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

Comprehensive Family Assessment Intake Baseline Study

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Submitted by

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Introduction

Since its inception almost 100 years ago, the Children's Bureau (CB) has upheld its mission of evaluating "all matters pertaining to the welfare of children" (Social Security Administration, 1956) by implementing policies and evaluating practices aimed to protect children from abuse and neglect. In 1994, the Child and Family Services Review (CFSR) - a federal program designed to assess the performance of State child welfare agencies with regard to achieving positive outcomes for children and families - was created (Children's Bureau, 2008), and in 2001 the first round of CFSRs was implemented.

The 2001 federal CFSRs indicated many areas throughout the country's child welfare systems needed improvement and required attention. One of the most significant areas needing improvement was that State agencies rarely went beyond initial risk and safety assessments in identifying the strengths and needs of families; inadequate comprehensive assessments were identified nationwide. Reviewers noted that the quality of these assessments affected other performance indicators, including safety, permanency, and well-being. 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 to States, and funded five State sites to examine and improve their comprehensive family assessment processes.

Ramsey County Community Human Services Department (RCCHSD), one of five federal grantees for the CFA project, has been working on the creation and implementation of strategies that guide comprehensive assessments, and has continuously attempted to improve practice methods in this area since 2001 (Children's Bureau, 2005). (See the *Comprehensive Family Assessment Program Baseline Study* report for a review of strategies RCCHSD has undertaken to improve practice methods in this area.) In 2007, RCCHSD 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 family assessment processes and a newly-designed practice model that would more fully incorporate the Comprehensive Family Assessment (CFA) Guidelines in RCCHSD Intake and in Case Management services.

Phase 1, the current phase, of the Comprehensive Family Assessment Project is an evaluative effort to understand how workers are assessing families who are involved with child protection services in Ramsey County. The evaluation of Case Management (Program) services was completed in 2009; findings of the evaluation can be accessed via the *Comprehensive Family Assessment Program Baseline Study* report (Wells et al., 2009). Case record reviews, interviews with families involved in child protection, a time study (reported previously), and worker focus groups form the basis for evaluation in this phase.

The *Comprehensive Family Assessment: Intake Baseline Study* report outlines findings of the evaluation of Intake (Traditional Investigation and Family Assessment) RCCHSD Child Protection using case record review data, intake worker and supervisor focus group data, and information gathered from ten families that received intake services. Baseline findings will be used in the development and evaluation of a new practice model for Comprehensive Family Assessment in Ramsey County Minnesota. RCCHSD's final version of the CFA practice model will incorporate feedback from evaluation efforts and will be disseminated to other counties and states to guide further CFA implementation. The intent is that the resulting thorough, specific, and holistic assessment will lead to greater client engagement as well as more targeted and cost-effective services that will improve family and child well-being.

While the Children's Bureau *Comprehensive Family Assessment Guidelines for Child Welfare* was not designed for Intake, 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 current intake and assessment practices *once a report of child maltreatment is screened in and the initial safety assessment is completed.* This template would be congruent with the CFSR requirements for Intake investigation and assessment, and provide guidance for evaluating and guiding the intake process. The CFA-derived focus in Intake, therefore, is on improving the assessments conducted as a way of beginning the process of gathering information from a family that is holistic, rather than focusing solely on a presenting problem. Further, RCCHSD seeks to improve documentation, incorporate findings from CFSR reviews, and ensure consistency between assessments in Intake and Case Management, and further integrate Intake and Case Management work.

Case Record Reviews

Methods

Instrument Development

A case record review instrument was developed to capture relevant information from randomly selected cases in Ramsey County. The instrument was 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 (see Appendix A). 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

For the purposes of the Comprehensive Family Assessment project, the sampling frame for Ramsey County child protection cases consisted of all cases opened in Intake between June 1, 2008 and November 15, 2008. Intake cases consisted of cases which had moved through the initial child protection screening process and had been assigned to an intake and investigation child protection case worker in either Traditional Investigation (TI) or Family Assessment (FA; Alternative/Differential Response), which 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.

The period under review was from the date of opening in Intake through the date of case closure by the Intake worker or transfer to Case Management (Program). Cases reviewed had been open 40 days (*SD* = 23.9) on average, but ranged from three to 105 days open in Intake. Traditional Investigation cases were open slightly longer than Family Assessment Cases (44 days (*SD* = 26.2) vs. 36 days (*SD* = 20.9), respectively).

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). The sampling frame included 110 Traditional Investigation cases (278 children) and 182 Family Assessment cases (439 children). To ensure that the sample was representative of both Traditional Investigation and Family Assessment cases, a stratified random sampling method was used. Consequently, 60 Traditional Investigation cases and 60 Family Assessment cases were selected from the sampling frame, for a total of 120 cases. Records were pulled from the Social Services Information Systems (SSIS) based in the RCCHSD Child Protection (CP) division. Case types included those records that received child protection Intake services and were closed or transferred to Case Management on or before December 31, 2008.

Three cases (all from TI) were rejected from the sample, and replaced with alternate, randomly sampled cases. One case was rejected during the review because the intake case worker was not able to locate the family, and was therefore unable to conduct a face-to-face meeting with the family during the time the case was open. The case was closed without an investigation of the allegation. A second case (a re-report on a case that was currently receiving on-going CP case management services) was rejected because the Intake case worker determined that there was no need for intake and investigation services upon verifying information about the case with a hospital social worker; the case was only open in Intake for a total of 45 minutes. The Intake worker did not complete a face-to-face meeting with the family because of this situation. A third case was rejected because although the case was opened in Ramsey County, the family resided in and received services from Hennepin County. Upon the worker learning this information, the case was transferred to Hennepin County for intake and investigation services.

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=120) 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.
Frame	12.4%	28.5%	35.6%	5.2%	11.6%	8.1%	11.2%	63.5%	22.8%	11.7%	2.0%
FA	11.0%	26.7%	40.5%	5.0%	10.0%	7.3%	10.5%	59.9%	30.0%	8.4%	1.7%
TI	14.7%	31.3%	27.7%	5.4%	14.0%	9.4%	12.2%	67.5%	14.8%	15.4%	2.3%
Sample	18.3%	40.0%	35.0%	3.3%	9.2%	10.0%	2.5%	64.0%	20.2%	9.8%	6.0%
FA	16.7%	38.3%	40.0%	1.7%	5.0%	10.0%	5.0%	65.1%	31.4%	1.2%	2.3%
TI	20.0%	41.7%	30.0%	5.0%	13.3%	10.0%	0.0%	62.1%	10.5%	17.9%	9.5%

Analyses of the demographic characteristics revealed that the proportions of African American, American Indian/Alaskan Native, Asian, and Pacific Islander children in the sample were comparative to those in the larger sampling frame. However, the sample appeared to be comprised of a larger proportion of Caucasian children than was the sampling frame. This difference may be explained by the method of coding race utilized in the sample as compared to that used in the sampling frame. Statistics about the racial composition of the sampling frame were derived from the RCCHSD administrative data, whereas UMN derived racial composition of the sample by reviewing both racial codes found in case files and case notes indicating the racial identity of children and their biological parents. Given that the coding scheme utilized by the UMN resulted in a much smaller number of children whose racial identity was not determined (in comparison to the sampling frame), it could be the case that children in the sampling frame whose racial identity was unable to be determined were actually Caucasian children whose racial identity was unknown at the time the worker entered racial codes into RCCHSD's data management system. This finding could account for the discrepancy among proportions of Caucasian children in the sample compared to the sampling frame. No large differences in the proportions of reported Hispanic ethnicity or allegations of neglect (general or

medical), physical abuse, or sexual abuse were evident between the sample and the larger sampling frame.

Case Record Reviews

Extensive training was conducted with case record reviewers prior to the collection of data used in the Intake Baseline 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 several 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 additional case record reviewers on using the instrument in both the paper and electronic formats. Each reviewer received approximately seven hours of initial training (not including completing background reading), followed by approximately 17 hours of on-going group training and additional individual training on a question-by-question basis over a period of 10 weeks.

Each team of reviewers – one for Family Assessment cases and one for Traditional Investigation cases – co-read cases for approximately 16 hours before beginning independent case record reviews. Reliability among readers was checked approximately one-third of the way through the review process and then again at the end of case record reviews. To protect against rater drift, each team of reviewers co-read one additional case approximately two thirds of the way through the review process. Discrepancies among reviewers noted during initial training sessions, reliability checks, or co-reading sessions were discussed during on-going training sessions and decision rules for these items were developed.

Inter-rater reliability for both teams of reviewers was acceptable at both the initial and final reliability checks. Kappa statistics ranged from .804 ($p < .001$) to .925 ($p < .001$), with an average of .872 ($p < .001$; outstanding inter-rater reliability). This provided evaluators with confidence that there was a high level of agreement between the reviewers

on each team. After completing reliability checks between each reviewer's individual reviews, each team negotiated discrepancies among item responses. One fully agreed-upon case record instrument was then compiled by each team to be used in data analysis. A total of 120 cases were reviewed from March 2009 through June 2009.

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. (See Appendix A for a more detailed table of the CFSR items and their associated case record review instrument questions.)

Analyses (including crosstabs, frequencies, and case summaries) were conducted using the Statistical Product and Service Solution (SPSS) software. Data were not compared to the 2005 Ramsey County CFSR results (as the Program/Case Management baseline data were) because the CFSR results were based on a case record review of *both* Intake and Case-Management (Program) services, whereas the results of the Intake Baseline Study are based on Intake services only. Most often needs assessed or services begun in Intake will be further carried out in Case-Management (Program).

Results

Safety and Risk Assessment

Overview

Evaluating for safety and risk is a crucial component in securing protection for each child within the home and building a foundation for thorough comprehensive assessments. *Safety*, *risk*, and *comprehensive assessments* are three independent procedures with unique guidelines as specified by the CFSR. While risk assessment and the foundation of a comprehensive assessment should be completed during investigation (or assessment, in FA cases) for *all* cases, safety assessments should only be completed for those cases with an apparent risk of harm. The baseline 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 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 in 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 conducted face-to-face visits with children who were alleged victims of maltreatment and their caregivers in 72% of TI cases and 75% of FA cases. Of the cases in which workers were not able to conduct a face-to-face visit in the appropriate timeframe, most (82% of TI cases and 93% of FA cases) 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. Three TI cases and one FA case had no documented attempts of face-to-face contact with the child or family within the required timeframe. Two cases had documented phone calls to the family within the timeframe; one case had no documented contacts or attempts; and one case had documented contact outside of the timeframe due to the worker's absence. Ninety percent compliance to this item is considered a strength in the CFSR. **Results of the Intake Baseline Study indicated that RCCSHD followed policies regarding timeliness of investigations in 95% of TI cases and 98% of FA cases, surpassing the standard set by the CFSR.**

Safety Assessments

The MNDHS places a high priority on the completion of safety assessments and the subsequent development of safety plans for all cases with risk of immediate harm. Of the cases reviewed, 97% (116 of 120) included a completed safety assessment; two cases (<2%) included no indication of a completed safety assessment; and reviewers were unable to determine if a safety assessment was completed in an additional two cases (<2%). There were 27 cases in which workers described risk of immediate harm to children (19 cases in TI and 8 cases in FA); of those cases, 25 (93%) had a safety plan on file. The two cases which documented a risk of immediate harm to children and had no safety plan on file were from Traditional Investigation. In two additional cases (one from each TI and FA), reviewers were unable to determine whether there was a risk of immediate harm to children; in these cases no safety plan was documented in the case. **Results of the Intake Baseline study indicated that RCCHSD followed policies regarding safety assessments and needed safety plans more than 90% of the time.**

Safety Plans, Services, and Family Member Involvement

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 TI and FA cases. In the Intake Baseline Study, 94% (31 of 33) of services provided to families who had a risk of placement or a concern for safety in TI cases appeared to match the safety or risk assessment and/or safety plan. Ninety percent (18 of 20) of services provided to families who had a risk of placement or a concern for safety in FA cases appeared to match the safety or risk assessment and/or safety plan. **Despite this success, more consistently connecting safety, risk, assessments, plans, and services for all cases is still necessary. For example, a large proportion (28%) of cases in which workers indicated the absence of safety threats also included safety plans; this was true for both TI and FA cases.**

Parent involvement and appropriate child involvement is another important aspect of safety and risk assessment according to the CFSR guidelines (Children's Bureau, 2007). **Encouragingly, both mothers and fathers were involved in safety planning the majority of the time, with target child involvement falling behind.** For example, safety planning involved *available mothers* 92% of the time (97% in TI cases and 87% in FA cases), children of at least school age 35% of the time (60% in TI cases and 9% in FA cases),

and *available fathers* 85% of the time (94% in TI cases and 75% in FA cases). **Although family members were often involved in safety planning when they were *available* (i.e., the worker knew where the parent(s) were and how to make contact with them), a large proportion of parents – namely, fathers - were not available to be included in the safety planning process.** Mothers (including biological, adoptive, and foster mothers) were available in 100% of TI cases and 90% of FA cases. Fathers (including biological, adoptive, and foster fathers), on the other hand, were available in 70% (35 of 50) of TI cases and only 55% (26 of 47) of FA cases.

Permanency

Once safety and risk have been assessed and the home is deemed unsafe, establishing an environment of permanency and stability for a child placed out-of-home is crucial. Because intake services focus their attention on completing the initial safety and risk assessments, and because intake services typically last a much shorter time than program services, the primary permanency concerns of intake services (as deemed by CFSR) are: 1) prior placements, and 2) making tribal inquiries.

Only 14 of the 120 cases reviewed in the Intake Baseline Study were considered placement or out-of-home cases. Ramsey County performed well on the two permanency outcomes that were appropriate to be evaluated for Intake services. **For example, of the 14 out-of-home cases, none had placements occurring within 12 months of a prior placement – a clear strength.** Additionally, of the 120 cases reviewed, 93% had records reporting an inquiry about tribal membership was conducted (90% for TI cases and 95% for FA cases). Five percent of the cases reviewed contained some *suggestion* of tribal inquiry in the case record but were missing the ICWA form; 2% of cases (3 FA cases) did not have any record about tribal membership inquiry. National standards mandate child protection make tribal inquiries in 100% of cases involving a Native American child. Thus, **preserving connections to tribes can be considered an area of strength for Ramsey County Intake services.**

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 needs and strengths. 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).

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/assessments; and connections to appropriate services in relation to needs. Because CFAs require the establishment of a partnership with the family and collaboration with community partners, it is not possible to conduct a true CFA in Intake. Rather, the beginnings of assessing the family from a holistic view (rather than focusing solely on the presenting problem) are deemed necessary in Intake. Therefore, the following analysis used the abovementioned criteria, with the exception of relying on the *initial* foundation of a CFA, to detail the extent of comprehensive assessment practice.

Many baseline cases included an initial or a partial initial comprehensive assessment of at least one family member. An *initial assessment* is defined as a CFA that is written up by the worker in a way that it is possible to reference all facets of the initial assessment in the case record, while a partial initial assessment is referenced in the case record (usually not presented as a single entry) that references most, but not all, facets of the initial assessment. Of the entire sample, 75% of cases included an initial comprehensive assessment (either a full initial or partial assessment) of all available family members. (Specific details of workers' completion of comprehensive assessments by family member are provided in the Family involvement section below.)

Family Involvement

A thorough initial comprehensive family assessment includes an 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: the completion of need assessments for each family member; the frequency and quality of worker visits with each family member; as well as how 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 again 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 (excludes people who were incarcerated as availability is unclear in those cases). Based on this definition, target children were available in all 120 cases; mothers (biological, adoptive, or step) were available in 100% of TI cases and 90% of FA cases; fathers (biological, adoptive, or step) were available in 70% of TI cases and 55% of FA cases; and other parents (parents' partners or other adoptive parents) were available in 9% of cases. These numbers were used in determining the percentage of comprehensive assessments that were completed for each family member.

Results of the analysis revealed that mothers and children were more often assessed (either via a partial, initial assessment or a full, initial assessment) than fathers and siblings (99% for mothers and 96% for children in comparison to 80% for dads and 81% for siblings – of available family members). Additionally, family members in Traditional Investigation intake cases were more often assessed (either via a partial, initial assessment or a full, initial assessment) than family members in Family Assessment intake cases, with the exception of siblings, who were more often assessed in FA cases than TI cases. The proportion of cases receiving an initial, a partial, or no initial comprehensive assessment during case opening in Intake is shown in Table 2.

Table 2: Comprehensive Assessments of Available Family Members

	Initial Assessment		Partial Assessment		No Assessment	
	TI	**FA**	**TI**	**FA**	**TI**	**FA**
Fathers (n=35 TI, n=26 FA)	31.4%	38.5%	51.4%	38.5%	17.1%	23.1%
Mothers (n=60 TI, n=53 FA)	38.3%	66.0%	61.7%	32.1%	0.0%	1.9%
Children (n=60 TI, n=59 FA)	36.7%	42.4%	60.0%	52.5%	3.3%	5.1%
Siblings (n=42 TI, n=47 FA)	17.0%	28.6%	63.8%	52.4%	19.1%	19.0%

Mothers were given a full, initial comprehensive assessment more frequently than any other family member, with siblings receiving the fewest full, initial comprehensive assessments. Target children and their siblings were more often given partial, initial comprehensive assessments 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.

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 while looking at 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 length and location during 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.

Results of the analysis showed that workers visited children at least once a month in 69% of the cases. Monthly contact with children was the most typical visitation pattern. Using the sufficiency guidelines mentioned above to determine the "strength" of visitation, the current data reflect "strength" results with **82% of all target children having sufficiently frequent visits and 71% 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. While sufficient frequency of visits was nearly equivalent between TI and FA cases, the quality of visits was much higher in FA cases (78%) than in TI cases (63%).**

The case record reviewers further analyzed the data by assessing whether the frequency and quality of visits between the caseworker and parent appeared to be sufficient in ensuring the safety, permanency, and well-being of the child. See Table 3 below for further details in regard to sufficiency of visit frequency and quality.

Table 3: Sufficient Visits with Available Parents

	Sufficient Frequency		Sufficient Quality	
	TI	**FA**	**TI**	**FA**
Fathers (n=35 TI, n=26 FA)	76.5%	92.3%	61.8%	80.8%
Mothers (n=60 TI, n=53 FA)	76.7%	92.5%	68.3%	86.8%

Available fathers received fewer visits from caseworkers than available mothers (75% of mothers were visited at least once a month in comparison to 61% of fathers – 66% of fathers in TI cases and 54% of fathers in FA cases); though both mothers and fathers were viewed to have equally sufficient frequency to ensure

safety, permanency, and well-being of the child. However, quality of visits with fathers was lower than was visits with mothers. Additionally, sufficient frequency and quality of visits to ensure child safety, permanency, and well-being were much higher in FA cases than TI cases for both mothers and fathers.

Most caseworkers made repeated efforts to contact parents, had ongoing contact with service providers, and talked with parents over the phone. **Areas of improvement for Ramsey County include initiating more comprehensive assessment across family members, but especially for fathers and siblings, who did not receive an initial comprehensive assessment in approximately 20% of all cases.** When comprehensive assessments were utilized, less than half of all family members received a *full*, initial assessment. Most family members only received a partial, initial assessment. **Additionally, the quality of visitation with fathers, increased visitation rates of children, and documentation of visitation with all family members are additional areas for improvement.** For example, in 31% of cases children were visited less than once per month. Furthermore, case file documentation of visitation was unclear as to whether or not the quality of visits was sufficient to ensure the safety, permanency, and well-being of children in 13% of cases in which fathers were available and 5% of cases in which mothers were available. Twenty-three percent of cases with available mothers could not be evaluated as having sufficient quality, and 30% of cases with available fathers could not be evaluated as having sufficient quality; improved documentation of visitation may decrease these numbers.

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 Intake Baseline data revealed that for the majority of time, workers adequately assessed strengths. **Family strengths were mentioned or appeared complete in 96% of all cases.** Strengths were more often assessed within the first 45 days receiving the case, and appeared in case notes and/or in Structured Decision Making (SDM) assessments. Strengths assessments for target children appeared complete or were mentioned in 88% of cases, with mother's strengths mentioned in 88% of TI cases and 96% of FA cases in which mothers were available. Complete or near-complete strength assessments of fathers were apparent in 71% of TI cases and 73% of FA cases. Of the 120 reviewed cases, community strengths were noted in 78% of cases. **Intake workers did well assessing mothers' strengths but paid only adequate attention to assessing fathers' strengths and identifying community strengths.**

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 whether needs were assessed for each family member as well as reasons why needs were not addressed by the worker or 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, the data showed that while TI and FA workers evaluated and documented need in the majority of cases, providing services to address these needs and documenting this service provision was not as successful.** In 19% of TI cases and 5% of FA cases in which the children had needs (as identified by case reviewers), workers failed to address these issues as "needs." Nearly 70% of children who were identified by the worker as having needs either did not have their needs addressed by services provided by the worker (35% for TI cases and 50% for FA cases) or it remained unclear if the needs were addressed by services provided by the worker (65% for TI cases and 6% of FA cases). Identified needs that were not addressed included housing, social

support, improved family relations, and counseling for children and family members. Further analysis showed that in most cases where the worker did not provide services, it was due to the fact that the child already received services from other resources (e.g., a child welfare worker in Program). However, vague or inconsistent documentation made it difficult for reviewers to determine whether children's needs were met by services in a large number of cases.

The evaluation of needs for fathers and mothers indicated that parents in FA cases more often had their needs assessed than parents in TI cases. In TI cases, workers did not assess the needs of 36% of mothers and 31% of fathers, whereas in FA cases, workers did not assess the needs of 7% of mothers and 16% of fathers. It is important that workers complete a thorough assessment of need for all family members because without doing so, the worker can potentially miss underlying issues within families that contribute to the need for agency intervention (United States Children's Bureau, 2007).

Collecting information about family needs is not an end in itself, but rather a starting point for developing a service plan that appropriately addresses strengths and needs. This service plan or strategy for intervention is meant to increase the likelihood that services will match a family's real needs, and that services "secure the link between existing needs and desired outcomes" (Children's Bureau, 2005). In evaluating past and present comprehensive family assessments, it is vital to evaluate whether services match problems, target specific needs (e.g. education, physical/mental health), and respond to comprehensive assessments as well as safety and risk assessments.

Once needs are assessed and identified, the focus turns to ensuring that these problems are sufficiently regarded through appropriate services so that family functioning can improve. The current review of Ramsey County cases indicated that services were often connected to families based on need, but varied by family member. **In 37% of cases (33% of TI cases and 43% of FA cases) in which the mother had identified needs, the worker did not connect her needs with appropriate services during Intake.** Some common services for mothers that were not addressed by the workers included housing, parenting, mental health, child care, employment, and domestic violence. In some cases, clients refused the services offered by the workers. **Workers did not provide services for**

27% of cases (25% of TI cases and 29% of FA cases) that included an available father who was in need of services during Intake. Needs that were not addressed by the services provided included chemical health, employment, and physical and mental health needs. In most cases where workers did not address the father's needs, the limitation was due to the worker not recognizing those needs, not being able to establish contact with the father, or the father's refusal to utilize the suggested service(s).

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 120 cases reviewed in Intake, only four target children (one from a TI case and three from FA cases) were identified as having problems with school. **Of these four children, three received appropriate services (the TI case and two of the three FA cases) to meet their educational needs - slightly below the 90% threshold required to meet substantial conformity in the CFSR.** However, it is possible that some of these needs are not being addressed in Intake because it is Ramsey County's procedure to address these needs in Case Management (Program) services.

Findings of the Intake Baseline Study indicated that all children with medical problems (n=5) and physical disabilities (n=1) in the sample had been provided appropriate services. However, children with mental health problems were less frequently matched with appropriate services. Children were most commonly matched with services to address issues of perpetrating domestic violence, general mental health, and behavioral problems. Children were rarely matched with services to address issues related to witnessing domestic violence or alcohol or drug use. It was unclear in many cases as to whether or not children had been matched to services according to their mental health needs, especially in cases which included child cognitive status or criminal behavior issues. (See Table 4.)

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. **For the majority of cases, services were provided that were appropriate to a child's risk of harm or risk of placement. Family counseling, individual counseling, and family-based**

service counseling were the most frequent services provided for children. Nearly 63% of all families received family counseling. Interestingly, mothers usually received family counseling (n=24), individual counseling (n=13), family based service counseling (n=5), family based service-life management skills (n=5) and respite care (n=2). Fathers rarely received services; only in two cases did fathers receive individual counseling. In one case, a father received family-based service counseling, and in one case a father received child care assistance. Other services, like parenting education, family support services, and family preservation services were not used for fathers.

Table 4: Child Mental Health Needs

	Yes		Unclear		No	
	TI	FA	TI	FA	TI	FA
Child alcohol abuse addressed (TI n=2; FA n=2)	0.0%	50.0%	50.0%	0.0%	50.0%	50.0%
Child other drug abuse addressed (TI n=2; FA n=3)	50.0%	33.3%	50.0%	0.0%	0.0%	66.7%
Child cognitive status addressed (TI n=3; FA n=1)	0.0%	0.0%	100.0%	0.0%	0.0%	100%
Child behavioral problem addressed (TI n=15; FA n=11)	53.4%	63.6%	33.3%	18.2%	13.3%	18.2%
Child mental health addressed (TI n=12; FA n=9)	66.7%	77.8%	25.0%	0.0%	8.3%	22.2%
Child criminal activities addressed (TI n=1; FA n=2)	0.0%	0.0%	100.0%	50.0%	0.0%	50.0%
Child witnessing domestic violence addressed (TI n=6; FA n=2)	16.7%	0.0%	33.3%	0.0%	50.0%	100.0%
Child perpetrating domestic violence addressed (TI n=1; FA n=3)	100.0%	66.7%	0.0%	0.0%	0.0%	33.3%

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 Intake Baseline 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. **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, 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 5 for complete findings.)

Table 5: Worker Actions to Connect Family to Services

	For Safety Plan		To Prevent Placement		In Response to Other Assessment	
	TI (n=40)	FA (n=42)	TI (n=52)	FA (n=54)	TI (n=30)	FA (n=20)
Provided information about services	66.7%	22.2%	22.2%	0.0%	53.3%	43.9%
Made a referral to services	0.0%	5.6%	0.0%	0.0%	6.7%	17.1%
Arranged services or contacted provider	35.0%	33.3%	33.3%	0.0%	43.3%	19.5%
Provided concrete services	10.0%	5.6%	12.5%	0.0%	16.7%	22.5%
Coordinated services	15.0%	16.7%	25.0%	0.0%	8.3%	17.1%
Met with other agencies	0.0%	11.1%	0.0%	0.0%	6.7%	9.8%
Negotiated with landlords	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%
Staffed meetings with providers	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%
Engaged family in services	65.0%	17.6%	37.5%	0.0%	33.3%	12.2%

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 shows that specialized assessments appeared completed in 35% of TI cases and 10% of FA cases; 37% of TI cases and 20% of FA cases mentioned a specialized assessment but it was not completed during Intake. **Results of the Intake Baseline Study indicated that specialized assessments may be an area of needed improvement for RCCHSD.**

Thorough Documentation

Vague or inconsistent case documentation was a recurrent theme throughout the case record review for both TI and FA cases, making it difficult for reviewers to accurately determine what was happening with a case. As noted in the *CFA Guidelines*, "clear and full documentation must be included in the case file at the completion of the initial process of the CFA as well as when the information is updated" (Children's Bureau, 2005). Thorough documentation is a vital component in ensuring that consistency and best practice occur throughout the course of a case. If documentation is unclear, evaluators have no way of determining whether standards are being met and new workers on the case muster- start the assessment process from the beginning. As noted previously, **documentation regarding the connection of safety threats to safety plans, details of worker visits with family members, and specific needs of family members was sometimes unclear.**

Cultural Competency

Child welfare and the entire social work profession have set a precedent in designing culturally competent services. The field recognizes that culture – including race, ethnicity, rituals, and traditions – can offer a powerful source of healing for clients. While this understanding is widely accepted in child welfare, the protocol for turning an abstract concept into effective practice is still up for debate. Ramsey County has been at the forefront of this attempt to provide culturally competent services through carrying out an anti-racist initiative throughout the agency. In the 2001 worker's guide for the *Children and Family Services Best Practice Framework*, the first practice principle stated: "We honor and respect the culture, experiences, history and values of the families we serve" (Ramsey County Community Human Services Department, 2001). Specific practice components included helping workers understanding their own biases, using Family Group Decision Making to assess culture, communicating in an appropriate language, and developing a culturally appropriate service plan, among others.

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). The Intake

Baseline Study found that **culturally competent practice is still an area that needs improvement.**

The majority of cases receiving Intake services – for both TI and FA – included no description of the family's environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances (see Table 6). Just under half of all TI cases included at least some mention of the family's environmental, cultural, ethnic, or linguistic contextual strengths or potential hindrances, but less than 10% of all FA cases included any mention of these descriptions. **While Ramsey County has made a continual effort to address cultural competency, more specific practice guidelines are needed to ensure that initial assessments are culturally relevant, especially in FA cases.**

Table 6: Assessment of Contextual Strengths and Hindrances

	Appeared Complete	Mentioned	Not Mentioned
Contextual strengths			
TI	10.0%	33.3%	56.7%
FA	3.3%	1.7%	95.0%
Potential contextual hindrances			
TI	11.7%	30.0%	58.3%
FA	3.3%	6.7%	90.0%

Conclusion

An assessment process that ensures the safety and well-being of the child(ren) while connecting appropriate services to the needs of *every* family member (as the Children's Bureau asserts) is a complex undertaking that depends of a number of variables. First and foremost, initial and ongoing safety and risk assessments must be completed in order to create appropriate safety plans and service provisions. The current study found that Ramsey County responded well to investigating incidents within the State's mandated timeframe. While most cases included a safety or risk assessment, and most cases which noted the presence of a safety threat included a safety plan, a large proportion of cases in which no safety threat was present also included a safety plan. Both mothers and fathers were adequately involved in the safety and risk assessment process, while children's

involvement was insufficient. Most cases were connected to services appropriate to safety, risk, and prevention of placement. Ramsey County also did well in permanency items, often preventing additional placements and making inquires about tribal affiliations of clientele.

Comprehensive family assessments (CFAs) are an important guide to capturing the "big picture" of a family involved in child protection. Current data showed that most family members were given a partial or full, initial comprehensive assessment; however, approximately 20% of cases which had available fathers and siblings did not include any type of foundational comprehensive assessment. To determine the quality of the overall assessments that were completed, the study looked at a number of factors, including family involvement, the identification of needs and strengths, and connections to appropriate services.

Case reviewers examined whether worker visits with each family member were able to address issues pertaining to the safety, permanency, and well-being of the child as well as achievement of case goals. Overall, the frequency and quality of worker visits were highest for children and mothers, and lowest for fathers involved in the case. Approximately 70% of children were being visited at least monthly. While this number is promising, increasing this statistic can lead to better assessments of strengths and potential issues of the family and community.

Evaluating community and family strengths, an important part of the CFA process, can help identify resources that can support a family's ability to better protect the children. Ramsey County workers did well in assessing strengths of mothers, and adequately assessed strengths of fathers and the community. However, culturally competent practice – assessing the environmental, cultural, ethnic, linguistic, contextual strengths and hindrances – is a needed improvement that can boost the efficacy of the assessment process and allow each worker to have the tools to better identify family assets and empower families to utilize their own protective factors in a way that fits each family.

While assessing for strengths, a worker must simultaneously evaluate family needs in order to determine appropriate services. In quite a few cases, especially for the target child, the worker failed to recognize a need or the need was recognized without an appropriate service attached. In looking at service connection in response to specific needs, the study found that children's physical health needs were matched with appropriate

services, while education and mental health needs were sporadically matched. Encouragingly, services were often provided that were appropriate to a child's risk of harm or risk of placement during Intake. Current data also showed that workers were more involved in connecting families to services in response to a safety plan or assessments other than risk and safety, and less active in connecting families in response to preventing placement (although only about 12% of all cases were out-of-home cases in the review). Fathers' needs were more often matched to services than were mothers' needs.

Documentation is a needed area of improvement for Ramsey County. In the current review, it was sometimes difficult to determine whether or not workers considered family members' presenting and underlying issues as "needs" and whether they were connected to services, especially when the services were provided by another worker or department. Details of meetings with family members were often vague or seemed inconsistent with worker evaluations of family strengths, needs, safety, and risk. Improved documentation of workers' visits with family members would also be helpful to reviewers' efforts in evaluating whether or not the quality of the visit is sufficient to ensure the safety, permanency, and well-being of the child.

The next phase of assessments must move beyond risk or safety in order to sufficiently capture a more holistic view of family members, including underlying needs, personal and community strengths, as well as specific cultural factors that could contribute to hindered or improved functioning. In moving towards including Intake as the foundation of a comprehensive assessment, new guidelines would promote family involvement throughout the case (especially for locating fathers and involving children) starting in Intake. By incorporating the principles of Comprehensive Family Assessment in Intake, family involvement will be promoted. A more thorough assessment will recognize that every family is unique, and that by reflecting individual strengths and needs in a service plan, a family can be empowered to make lasting change.

Focus Groups

Methods

Focus groups were held for all Ramsey County child protection Intake and Investigation units from February through May 2009. Three units (two units of approximately 10-11 workers each, and one unit of three workers) were invited to participate in unit-based focus groups; supervisors for each of the three units were also invited to participate in a *separate* supervisor focus group. Focus groups were held during established unit meetings, with the exception of the supervisor focus group which was scheduled. Focus group participation was voluntary. A University of Minnesota facilitator and note-taker were present for each focus group.

In each focus group, participants were presented with a series of questions (14 questions for worker groups and 18 questions for the supervisor group) about the baseline assessment practice model used by Intake and Investigation. Worker focus groups were comprised of two, nine, and 10 workers, respectively; all three supervisors participated in the supervisor focus group. A University of Minnesota researcher acted as facilitator of the focus groups, as well as provided an overview of the Comprehensive Family Assessment project. The focus groups also served as an opportunity for researchers to introduce the project and solicit feedback on selected methodological questions. Analysis and dissemination of the focus group responses were completed using the qualitative data analysis software package NVivo.

Results

Overall Assessment Process

Intake focus group participants reported that the assessment in Intake is a widely varied process. This is consistent with what case management workers reported in baseline focus groups. Intake workers who participated in focus groups reported that they do not use a standardized process to complete assessments with families. The assessment process varies from intake worker to intake worker, and also varies from case to case. One participant stated, "People do things differently. The idea is to see kids with family, but not everyone does it that way. Sometimes it depends on

the situation; some workers always see kids at school with family or alone at school, or always with family in the office or the home. Different people do it differently."

Unlike in Case Management, intake workers reported that they were not familiar with a Ramsey-specific assessment process for Intake, like the Family Centered Assessment (FCA). Rather, workers used a variety of skills and strategies to assess families in their caseload. Although a few participants reported they had a somewhat standardized list of questions they ask families, these are not shared questions. "I have the questions memorized, not on a form. That way, I can use them naturally in the interview process in a holistic manner. This helps me understand what's going on in the case, and guide the interview appropriately. For example, I'm going to ask different questions if the family will be homeless next month, than if it's another issue."

Focus group participants shared varying opinions on the diversity of assessment techniques currently being used. Many workers reported that they struggled with the inconsistency of the assessment process. Workers "…need more support on how to work with families, we need more consistency on how we work. Everyone has their own approach. There is no consistency. Older workers do more investigation; less assessment and less strengths-based approach." Another intake worker reported that the assessment was "not consistent between workers. I wish that everyone had the same process. Like, 'answer these questions to assess.' Not everyone uses questions, and if they do, they are vague, not specific to ensure that all workers capture all the same type of information."

Workers suggested that this varied assessment process is the result of unclear messaging and expectations from Ramsey County Human Services management.

> "It's tough. There are mixed messages that the workers hear. Some hear, 'get in-get out,' others hear, 'find the big picture, of all that is going on.' A lot has to do with individual workers, and their skill level and their comfort level, which impacts how they work with people. There is no consistent expectation of workers on how to get the big picture."

While a number or workers were critical of the wide processes used to assess families, many still appreciated the flexibility afforded by not having a standardized

tool or instrument when performing assessment. For example, one participant stated "if I have a list of irrelevant things to ask, it's going to get in the way of my job." Another concern with a standardized instrument was how it has the potential to interfere with family privacy. One worker stated, "A boiler plate doesn't fit with every family. I don't want to get too involved and ultimately make it worse for the kids. We need to individuate services." Several other focus group members contributed that they felt that standardization was appropriate to gain basic information, but that it could become intrusive if they have to gather too much information for "federal goal[s]."

Although the **responses of intake workers about their feelings and opinions related to the assessment process may appear to be contradictory, upon further consideration, they are not. In fact, some focus group participants reported that they favored both a standardized assessment process and that they liked having flexibility to work with families and to individuate their assessments.** (Recommendations for finding balance between standardization and flexibility are offered in the Conclusion of this report.)

Timelines

A common theme among the focus group members was that of timelines. Specifically, most workers discussed how difficult it was for them to complete their tasks in the time allotted. Many workers stated that their superiors have "unrealistic expectations" for what the workers can do in the period they are given to assess and close or refer a case. One worker summarized his/her perception of how timelines affect their work in the following way:

> "In Program you have the time, the luxury to have a small case load of 12 and to only see a family once a month. We have that many cases, but without the luxury of time. We are moving cases in and out within hours. We do a quick assessment for child safety within hours or days of getting a report and then make a quick determination of service needs. We then offer the family services and move the case. Moving cases, moving cases, moving cases. It's what we do."

Several workers noted that in addition to the short window of time they have to see

and refer or close a case, they also have other barriers to getting families the help that they need. One barrier is often that workers find it difficult to make contact with some families within the mandated 24 hours. One worker reported, "I just had a 24 hour case but no one spoke English…24 hour cases that don't speak English shouldn't go to a person who doesn't speak that language. [I was] spinning [my] wheels [on this] case because they kept hanging up on me."

Several workers raised concerns about policy and practice changes that would make their workload even more unmanageable, given the restrictive timelines in Intake. The common concern was that these workers felt as though they do not have enough time to do the work they already have, and they fear that they will be asked to do work from other units (e.g. Program) or that more work will be created by federal mandates. One worker reported that "they [management] are now asking us to create out-of-home placement plans. We only have the case for 20 days! We weren't doing them before but we are now. We are worried that there is more to come…more work that should not be our job and that we don't have time to do."

Inefficient Policies and Practices

Inefficient or ineffective policies and practices was a theme that emerged from the focus groups with intake workers. Common concerns around policies and practices included concerns that there was too much paperwork, that much of the paperwork was inefficient (repetitive), and that filling out this paperwork interfered with workers' ability to actually "work" with the families. In short, their assessment process was hindered rather than helped by the policies associated with documentation.

A worker described:

> "We have got stuff, paper work just piled on to us, that we don't have time to do, and it's not adding value to the services we provide. They dumped it on us because the work wasn't getting done at the next level. It worries me about this new model, they are going to pile more things on us and our resources are tapped. And when they add on more work, they don't take away any work that we are already doing. So we have to do more in the same amount of time."

This voice is echoed by other workers who stated, "There are rules such as no overtime [but there's] too much paperwork. Other counties pass things on electronically but we are printing." Furthermore, workers commented that their education and expertise were not being put to use filling out structured forms, which leave no room for much dialogue with the family, let alone room for worker expertise or practice wisdom. One worker stated that "when I first started this job I was told that 80% of my time would be in the field; now 80% of my time is in the office and 20% is in the field….why do I have this degree if most of my job is clerical?"

In addition to the amount of paperwork workers must do**, some workers raised questions about how efficient the assessment process is. Some workers were concerned that they had too many questions to ask and forms mandated by the government to fill out about families that took time away from actually listening to a family's story.** In response to this, one worker contributed:

> "We have a form where we ask folks if they are native or not [the ICWA form], it seems ridiculous! We have to ask everyone, even if they are a new immigrant from Sweden. We need to use our judgment and not burden the family with questions that are ridiculous. You have the interpreter there, speaking Hmong, and you have to ask if they are Native American. It is a foolish waste of our time."

This concern was not isolated to the workers. Many supervisors stated that inefficient policies and procedures get in the way of their supervisory duties. One supervisor commented that "there is too much systematic stuff that gets in the way of us doing the work. Systematic fluff, writing up policies, reinventing the practice, meetings, meetings, meetings, there is too much time in these areas. And it zaps your time and energy away from being a resource to our workers. People flow in and out of the office all the time, but we are not available enough to our workers, because of all the meetings."

An additional concern was that of insufficient training. Supervisors recognized that their workers spend much of their time on paperwork, but suggested that better training for their workers might cut down on inefficient work, stating,

> "Another challenge is that workers spend so much of their time on documentation. We would like to be able to train our workers better on documentation, so they are doing quality work in less time…We want our workers to be concise and relevant to their documentation, and have a better understanding of what is relevant versus what could be private and omitted….We want our workers to maximize time with clients, not on documentation."

Culture

Many intake workers who participated in focus groups stated that they were not doing enough to address the culture of the families that they work with. Working with a person's culture was perceived as complex, because each member of that culture has unique needs. A worker went on to state the complexity of working with someone from a different culture that they face as front line workers:

> "Overall, we have no formal or common process to address family culture in a meaningful way for all families. We try to identify culturally. But outside of ICWA, there are no formalized processes to address culture…There is no category in the assessment tool to get cultural info outside ICWA."

Several participants responded that they address culture with their families "very poorly" and that "ICWA is the only issue we address."

With regard to training on culture, one worker stated that "we get tons of diversity training." **However, incorporating family culture into an assessment with a family is a more complex task than general diversity training prepares workers to do.** Another worker responded that we get "no guidance on how to address [culture] in the assessment". Even more strongly, other workers felt as though the assessment tools and forms that they use were not culturally sensitive. One focus group participant responded,

> "It's a lot to have people sign all of these forms, they are scared, and they don't know what it is. The forms are in English only, so if they are not literate in English they don't know what they are signing. They are scared that they could be signing the rights to their kids away, when it's just a mandatory form. That kills trust."

Similarly, other workers fear that they might "kill trust" and defy cultural norms just by going in the family's home with a list of questions. Several members of the worker focus group responded to the process of assigning caseworkers to families of a different culture. Several workers reported encountering roadblocks in meeting with families on 24-hour cases because of language and cultural barriers.

Hierarchy Conflict

Overall, there was a sense of conflict or mistrust between workers, supervisors, and management. Many workers and supervisors commented on the poor communication used between the three levels, the lack of consistency, and the "top down" hierarchy that created an uneven power dynamic. Many workers related a sense that management was "out of touch" with what the workers were doing on the "front lines." One worker called management "a hindrance" to their work. Workers and supervisors both describe the communication between themselves and management as "disorganized" and one sided.

Within the **worker participant focus group, communication with supervisors and management was seen as "top down," where management gave them directives but did not listen to worker input.** Workers reported being upset that management created tools and made policy without inviting ideas from the workers, who had to use the tools. Most workers echoed the same idea, that: "[management doesn't] understand us or value our perspective." Others noted that they have been asked for input, but that management either "twists" the ideas or the ideas are not incorporated into policy or practice. This engagement style was viewed negatively by the workers, and made many feel that they were "never given the power" to "engage in the change" process.

Amongst the workers, there was a tone of hopelessness that things with management would change. One worker summarized his/her feelings in the following quote: "I've lost hope that things will change with this new administration. I had hoped. Management doesn't listen. They come with set agendas…but nothing changes." Supervisors, as well, found conflict with management. Supervisors reported hearing mixed messages from management about their work as supervisors. A participant contributed:

> "What we hear from the others [supervisors] is how good our unit is…but that is hard for us to believe when the reins are pulled in and we have to check in all the time with management. My main complaints are that our decisions are overturned by management without any rational given to us…that our supervisor doesn't know the job."

Having one's decisions overturned by management was a common complaint amongst the supervisors. One supervisor was dissatisfied that "the management can overturn us as supervisors even if we all agree amongst ourselves."

Alternately, at least one worker responded positively to management. This worker reported that "management communication is getting better. There are now all staff meetings—there is now almost too much communication, between all the staff meetings, the newsletter; sometimes we don't have anything to talk about! But with case decisions, we could communicate better…"

Supervision

The overall tone amongst the workers about the supervision they received was that communication was inefficient, that it was difficult for them to connect with their supervisors, and that they (the workers) did not have much power in the relationship. Furthermore, many workers echoed the sentiment that they just "checked in" with supervisors to "cover their backs" with regard to cases.

The amount of communication between a worker and his or her supervisor is also affected by the seniority of workers. Workers reported that supervision may vary for those who have been in the field for longer. Workers with more seniority may not go to their supervisors as often. This is the case for one of the participants, who replied to the question on supervision by stating that "I don't think I need [a] conversation because I rarely get anything back that says it needs to be done some other way." Furthermore, it appears that some workers avoid going to their supervisor if their supervisor has less experience then they do. One worker stated, "I've done over 2000 assessments, but the manager of our unit has never done an assessment in Child Protection. I'm willing to talk to her to cover my butt before I make a determination of maltreatment-but it's asinine."

Additionally, it appeared that the fast pace that is kept on the intake unit may be a barrier in receiving adequate supervision. Some workers commented that although they are supposed to meet with their supervisors every first and third week, it lacks consistency. A participant stated that "we [the workers] are supposed to check in with them [the supervisors] about everything, yet checking in is unrealistic, because we often can't find our supervisors to connect and talk." Participants also raised concerns about inconsistencies among different supervisors and that they were not able to go to another supervisor if their supervisor was unavailable.

Alternately, some participants felt as though they received adequate supervision from their supervisor, especially on difficult cases. One participant acknowledged that: "yes she's [my supervisor] available; she says 'come here.' And we have supervision meetings, too, and we discuss our cases in our meetings. In [difficult] cases when I need to talk to her I just pop in."

Several workers brought up the topic of peer-consultation as an alternate way to get supervision on a case. Participants contributed that they often turn to peers for case consulting and that "we find our peers more helpful, they know more."

In addition to the worker's thoughts on supervision, supervisors had the chance to voice their ideas in their own focus group. The responses from supervisors were mixed on their success in supervising workers. One responded that the supervisors have "an open door policy to keep up with what is happening, to be available as needed for informal curbside consults, which can take a few minutes, fifteen minutes, up to an hour…" Some supervisors commented that they were so busy with meetings and paperwork themselves, that they did not have time to meet with their staff as they would have liked. For example, one intake supervisor stated that "there is too much systematic stuff that gets in the way of us doing this work….we are not available enough to our workers because of all the meetings."

In the intake supervisor focus group, much like the workers, supervisors commented on how there was "friction" between supervisors because of differences in style. It was noted that there was no consistency between supervisors, and this led to inefficient work. One supervisor summed their thoughts up in the following excerpt:

> "Some things we do well, some things we can improve on. We need one voice; the workers feel that each supervisor will give them a different answer. No consistency between decisions from different supervisors. We don't have time to consult with supervisors, to give a unified answer, a consensus... We are always clashing on how we see the cases…It works when we come together as a group of supervisors, it can be okay…we need a clear policy."

The informal supervision that was reported by workers in Intake was similar to Program workers' reports of supervision in Case Management. Worker impression is that most supervision they experience is done informally, on an as-needed basis.

Communication

Overall, communication between workers, their supervisors, and management was considered poor and inefficient (see sections on Management and Supervision.) **Many workers in the focus group responded that there was not enough consistency among policies and procedures. Furthermore, several noted that their work had been impacted by inefficient communication. Changes to policy and procedures were not communicated effectively to them, which made it difficult for them to prepare.** One worker reported that "there are times when Ramsey County changes rules and what they used to be looking at…and communication is not good so we hear about it later and that I don't like. So, I'm not resistant, but if you change the rules let me know so I can be efficient." Most workers stressed the importance of improved and consistent communication between themselves and their supervisors in order to improve morale and their work. This is a message that was clear from case management workers in baseline focus groups as well.

Similarly, supervisors noted that they needed more consistency in the way they communicated with workers, as there were mixed messages being sent out. In this focus group, supervisors called for a more "unified voice" when it came to making case decisions.

Workers and supervisors alike commented that the communication used in unit meetings needs to improve in order to increase productivity and make the meetings worthwhile to attend. A worker stated, "Information is not disseminated well, but when I

say this then they drag us in to an all staff unit meeting and say nothing. But if we're feeling unprepared [it's a reflection on the fact that] they are not prepared."

Participant Recommendations

Recommendations for improvement were limited from all four focus groups. **Many of the recommendations involved suggestions of improving communication amongst both supervisors and management.** Supervisors agreed with workers that they need to have "one voice" when addressing the units. **Furthermore, it was suggested in many places that both supervisors and management increase consistency in their decision making about policies and procedures.** Additionally, some workers called for more transparency in communication between supervisors and themselves. To do this, there was a suggestion to create a website in lieu of email where workers and supervisors could communicate electronically, and hopefully, more quickly and efficiently. Other recommendations were for workers to "dictate and have automatic transcription" and to have "mobile tablets" so that they could do their work more efficiently in the field. One additional recommendation that was echoed throughout the focus groups was to streamline and/or decrease the amount of paperwork that the workers needed to fill out. One worker suggested, specifically, that there be less paperwork for cases that do not open than for those who do open.

Conclusion

One of the overarching themes of the focus groups was a perceived inconsistency in assessment. Many workers were dissatisfied with the assessment process because there was so much variability in the process. Some workers used a form, others did not, and there were differing opinions on which one is more practical. The vast majority of workers were overwhelmed with paperwork and pointed to it as the single most difficult and time consuming part of their job.

Furthermore, much of the worker and supervisory dialogue was devoted to communication. Many participants expressed dislike for the perceived "top down" communication style at Ramsey County. Workers expressed frustration with "mixed messages" and inefficient communication given to them. They reported that they were not offered the opportunity to give input on policy or practice, although they were the ones

undertaking both on the frontlines. Supervisors spoke to their frustration with management about overturned decisions on cases. Both workers and supervisors commented on the unequal power between the different levels of staffing.

The predominant themes that emerged from the intake worker and supervisor focus groups have the potential to assist in informing a practice model for Comprehensive Family Assessment in Intake nicely. Each of the areas addressed within the Focus Group section of the Baseline Report have been incorporated into the Recommendations section of this report for the potential development and implementation of a CFA practice model for Intake.

Discussion

The findings from the baseline case record reviews, worker focus groups, and family interviews offer key insights regarding current practice in Ramsey County Child Protection intake services. Further, these findings provide guidance on developing a new foundational practice model for comprehensive family assessment in Intake. As a means of developing the new framework for CFA in Intake, University of Minnesota evaluators offer the following recommendations, guided by findings of the Intake Baseline Study:

Recommendations for Development of CFA Practice:

1. Develop *realistic* practice approaches for involving *all family members where appropriate.* By maximizing the number of family members involved in working the case from the beginning a more comprehensive picture of the families' needs and protective capacities will be achieved. If out of home placement is warranted, the family finding process will already be underway. Additionally, the county will be in alignment with Fostering Connections legislation because there will be a greater understating the dynamics of families served. Further, workers will have an improved ability to evaluate the relationships that need to be maintained between family members, communities and family culture through the assessment of all relevant family members.
2. Create a practice model that is uniform and standard but still leaves room for flexibility. This may include having a standardized form or process that guides intake workers in their assessment, but leaves room for worker expertise and

individual family difference. It may also include altering aspects of the Intake CFA practice model to be appropriate for the philosophy of Family Assessment cases. This may mean development of a unique counterpart for Family Assessment cases within the CFA practice model. Incorporate concrete strategies or guidelines for workers to integrate family culture (e.g., documenting contextual strengths and potential contextual hindrances, providing culturally-appropriate services, etc.) in Intake. This recommendation moves beyond providing workers with diversity training and toward the development of specific strategies or guidelines for considering family culture within the initial assessment with families.

3. Develop a system of standardized documentation for case notes and contact summaries, especially in terms of worker visits with family members and collaboration between workers in different departments and/or agencies regarding family assessments and service provision. We recommend that this include the elimination of documentation requirements that are redundant or that can be incorporated within other documentation requirements.
4. Create a standardized method to more consistently connect safety, risk, intake assessments, plans, and services for all cases. For example, training may need to be developed to allow workers to better distinguish between safety threats and risk. In addition, creating protocols to assist workers apply knowledge gained from safety, risk and other assessments to the development of safety plans, suggested case plans, and delivery of services in Intake may be necessary for consistent connection among these concepts.
5. Develop CFA policies and practices that are congruent with timelines and/or expectations that are established by statute. This is a concern for intake workers in particular. Given the inflexible timelines required for cases in intake (24 hours or five days), it is important the requirements of CFA coincide.

Recommendations for Implementation of CFA Practice:

6. Develop a standardized approach for training intake workers in CFA. Baseline data from both Case Management and Intake suggest that assessment is a

process that workers have adapted on an individual basis, often in spite of a "standardized" form. As a practice model for CFA in Intake is developed, we suggest that training attempt to address this issue. Here are a few suggested strategies to work toward CFA practice fidelity:

a. Provide an overview of CFA: Its history, purpose, and goals
b. Use case examples to illustrate different elements of the practice
c. Create/establish clear criteria for handling different types of cases. For example, how are educational neglect cases handled under the newly developed practice? Some criteria or protocols will emerge once the practice is being implemented. This requires:
d. Ongoing training. Develop and implement a plan for how new hires will be trained in the use of CFA. Create refresher courses or updated trainings that provide workers with new or revised elements of the practice. Allow for worker input on topics for training.
e. Train at all levels: case aides, front line workers, and supervisors. Provide specific training for different jobs so that all staff members get training that directly applies to their job responsibilities and expectations.
f. Create a system for disseminating information (e.g., policy updates, changes in CFA, on-going training, etc.) across levels. Consider developing a standing meeting or time slot within a meeting to disseminate information. For example at all unit meetings, have a standing agenda item to address policy changes and how these will *specifically* impact practice.

7. Utilize communication and training to develop a common understanding of RCCHSD's mission and/or goals for the agency. Having a clear and shared vision that is communicated consistently at each level can provide supervisors and workers with a broader context for their work with families. For example, should workers focus on families comprehensively or should they focus on the presenting problem? What are the goals associated with the philosophy of practice that CFA defines?

8. Adjust supervision protocols for Intake. Workers noted that the fast pace of intake services makes the current model of supervision ineffective or difficult work to work with. For example, it would be inadvisable to develop a CFA standard that intake workers meet with their supervisors before making contact with a family, since this would not always be possible.

These recommendations were created based on baseline data collected through the intake case record reviews, worker and supervisor focus groups, and family interviews. University of Minnesota evaluators recognize that the intake data can only provide a limited framework for guidance in the development and implementation of CFA at Ramsey County. Incorporating results of the Intake Baseline Study with working knowledge of Ramsey County practices will be of utmost importance when developing the CFA Intake practice model.

The development of a foundational practice model of CFA in Intake will allow workers to begin a process for gathering a holistic, "big picture" assessment of family patterns over time rather than focusing solely on the incident that brought the family to child protection. Looking at the "big picture" or utilizing Comprehensive Family Assessment does not necessitate addressing or assessing all potential problems or concerns a family may be facing. Rather CFA encourages looking beyond the presenting problem solely, by utilizing a broader perspective to understand the presenting problem within the context of related family concerns/issues. By building a foundation for CFA in Intake, RCCHSD will be able to better ensure consistency between assessments in Intake and Case Management, and further integrate Intake and Case Management work for families in child protection.

The intake baseline study is the part of the first phase of the overall CFA evaluation project. The final version of the RCCHSD CFA practice model will eventually be disseminated to other counties and states to guide other CFA implementations. The hope is that by accurately evaluating the results of the new protocol, and making necessary adjustments, the assessment and its creation process will help other counties across the nation improve family and child well-being.

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APPENDIX A
Select CFSR Items and Corresponding Case Record Reading Tool (CRR) Questions

CFSR Item Number	CFSR Item	CRR Question #	CRR Tool Question
1	Timeliness of initiating assessments/investigations	20 - 22	Response timeline, timeline of attempted and/or completed face-to-face contact with child
3	Applicability of 3	38, 39	Initial Threats to safety?
		45	Initial Risk of placement?
		38, 39	Ongoing threats to safety?
		45	Ongoing Risk of placement?
3 A	Provide or arrange appropriate services to ensure safety & prevent placement	63	Svcs correspond to assessment of safety and risk of placement
		62	Wrkr connects family to services
3 B	If child removed w/out svcs was this necessary to ensure safety?	84	No time for placement preventive svcs, child in immediate danger
4 C (1)	Initial safety assess	38, 39	Initial threats to safety and assess of safety
4 C (2)	Safety plan	41	Safety plan
4 C	Safety plan	43	Safety plan supporting documentation
4 D (1)	Ongoing safety assess **AND:**	38, 39	Ongoing threats to safety and assessments of safety
	Safety assess at critical times, e.g., case closing	38, 39	Threats to safety and safety assessment before closing
4 D (2)	Monitor & update safety plan	44	Monitor & update safety plan
4 E	Safety concerns about target child not addressed	41, 43, 64	Safety risks not addressed
4 F	Safety concerns about target child in foster care during visitation	39 - 43	Source of threats to safety, those included in safety assessment & safety plan
4 G	Safety concerns about target child from foster family or facility	39 - 43	Source of threats to safety, those included in safety assessment & safety plan
4 H	Safety concerns about target child with family if reunited	39-43	Assessment of safety after return home, those included in safety assessment & safety plan
5 A	Plcmt w/in 12 mos of prior placement	82	Placement in 12 months of prior placement

CFSR Item Number	CFSR Item	CRR Question #	CRR Tool Question
5 B	Evidence to prevent re-entry	63, 84	Services to prevent need for placement
14 B	Child member or eligible to be member of Indian Tribe	9b	Inquiry about membership or eligibility in tribe
17 A (1.1)	Initial Comprehensive assess **(if case opened during period under review) OR**	49, 50, 60	Initial Comprehensive assessment of Child
17 A (1.2)	Ongoing Comprehensive assess	49, 50, 60	Ongoing comprehensive assessment of Child
17 A (2)	Appropriate services to meet child's identified needs?	60, 84	Child Problems contributing to need for CPS or difficulties functioning except education, health, MH, behavior
		63, 66	Services correspond to assessment except education, health, MH, behavior
17 B (1)	Formal or informal initial Comprehensive assess of mother's needs (initial or ongoing) **OR**	49, 50, 55	Initial Comprehensive assessment of mother
	Formal or informal ongoing Comprehensive assess of mother's needs (initial **or** ongoing)	49, 50, 55	Ongoing comprehensive assessment of mother
17 B (2)	Formal or informal initial Comprehensive assess of father's needs (initial **or** ongoing) **OR**	49, 50, 55	Initial Comprehensive assessment of father
	Formal or informal ongoing Comprehensive assess of father's needs (initial **or** ongoing)	49, 50, 55	Ongoing comprehensive assessment of father
17		51 - 54	Family and community strengths as part of comprehensive assessment
17 B (3)	Services appropriate to comp assessment needs for	63, 68, 69	Services appropriate to comp assessment needs for mother

CFSR Item Number	CFSR Item	CRR Question #	CRR Tool Question
	mother		
17 B (4)	Services appropriate to comp assessment needs for father	63, 68, 69	Services appropriate to comp assessment needs for father
17 C (1)	Comprehensive assessment of needs of foster family	49, 50	Comprehensive assessment of foster family
17 C (2)	Services appropriate to comp assessment needs for foster family	63, 68, 69	Services appropriate to comp assessment needs of foster family/facility
18 A	Involve child in case planning	43, 44	Family members involved in case plan: child
18 B	Involve mother in case planning	43, 44	Family members involved in case plan: mother
18 C	Involve father in case planning	43, 44	Family members involved in case plan: father
19 A	Pattern of visits: child	28, 70	Visitation worker & child pattern
	Frequency sufficient: child	28, 71	Visitation with child frequency sufficient to purpose of intervention
19 B	Quality sufficient: child	72	Visitation worker & child of quality sufficient to purpose of intervention
20 A (1)	Frequency sufficient: mother	31, 74	Visitation with mother frequency sufficient to purpose of intervention
20 A (2)	Pattern of visits: mother	31, 73	Visitation worker & mother pattern
20 B (1)	Frequency sufficient: father	33, 77	Visitation with father frequency sufficient to purpose of intervention
20 B (2)	Pattern of visits: father	33, 76	Visitation worker & father pattern
20 C	Quality sufficient: mother	75	Visitation worker & mother of quality sufficient to purpose of intervention
20 D	Quality sufficient: father	78	Visitation worker & father of quality sufficient to purpose of intervention
21 A	Concerted efforts to assess child's educational needs	49, 50, 60, 84	Child Problems contributing to need for CPS or difficulties functioning
21 B	Concerted efforts to address child's educational needs w/svcs	63, 66	Services appropriate to educ needs if educ problems identified
22 A	Concerted efforts to assess	49, 50, 60,	Child Problems contributing to need

CFSR Item Number	CFSR Item	CRR Question #	CRR Tool Question
	child's health needs	84	for CPS or difficulties functioning
22B	Concerted efforts to address child's health needs w/svcs	63, 66	Services appropriate to educ needs if educ problems identified
23 A	Concerted efforts to assess child's MH/behavioral needs	49, 50, 60, 84	Child Problems contributing to need for CPS or difficulties functioning
23 B	Concerted efforts to address child's MH/behavioral needs w/svcs	63, 66	Services appropriate to educ needs if educ problems identified