- Harrison, M., Piescher, K., LaLiberte, T. L., Snyder, E., & Wells, S. J. (2009). *Comprehensive Family Assessment Case Management baseline report: Family interview addendum*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at <http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/CFA-IntakeBaselineReport.pdf>
- Kim, J. R., Heldt, J., Piescher, K., Snyder, E. M., LaLiberte, T. L., & Wells, S. J. (2012). *Comprehensive Family Assessment intake baseline report: Family interview addendum*, Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN.
- Kim, J. R., LaLiberte, T. L., Heldt, J., Piescher, K., & Snyder, E. M. (2012). *Comprehensive Family Assessment intake baseline addendum: Summary of cultural advisory group findings*, Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN.
- Kim, J. R., Piescher, K., & LaLiberte, T. L. (2010). *Comprehensive Family Assessment formative evaluation: Findings, implications, and recommendations*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at <http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/CFA-FormativeEvaluationReport.pdf>



- Minnesota Department of Human Services, Child Safety and Permanency Division. (2005). *Evaluating Minnesota's child welfare system: A review of safety, permanency and well-being outcomes for children and families in Ramsey County*. St. Paul, MN.
- Minnesota Department of Human Services. (2008). *Executive summary final report: Minnesota child and family services review*. Unpublished report.
- Minnesota Department of Human Services, Children and Family Services (2009). *Minnesota's child welfare report 2008: Report to the 2009 Minnesota legislature* (MN DHS Report No. DHS-5408A-ENG). Retrieved from the Minnesota Department of Human Services website: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5408A-ENG>
- Piescher, K., Bidwell, L., LaLiberte, T., & Snyder, E. (2012). *Comprehensive Family Assessment posttest supervisor study: Findings, implications, and recommendations*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN.
- Piescher, K., Heldt, J., LaLiberte, T., & Snyder, E. (2013). *How workers think about and utilize culture in child welfare practice*, Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at [http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/Fidelity\\_2\\_Report.pdf](http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/Fidelity_2_Report.pdf)
- Piescher, K., Kim, J. R., Heldt, J., Stump, T., & LaLiberte, T. L. (2011). *Comprehensive Family Assessment intake and case management fidelity: Findings, implications, and recommendations*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at [http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/Fidelity\\_2\\_Report.pdf](http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/Fidelity_2_Report.pdf)
- Piescher, K., LaLiberte, T. L., Merritt, L., Snyder, E., & Wells, S. J. (2009). *Comprehensive Family Assessment Case Management baseline report: Workload study addendum*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at <http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/CFA-IntakeBaselineReport.pdf>

- Piescher, K., Snyder, E., Nguyen, H., LaLiberte, T. L., & Wells, S. J. (2010). *Comprehensive Family Assessment Intake baseline study*. Center for Advanced Studies in Child Welfare, University of Minnesota, St. Paul, MN. Available at <http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Evaluation/CFA-IntakeBaselineReport.pdf>
- Ramsey County Community Human Services Department. (2001). *Worker's guide: Children and family services best practice framework*. Unpublished document.
- Ramsey County Community Human Services Department. (n.d.) *Model overview*. <http://www.cehd.umn.edu/ssw/cascw/research/RamseyCFAProject/ModelOverview.aspx>
- Social Security Administration. (1956). *Four decades of action for children: A short history of the Children's Bureau*. Washington, DC: U.S. Government Printing Office. Retrieved November 3, 2008, from <http://www.ssa.gov/history/pdf/child1.pdf>
- U.S. Department of Health and Human Services, National Council on Crime and Delinquency. (1997). *Child Abuse and Neglect: Improving Consistency in Decision Making*. (NCJ No. 176483). Oakland, CA: S.C. Baird.
- U.S. Department of Health and Human Services, Children's Bureau. (2008). *Child and family services reviews: Onsite review instrument and instructions*. (OMB Control No. 0970-0214). Retrieved November 4, 2008, from [http://www.acf.hhs.gov/programs/cb/cwmonitoring/tools\\_guide/onsitefinal.htm](http://www.acf.hhs.gov/programs/cb/cwmonitoring/tools_guide/onsitefinal.htm)
- Wells, S. J., LaLiberte, T., Neuman, M., Harrison, M., Snyder, E., & Piescher, K, N. (2009). *Comprehensive family assessment Program Baseline Study*. Retrieved from the Center for Advanced Studies in Child Welfare (CASCW) website: <http://www.cehd.umn.edu/SSW/cascw/Attributes-CFA/PDF/Case%20Mgmt%20Program%20Study%20Report.pdf>
- Weston, C. McAlpine, L. & Bordonaro, T. (1995). A model for understanding formative evaluation in instructional design. *Education Technology Research and Development*, 43(3), 29–48.