**From:** Landry, Todd A <Todd.A.Landry@maine.gov>
**Sent:** Tuesday, April 5, 2022 2:11 PM
**To:** Farwell, Scott <Scott.Farwell@legislature.maine.gov>; Johnson, Bobbi <bobbi.johnson@maine.gov>; Bogart, Molly <molly.bogart@maine.gov>
**Cc:** Ripley, Erin <erin.ripley@maine.gov>; Nixon, Lucia <Lucia.Nixon@legislature.maine.gov>; Kruk, Matthew <matthew.kruk@legislature.maine.gov>
**Subject:** RE: GOC meeting follow-up



Scott – please see the attached documents and responses below to the questions posed by the Government Oversight Committee and/or Health and Human Services Committee:

**Regarding the SDM tools:**

- **Director Landry mentioned Flowcharts and SDM explanation documents that may have already been provided to OPEGA. However we have been unable to locate, so please provide these items.**
  Please see the attached flowcharts/SDM Tools that have been provided to staff. I believe the documents provided to OPEGA previously were the SDM Tool Policy and Procedures Manuals for each tool – Safety Assessment, Risk Assessment, Case Plan, Reunification, and Risk Reassessment. We have also included a summary document that we developed based on information from the Evident Change website and training materials ("Structured Decision Making (GOC-OPEGA) 4.4.22.docx").
  ***[See attached]***

  It is important to note that the name of the organization which developed SDM has changed from the National Council on Crime & Delinquency and Children's Research Center (NCCD) to Evident Change.

- **Additional information on the evidence base for the SDM was also requested by the GOC.**
  Following is a link to the California Clearing House which includes program information as well as links to scholarly research articles about the Structure Decision Making model:
  https://www.cebc4cw.org/program/structured-decision-making/
  ***[See attached]***

**In addition, Senator Libby asked for information on the number of applicants for currently funded open positions, which Director Landry also offered to provide.**
In the first quarter of 2022 OCFS had 102 individual applicants for caseworker positions. Some applicants applied to work in more than one office for a total of 187 distinct applications. Of the 102, 46 were determined to be qualified and passed the initial screening (which consists of an initial panel interview and the submission of a writing sample). Whether an applicant is qualified depends on their post-secondary degree and/or coursework. Generally a degree in social work or in a "sufficiently related" area (as determined by the Board of Social Work Licensure) is required. Examples of "sufficiently related" degrees include psychology, sociology, mental health and human services, rehabilitation, and child/human development. Applicants with other degrees may also qualify with a minimum of 12 classes completed in these areas of study. 12 applicants were determined to be qualified but declined to

proceed with the hiring process, with most indicating they had been offered and accepted another position. 24 of the 46 who completed the initial screening were offered and accepted a job. An additional 9 candidates were offered a job and declined, with the most common reason for declining being the afterhours and overtime expectations of the position. OCFS is hopeful that these challenges will be addressed by the budget initiative to establish dedicated afterhours staff. OCFS would also note that during the first quarter of 2022, 2 candidates who were hired from out of state accepted positions and then withdrew due to difficulty securing housing.

**Representative Madigan asked for a copy of the information sharing guidance recently issued to behavioral health providers.**
This guidance is available here: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Guidance%20for%20Behavioral%20Health%20Providers%20FINAL.pdf?utm_medium=email&utm_source=govdelivery
***[See attached]***

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All Maine Children & Families
SAFE, STABLE,
HAPPY, HEALTHY

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Commissioner

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# Child Welfare and Behavioral Health Professionals Working Together to Ensure Open Communication, Support and Positive Outcomes for Children and Families

Behavioral Health (Mental Health and Substance Use Disorder Treatment) professionals are key to ensuring parents/caregivers that are involved with the child welfare system receive the treatment they need to keep their families intact and/or to reunify. When child welfare staff and behavioral health professionals communicate and collaborate, children and families receive the support necessary to secure the services to promote safety, permanency, and well-being. This guidance memo provides information regarding effective collaboration between child welfare staff and behavioral health professionals, including some of the benefits, barriers, and solutions that will assist parents who are involved in the child welfare system.

***What are the benefits to working together as part of the system of care for a family?***

- Families, child welfare staff, and behavioral health providers will have clear expectations as to what needs to change for a child to remain in the home or to be reunified with the parent/caregiver.
- The parent/caregiver understands that their treatment plan will come with expectations to change patterns of behaviors that have led their child(ren) to be in unsafe situations.
- Progress in the treatment plan will be measured and timely.
- Information sharing between child welfare staff and behavioral health professionals will be open, collaborative, and responsive.

***What are some of the barriers that can impact behavioral health providers and child welfare staff working together?***

- Miscommunication and misunderstanding between the behavioral health provider and child welfare staff can occur.
- A treatment plan may be developed that does not focus on the behavioral changes necessary to ensure the parent can provide safety for their child.
- Treatment may focus only on the parent and not take into consideration the child and others impacted by the trauma and abuse and/or neglect that has occurred within the family unit.
- Misunderstandings may occur regarding confidentiality and what can and cannot be shared between child welfare staff and behavioral health professionals.
- Behavioral health professionals may have concerns regarding testifying in child welfare court proceedings, including ethical and boundary issues, and the amount of time that will be necessary to prepare and testify.

***What can behavioral health providers do while working with families involved with child welfare?***

- Work with the parent/caregiver to recognize the importance of a free flow of information. Secure necessary releases of information as a prerequisite to treatment which is provided through informed consent. This should include the limits of confidentiality and privilege, communication with other parties, and the potential to testify in a court proceeding. This discussion should be updated as the situation changes or requires.
- Meet with child welfare staff that are working with the parent/caregiver.
- Strive to understand the reason why child welfare is involved and gather this information from those involved including the caseworker, parent, child, and other family members.
- Recognize that for families involved with child welfare it is necessary for the family to be considered as a whole unit and discussed during treatment. Have conversations regarding the abuse and/or neglect the child experienced and how the child was impacted. Assist the parent with understanding their role in what happened to their child while using techniques that maximize therapeutic engagement.
- Make themselves aware of evidence-based treatment modalities and use those treatments to fidelity.
- Develop treatment plans in collaboration with the parent/caregiver that meet the expectations of the parent's/caregiver's Child Welfare Family Plan/Rehabilitation and Reunification Plan.
- Provide progress notes to child welfare staff every 90 days, or more frequently, if needed, that specify what progress has been made, how it relates to the Family Plan/Rehabilitation and Reunification plan, and how the parent/caregiver has demonstrated behavioral change as outlined in the treatment plan.
- Participate in family team meetings, whether in person, on the phone, virtually, or via written correspondence that provides the family team participants with an update.

***What can behavioral health providers expect from child welfare staff?***

- Referral for services will include information about the parents/caregivers and their children, as well as why the family is involved with the child welfare system.
- Releases that have been signed by the parents and child welfare staff that will allow sharing of information to build a transparent partnership to support the success of the family.
- Contact information from the child welfare caseworker that will include the name of the caseworker, name of the caseworker's supervisor, phone number, business address, email, and fax number.
- Messages returned in a timely manner.
- Plans that have been developed by the family and their team in collaboration with the child welfare caseworker will be shared with the treatment provider.
- Ongoing communication by the child welfare caseworker to share information, concerns, and updates regarding a family's progress to inform initial decision-making and periodic re-assessment of the family's functioning.

- The behavioral health provider will be invited to participate in family team meetings and will be given the opportunity to attend in person, by phone, or virtually.

***The hope is that with collaboration between Child Welfare and Behavioral Health Providers:***

- Parents/caregivers will receive treatment that focuses on the family as a whole unit.
- Parents/caregivers will have clear and realistic expectations in their treatment goals.
- Parents/caregivers, child welfare staff and behavioral health providers will work together effectively via open communication, essential collaboration, and work as a team to ensure success for the families served.

In the next several months, the Office of Child and Family Services will continue to work in partnership with behavioral health providers to build a collaborative approach to supporting families. These efforts will engage providers and staff in discussions on this topic. Meetings, webinars, and trainings will focus on the child welfare system, the need for behavioral health services for parents involved in the child welfare system, and how the staff and providers can work together to ensure parents/caregivers receive the support they need to address the abuse and neglect that has occurred within their family system.

**Maine statute regarding confidential and privileged communication:**
https://legislature.maine.gov/statutes/22/title22sec4015.html

Structured Decision Making (SDM)

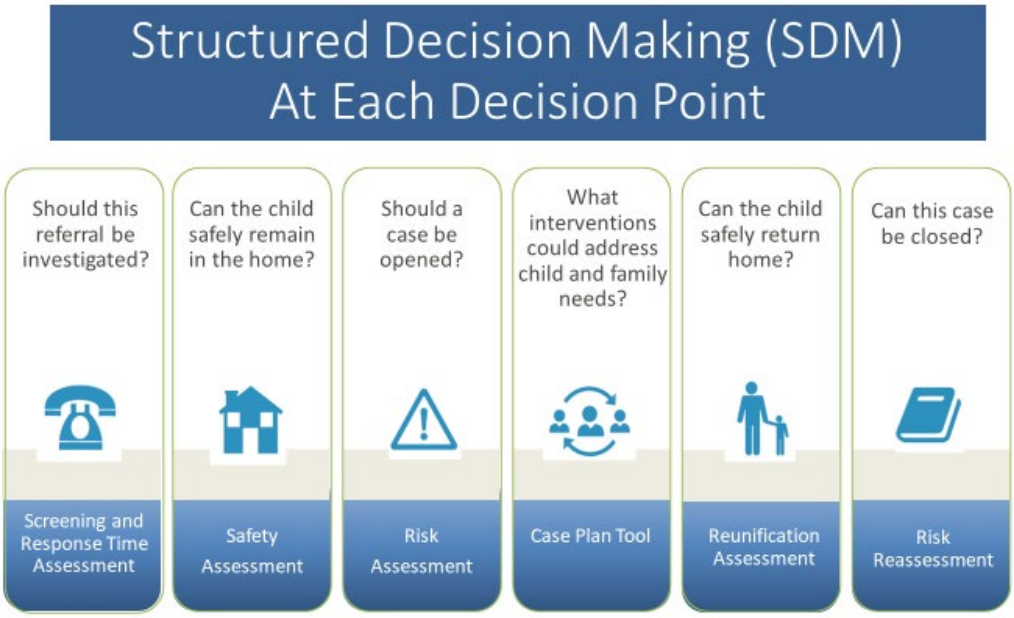
The Structured Decision Making® (SDM) model is a suite of decision-support tools that promote safety and well-being for children and adults.

The SDM® model combines research with best practices, offering workers a framework for consistent decision making and offering agencies a way to target in-demand resources toward those who can benefit most.

The Structured Decision Making® (SDM) model combines research with best practices for consistent, accurate social service decisions.

The Structured Decision Making® (SDM) model for child protection assists agencies and workers in meeting their goals to promote the ongoing safety and well-being of children. This evidence- and research-based system identifies the key points in the life of a child welfare case and uses structured assessments to improve the consistency and validity of each decision. The SDM model additionally includes clearly defined service standards, mechanisms for timely reassessments, methods for measuring workload, and mechanisms for ensuring accountability and quality controls. The model consists of several assessments that help agencies work to reduce subsequent harm to children and to expedite permanency:

- Intake assessment: The screening section of the intake assessment helps child abuse hotline workers determine if the current report requires a child protective services (CPS) investigation response. The response priority section helps workers determine how swiftly an investigation must be initiated for those reports accepted for investigation.
- Safety assessment: The assessment helps workers at all points in a case determine if a child may safely remain in the home, with or without a safety plan in place. A second safety assessment, customized for use in foster and substitute care, has also been developed.
- Risk assessment: This actuarial assessment estimates the likelihood of future child welfare system involvement, and assists investigation workers in determining which cases should be continued for ongoing services and which may be closed at the end of an investigation.
- Family strengths and needs assessment: The FSNA informs case planning by structuring the worker's assessment of family caregivers and all children across a common set of domains of family functioning. For the case plan, priority areas of need are chosen as the focus of efforts to improve family functioning and child safety.
- Risk reassessment: For families receiving in-home services, the actuarial risk reassessment helps the ongoing service worker determine when risk has been reduced sufficiently that the case may be recommended for closure.
- Reunification assessment: For families with a child in out-of-home care with a goal of reunification, this assessment helps the worker determine when a child may safely be returned to the home, or when a change in permanency goal should be considered. The assessment has three sections that focus on risk, caregiver-child visitation, and safety.

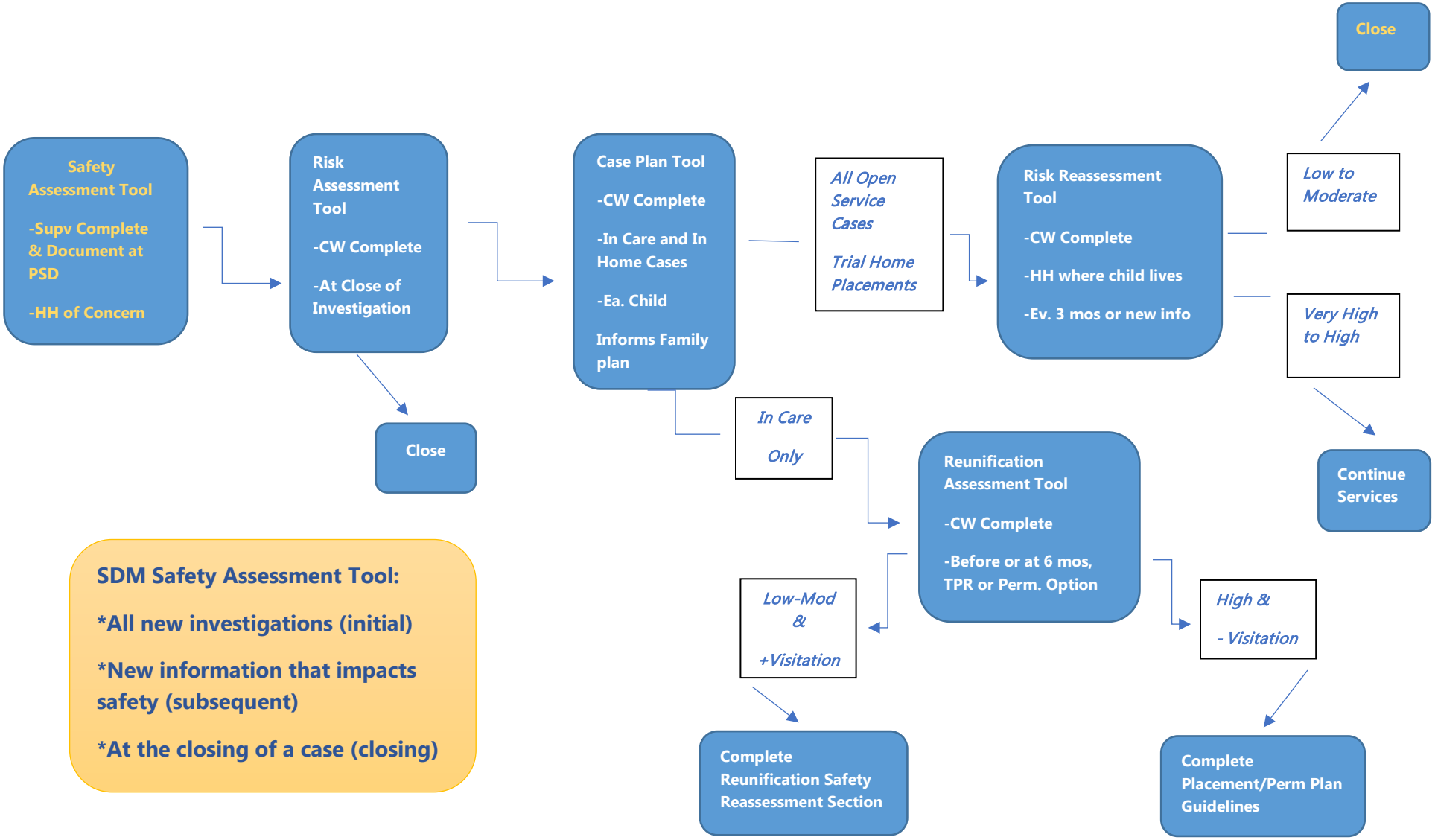



Evident Change views the SDM model as a vital component of a child welfare practice model that also includes engagement and solution-focused approaches to working with families, as well as evaluation and quality improvement activities. The SDM model offers an elegant, comprehensive way to incorporate research and consistency into key child welfare decisions. To date, no set of CPS assessments has demonstrated the degree of reliability and validity, nor the improved outcomes, of the SDM model.

Note: The tools were developed by Evident Change in collaboration with OCFS based on laws, policies, and procedures of the State of Maine.

# Structured Decision Making Tools

## Flow Chart



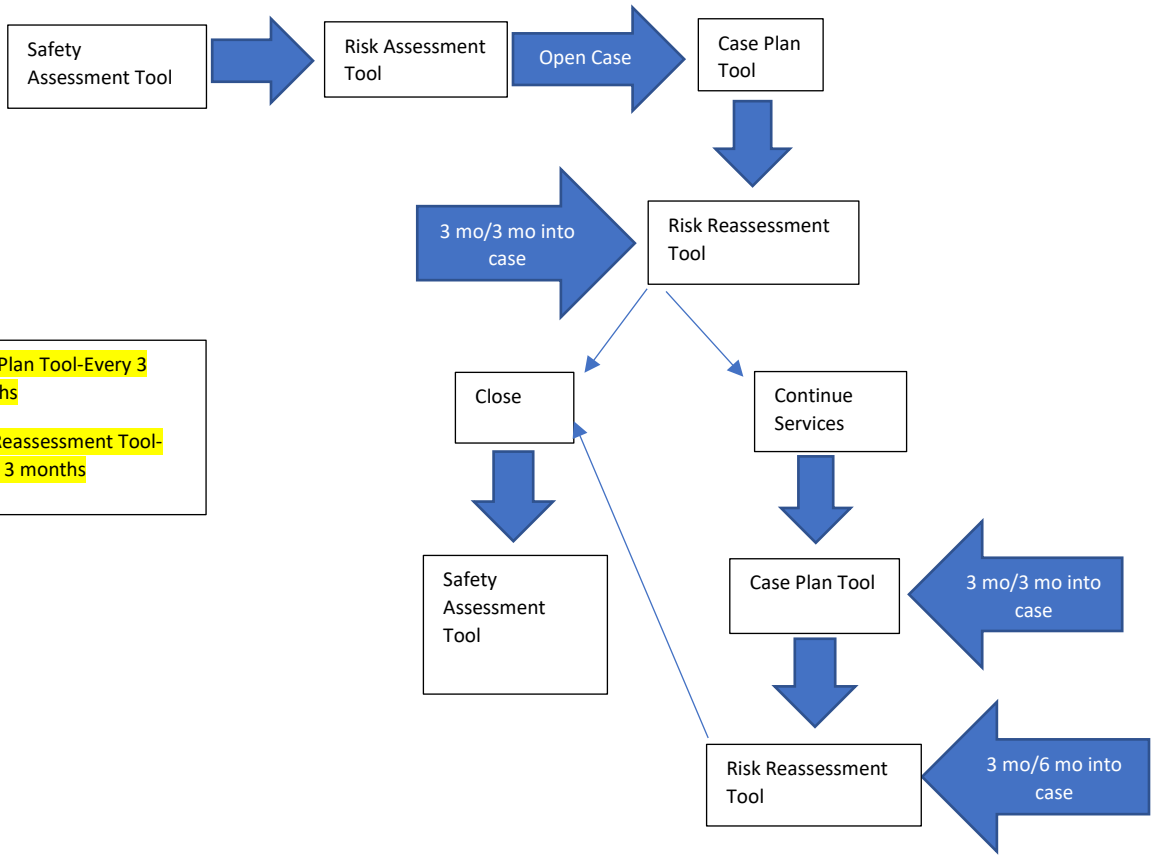

**SDM Safety Assessment Tool:**

***All new investigations (initial)**

***New information that impacts safety (subsequent)**

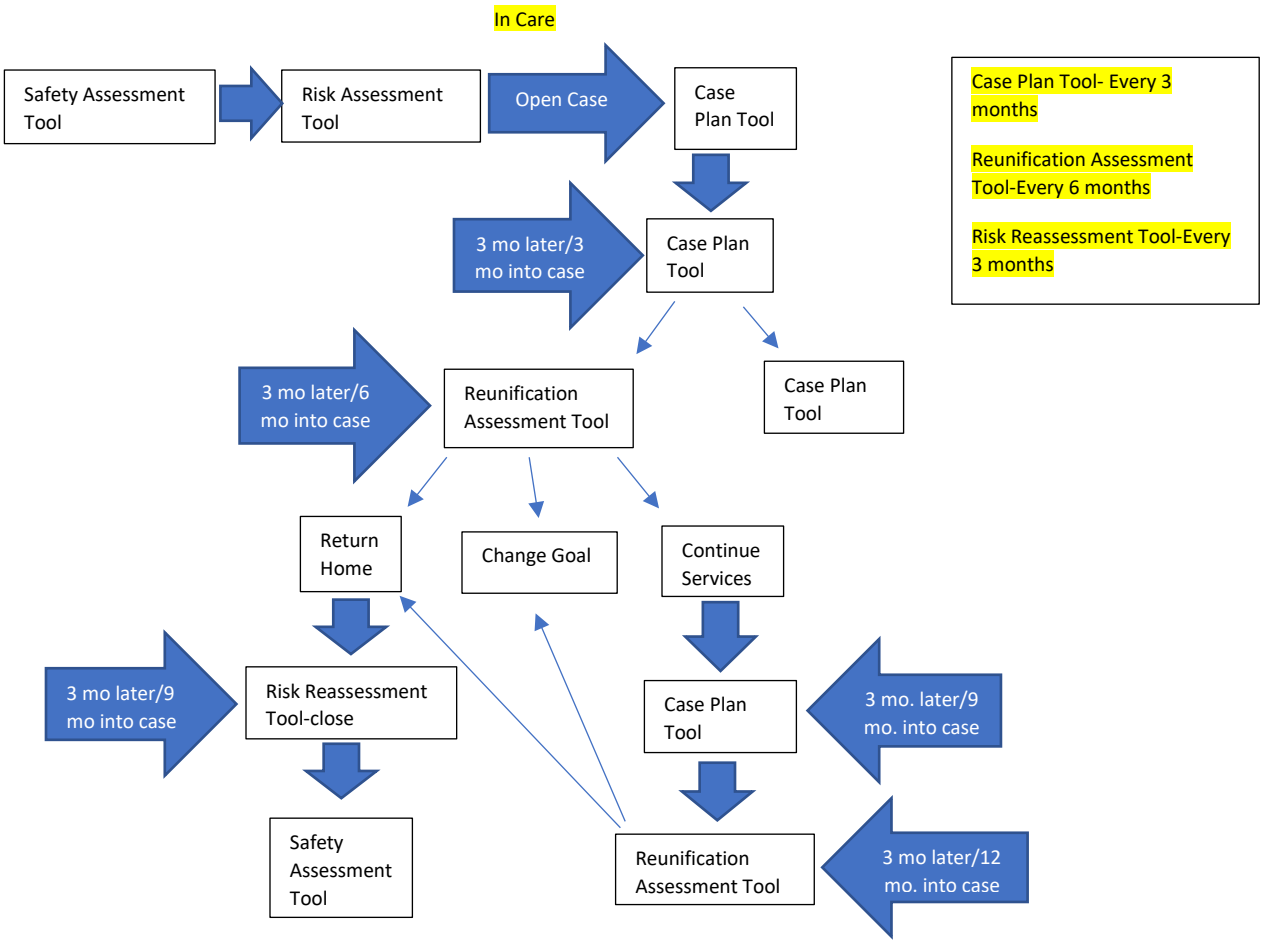
***At the closing of a case (closing)**

Service Case




Case Plan Tool-Every 3 months

Risk Reassessment Tool-Every 3 months


In Care
Safety Assessment Tool
Risk Assessment Tool
Open Case
Case Plan Tool
Case Plan Tool- Every 3 months
Reunification Assessment Tool-Every 6 months
Risk Reassessment Tool-Every 3 months
3 mo later/3 mo into case
Case Plan Tool
3 mo later/6 mo into case
Reunification Assessment Tool
Case Plan Tool
Return Home
Change Goal
Continue Services
3 mo later/9 mo into case
Risk Reassessment Tool-close
Case Plan Tool
3 mo. later/9 mo. into case
Safety Assessment Tool
Reunification Assessment Tool
3 mo later/12 mo. into case

# Safety Assessment Tool

- **Complete on all investigations on the Household of Concern**
- **Complete when closing a case on household where child will primarily reside**
- **Complete at time of PSD; change in household; change of information which impacts safety; change in plan**
- **Supervisor completes Initial Safety Assessment Tool at PSD**
- **Caseworker Completes Closing Safety Assessment Tool**
- **DO NOT COMPLETE IF FAMILY CANNOT BE LOCATED**
- **MUST BE COMPLETED EVEN IF FAMILY REFUSES TO ENGAGE**
- **MUST MEET EVERY PART OF THE DEFINITION**

# Risk Assessment Tool

- **All Investigations**
- **Complete on Household of Concern**
- **DO NOT COMPLETE IF CANNOT LOCATE OR REFUSAL TO ENGAGE**
- **Must answer all questions**
- **Complete prior to 35 Day Timeframe for closure**
- **Completed by Caseworker and Approved by Supervisor**
- **MUST MEET EVERY PART OF DEFINITION**

# Case Plan Tool

- **Completed on every open case**
- **Completed within 30 days of case opening (1st by CPS)**
- **Completed every 3 months by Permanency Caseworker**
- **Completed on Household of Concern**
- **Completed on each child as they relate to each household**
- **DO NOT NEED TO MEET EVERY PART OF DEFINITION**
- **Informs Family Plans**
- **Informs Child Plans**

# Reunification Assessment Tool

- **Use in every case when at least 1 child is in custody with a goal of reunification**
- **Household of Concern**
- **Complete at least every 6 months or when considering a trial home placement or change in goal**
- **Can override up or down - with Supervisory Approval**
- **Permanency Caseworker completes tool**
- **Supervisor Approves**
- **DO NOT NEED TO MEET ALL PARTS OF DEFINITION**

## Risk Reassessment Tool

- **Completed on all service cases or cases in which all children have returned home.**
- **Complete on household where child will primarily reside**
- **Completed by Permanency Caseworker**
- **Approved by Supervisor**
- **Completed every 3 months from the time of transfer to a Permanency Caseworker or return home**
- **DO NOT NEED TO MEET ALL PARTS OF DEFINITION**


https://www.cebc4cw.org/program/structured-decision-making/

## Relevant Published, Peer-Reviewed Research

A meta-analysis, see citation following, has been conducted on the ***Structured Decision Making (SDM)***, however, this article is not used for rating and therefore is not summarized:

- van der Put, C. E., Assink, M., & van Solinge, N. F. B. (2017). Predicting child maltreatment: A meta-analysis of the predictive validity of risk assessment instruments. *Child Abuse & Neglect, 73*, 71-88. https://doi.org/10.1016/j.chiabu.2017.09.016

When more than 10 research articles have been published in peer-reviewed journals, the CEBC reviews all of the articles as part of the rating process and identifies the most relevant articles, with a focus on randomized controlled trials (RCTs) and controlled studies that have an impact on the rating. **The 11 articles chosen for *Structured Decision Making (SDM)* are summarized below:**

**Baird, C., Wagner, D., Healy, T., & Johnson, K.** (1999). Risk assessment in child protective services: consensus and actuarial model reliability. *Child Welfare*, 78(6), 723-748

**Type of Study:** Validation study
**Number of Participants:** 80 child abuse/neglect reports
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were families involved in child welfare systems.

**Location/Institution:** Alameda County, California; Dade County, Florida; Jackson County, Missouri; and Macomb, Muskegon, Ottawa, and Wayne Counties in Michigan
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
Three widely used child protective service risk assessment models, two consensus-based Washington Risk Assessment Matrix (WRAM), and the California Family Assessment Factor Analysis (CFAFA), and one

actuarial, the Michigan ***Structured Decision Making (SDM)*** Systems Family Risk Assessment of Abuse and Neglect (FRAAN) were examined to determine their reliability. Rates of subsequent investigations, substantiations, and placements were computed for cases classified at low, moderate, and high risk levels in each model. Results indicate that although no system approached 100% interrater reliability, raters employing the actuarial model made consistent estimates of risk for a high percentage of the cases they assessed, and interrater reliability for the actuarial model was much higher than that of the other systems. Limitations include the absence of blinding to previous risk assessments and a lack of population descriptive data.
**Length of postintervention follow-up:** None.

**Baird, C., & Wagner, D. (2000). The relative validity of actuarial-and consensus-based risk assessment systems.** *Children and Youth Services Review*, 22(11-12), 839-871. https://doi.org/10.1016/S0190-7409(00)00122-5

**Type of Study:** Validation study
**Number of Participants:** 1,400 child abuse/neglect reports
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were families involved in child welfare systems.

**Location/Institution:** Alameda County, California; Dade County, Florida; Jackson County, Missouri; and Macomb, Muskegon, Ottawa, and Wayne Counties in Michigan
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
This study is the first to directly compare the relative validity of these two approaches. Three risk assessment instruments were completed on cohorts of cases from four different jurisdictions. Two of the instruments were consensus-based (Washington Risk Assessment Matrix and the California Family Assessment Factor Analysis), and one was actuarial, the Michigan ***Structured Decision Making (SDM)*** Systems Family Risk Assessment of Abuse and Neglect Outcome information was collected over an 18-month follow-up period. Rates of subsequent investigations, substantiations, and placements were computed for cases classified at low-, moderate-, and high-risk levels in each model. Results clearly demonstrate that ***SDM*** more accurately classifies cases to different risk levels. Limitations include the absence of blinding to previous risk assessments and a lack of population descriptive data.
**Length of postintervention follow-up:** 18 months.

**Johnson, K., & Wagner, D. (2005). Evaluation of Michigan's foster care case management system.** *Research on Social Work Practice, 15*(5), 372-380. https://doi.org/10.1177/1049731505276312

**Type of Study:** Pretest-posttest study with a nonequivalent control group
**Number of Participants:** 1,722
**Population:**

- **Age —** 0-18 years
- **Race/Ethnicity —** SDM: 79.5% White, 19.1% African American, and 5% Other/Unknown; Comparison: 49.1% White, 43.9% African American, and 7% Other/Unknown
- **Gender —** Not specified

- **Status —** Participants were children in foster care at the beginning of the intervention.

**Location/Institution:** Michigan
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
The purpose of this study was to assess the efficacy of ***Structured Decision Making (SDM)***. Counties implementing ***SDM*** were matched with counties using standard case management on demographics including race, percentage receiving public assistance, percentage below poverty line, and percentage in rural areas. They were also matched on administrative characteristics such as foster care caseload, ratio of cases per foster care worker, and percentage of cases managed under private agencies. Results showed a significantly higher percentage of permanent placements for the counties using ***SDM*** than for the comparison group. This difference held when controlling for age, ethnicity, and initial type of placement. A greater number of comparison group children re-entered foster care than those in the counties using ***SDM***, although this difference was not statistically significant. Limitations included nonrandomization and generalizability due to ethnicity of participants.
**Length of postintervention follow-up:** 15 months.

**Johnson, W. L. (2011).** The validity and utility of the California Family Risk Assessment under practice conditions in the field: A prospective study. *Child Abuse & Neglect, 35*(1), 18-28. https://doi.org/10.1016/j.chiabu.2010.08.002

**Type of Study:** Validation study
**Number of Participants:** 7,685 child abuse/neglect reports
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were social workers in child welfare systems.

**Location/Institution:** Los Angeles, Humboldt, Orange, San Luis Obispo, and Sutter counties in California
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
This study presents the analysis of the validity and implementation of the California Family Risk Assessment (CFRA; now called ***Structured Decision Making***). The study analyzes reports originating in 5 California counties followed prospectively for 2 years to identify further substantiated child abuse/neglect. Measures of model calibration and discrimination were used to assess CFRA validity and compare its accuracy with the accuracy of clinical predictions made by child welfare workers. Results indicate imperfect but better-than-chance predictive validity was found for the CFRA on a range of measures. For 114 cases, where both CFRA risk assessments and child welfare worker clinical risk assessments were available, the CFRA exhibited evidence of imperfect but better-than-chance predictive validity, while child welfare worker risk assessments were found to be invalid. Child welfare workers overrode CFRA risk assessments in only 114 of 7,685 cases and provided in-home services in statistically significantly larger proportions of higher versus lower risk cases, consistent with heavy reliance on the CFRA. Limitations include the absence of blinding to previous risk assessments and a lack of population descriptive data
**Length of postintervention follow-up:** None.

**Coohey, C., Johnson, K., Renner, L. M., & Easton, S. D. (2012).** Actuarial risk assessment in child protective services: Construction methodology and performance criteria. *Children and Youth Services Review, 35*(1), 151-161. https://doi.org/10.1016/j.childyouth.2012.09.020

**Type of Study:** Validation study
**Number of Participants:** 6832 child abuse/neglect reports
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** 73.4% White, 7.1% African American, 4.2% Latino, 1.1% Asian, 0.8% Native American, 0.2% Pacific Islander, 2.9% More than one group, and 10.2% Unknown
- **Gender —** Not specified
- **Status —** Participants were families involved in child welfare systems.

**Location/Institution:** Iowa
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
This article describes methodology to construct and revise , Colorado's Family Risk Assessment (CFRA) [now called ***Structured Decision Making (SDM)***]; reviews criteria to evaluate the performance of actuarial tools; and applies a methodology and performance criteria in one state. Rates of subsequent investigations, substantiations, and placements were computed for cases classified at low, moderate, and high risk levels in each model. Results indicate that both the adopted and the revised tools had adequate separation and good predictive accuracy for all families and for the state's three largest ethnic/racial groups (White, Latino, and African American). The adopted tool classified relatively few families in the low-risk category; the revised tool distributed families across risk categories. Limitations include unknown inter-rater reliability and external validity and the sample included families with substantiated maltreatment only.
**Length of postintervention follow-up:** None.

**Johnson, K., O'Connor, D., Berry, S., Ramelmeier, D., & Pecora, P. J. (2012).** Structuring the decision to accept a child protection report. *Journal of Public Child Welfare, 6*(2), 191-205. https://doi.org/10.1080/15548732.2012.667736

**Type of Study:** Validation study
**Number of Participants:** 46
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were social workers in child welfare systems.

**Location/Institution:** Maryland
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
Three agencies collaborated to construct, implement, and evaluate ***Structured Decision Making (SDM)*** for child protective services intake staff in Maryland. Evaluation activities included reliability testing of the assessment, a qualitative review of screening decisions conducted before and after implementation, and a survey of workers about the assessment and its implementation. Interrater reliability testing among field staff showed high rates of agreement for screening assessment items and the resulting decision. Results indicate that the assessment and associated definitions can help workers make consistent screening decisions when provided with the same information. Limitations include interrater reliability testing, possible sample bias, and lack of follow-up.
**Length of postintervention follow-up:** None.

**Wells, M., & Correia, M. (2012).** Reentry into out-of-home care: Implications of child welfare workers'™ assessments of risk and safety. *Social Work Research, 36*(3), 181-195. https://doi.org/10.1093/swr/svs011

**Type of Study:** Validation study
**Number of Participants:** 2,507
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** 3.6% Dutch, 21.4% Moroccan, Turkish, 19.6% Surinamese, Antillean, and 25.5% Other (e.g., Cape Verdeans, other Africans, and Eastern Europeans)
- **Gender —** Not specified
- **Status —** Participants were families involved families with the child welfare system.

**Location/Institution:** Chicago
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
This study examined predictors or reentry to foster care among children and youths who entered foster care between 2001 and 2007. Three sources of administrative data (Chapin Hall Center for Children longitudinal files, National Child Abuse and Neglect Data System, and ***Structured Decision Making [SDM]***) from one state was used to assess whether Child Protective Services workers risk and safety assessment decisions are predictive of reentry into foster care. Results indicate that cases with current neglect assessments, problems with parenting skills, motivation to improve parenting, safety assessment decision, length of stay, substantiated allegations, and unsubstantiated allegations were likelihood of reentry. Limitations include possible worker error when entering data, missing records, and generalizability to the state data that was collected.
**Length of postintervention follow-up:** None.

**Johnson, W., Clancy, T., & Bastian, P. (2015).** Child abuse/neglect risk assessment under field practice conditions: Tests of external and temporal validity and comparison with heart disease prediction. *Children and Youth Services Review, 56*, 76-85. https://doi.org/10.1016/j.childyouth.2015.06.013

**Type of Study:** Validation study
**Number of Participants:** 6,543 child abuse/neglect reports
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were social workers in child welfare systems.

**Location/Institution:** San Luis Obispo, Sutter, Orange, Los Angeles, and Humboldt counties
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
The purpose of this study was to identify validation design and accuracy assessment standards for medical prognostic models applicable to evaluation of child abuse/neglect (CA/N) risk assessment models. (2) Assess the accuracy of the California Family Risk Assessment (CFRA) [now called ***Structured Decision Making (SDM)***] in predicting CA/N using the foregoing standards. (3) Compare the prediction accuracy of the CFRA with the prediction accuracy of coronary heart disease (CHD) prediction models. Data was used from the California's computerized Child Welfare Services/Case Management System (CWS/CMS). Results indicate that external and temporal validation samples support the accuracy of CFRA prediction of CA/N. Limitations include is the small size (N=236) of the external validation sample.
**Length of postintervention follow-up:** None.

**Mendoza, N. S., Rose, R. A., Geiger, J. M., & Cash, S. J. (2016).** Risk assessment with actuarial and clinical methods: Measurement and evidence-based practice. *Child Abuse & Neglect, 61*, 1-12. https://doi.org/10.1016/j.chiabu.2016.09.004

**Type of Study:** Validation study
**Number of Participants:** 2178
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** 76.6% White
- **Gender —** Not specified
- **Status —** Participants were social workers in child welfare systems

**Location/Institution:** Ohio
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
The purpose of the current study is to compare clinical and actuarial methods of risk assessment used by child welfare workers to make decisions about substantiation and services, the Comprehensive Assessment and Planning Model-Interim Solution(CAPMIS). The tool used in the current study was adapted from the National Council on Crime & Delinquency (NCCD)
**Length of postintervention follow-up:** None.

**van der Put, C. E., Hermanns, J., van Rijn-van Gelderen, L., & Sondeijker, F. (2016).** Detection of unsafety in families with parental and/or child developmental problems at the start of family support. *BMC Psychiatry, 16*(1), 15. https://doi.org/10.1186/s12888-016-0715-y

**Type of Study:** Validation study
**Number of Participants:** 87,329
**Population:**

- **Age —** Not specified
- **Race/Ethnicity —** 33.6% Dutch, 21.4% Moroccan, Turkish, 19.6% Surinamese, Antillean, 25.5% Other (e.g., Cape Verdeans, other Africans, and Eastern Europeans)
- **Gender —** Not specified
- **Status —** Participants were Dutch families who experienced parenting and/or child developmental problems and were referred by the Centres for Youth and Family for family support.

**Location/Institution:** Netherlands
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
The predictive validity of the California Family Risk Assessment (CFRA) [now called ***Structured Decision Making (SDM)***] was examined in Dutch families who received family support. In addition, the added value of a number of experimental items was examined. Finally, it was examined whether the predictive value of the instrument could be improved by modifying the scoring procedure. Results indicate that about half of the individual CFRA items were not related to future reports of child maltreatment. The predictive validity of the CFRA in predicting future reports of child maltreatment was found to be modest. The addition of some of the experimental items and the modification of the scoring procedure by including only items that were significantly associated with future maltreatment reports resulted in a '˜high' predictive validity. Limitations include limited financial resources prevented us to verify the 6-month follow-up reports of child maltreatment by field investigation, not every case of child maltreatment is reported to the ARCAN and the number of cases of emotional abuse and neglect may be underreported.
**Length of postintervention follow-up:** None.

**Jenkins, B. Q., Tilbury, C., Hayes, H., & Mazerolle, P. (2018).** Factors associated with child protection recurrence in Australia. *Child Abuse & Neglect, 81*, 181-191. https://doi.org/10.1016/j.chiabu.2018.05.002

**Type of Study:** Validation study
**Number of Participants:** 9,608 child abuse/neglect reports
**Population:**

- **Age —** 0-17 years
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were families involved in child welfare systems.

**Location/Institution:** Queensland, Australia
**Summary:** *(To include basic study design, measures, results, and notable limitations)*
The aim of the current research was to advance understanding of child protection in Australia by examining the factors associated with recurrence of child protection notifications to the formal child protection system. The risk assessment tool used in this study was the ***Structured Decision Making (SDM)*** *Family Risk Evaluation* in Queensland and known as the ***SDM*** *Family Risk Assessment*. Administrative data were obtained for a sample of 9,608 children first subject to a screened-in report in 2011-2012. Children were followed for 12 months. Cox Proportional Hazard models were used to measure associations between 26 independent variables and four types of recurrence: subsequent reports, subsequent investigations, subsequent substantiations, and subsequent intervention. Factors associated with recurrence in Australia were broadly similar to those identified in other jurisdictions, including reports and substantiation for neglect, younger age, prior child protection involvement in the household, and parental characteristics including drug use, mental health problems, and history of maltreatment as a child. Results indicate that as in previous studies, post-investigative service provision was positively associated with recurrence. In prior US research, race did not predict recurrence. However, in the present study, Indigenous Australian children were significantly more likely to be subject to all types of recurrence measured. Future research on recurrence should aim to disentangle the complex relationships between child protection recurrence, child maltreatment, and service delivery. Recurrence is not a good proxy indicator of child safety. Limitations include utilization of administrative data so it was only possible to analyse the factors that were routinely recorded by practitioners in the course of their work.
**Length of postintervention follow-up:** None.