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TRANSLATING RISKS TO POSITIVE OUTCOMES:

Outcome-oriented Case Management from Risk Assessment Information

—by Wayne Holder and Therese Roe Lund

The connection of a risk assessment to client outcomes provides direction and clarity to child protective services (CPS) casework practice and case management. In simple terms, it involves matching a negative behavior or problematic family condition with a positive expected result. Working toward this desirable result provides the structure for setting case goals, planning treatment, and measuring progress.

Although defining and evaluating outcomes are not new concepts to child welfare and human service agencies (Barth & Berry, 1987; Courtney, 1993; Magura & Moses, 1986; McDonald et al., 1989; Youth et al., 1994), the field has not sufficiently developed the potential benefits of linking risk assessments to client outcomes as a method for targeting and evaluating client change and measuring risk reduction. Risk assessment, now available in more than 42 states (Berkowitz, 1991), has been applied primarily to determining which families should be served, but has not influenced how families can be served (Cicchinelli & Keller, 1990; Wald & Woolverton, 1991).

Client outcomes are positive changes in a client's behavior; mental, physical, or emotional functioning; motives; knowledge; or resources that, when achieved, reduce the risk of maltreatment.

Courtney (1993) suggests that three levels of outcomes have relevance to child welfare agencies: 1) program structural characteristics, including variables such as numbers of staff or caseload size; 2) program process characteristics, such as timely investigation of reports or development of case plans within the required amount of time; and 3) case outcomes, which measure meaningful change in the clients being served by a given program. Magura and Moses (1986) further suggest three levels of case outcomes: 1) case status outcomes that target changes in a client's service status, such as reunification; 2) client status outcomes, which are used to measure changes in a client's behavior, mental state, physical functioning, emotional functioning, motives, knowledge, or resources; and 3) client satisfaction outcomes, used to assess how well services have fulfilled the client's subjective needs, expectations, or wishes.

Currently, over 20 states are involved in planning a redesign of their child welfare systems around outcome measures. (American Humane Association and the National Association of Public Child Welfare Administrators, 1995). However, the focus of this activity is primarily agency planning and evaluation as well as measurement of case status outcomes; less attention has been paid to client status outcomes.

Defining risk assessment and client outcomes

Risk assessment is a judgment about the likelihood that a family will maltreat its children in the future. The assessment is typically based on the identification and analysis of family conditions or risk influences/risk factors associated with families who maltreat their children. The risk assessment shapes the decision regarding who will be served. Further, it is the reduction of risk influences that leads a CPS agency to disengage services. Because risk assessment instruments are far from perfect measures of the likelihood of future maltreatment, however, determining that a case can be closed should be based on more than a second risk assessment. It should be based on clear documentation of changes in the behaviors and conditions that could lead to potential maltreatment.

Client outcomes are positive changes in a client's behavior; mental, physical, or emotional functioning; motives; knowledge; or resources (Magura & Moses, 1986) that, when achieved, reduce the risk of maltreatment. To achieve risk

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reduction, critical risk influences must be correctly matched with client outcomes, and goals and services must be directed toward empowering individuals and families to achieve these outcomes (see Figure 1).

Figure 1. THE RISK REDUCTION PROCESS

Identify Risk Influences/Strengths ➡ Define Case Goals ➡ Provide Services to Promote Goal Achievement ➡ Evaluate Goal Achievement and Modify Goals ➡ Achieve Outcomes

Translating risk influences to client outcomes

Use of the strengths perspective rather than the deficit model reframes the nature of the intervention relationship from an involuntary and intrusive one to a partnership with the child and family.

To accomplish an adequate translation from risk influences to client outcomes, certain characteristics must be apparent. Risk influences must be conditions that are specifically defined and identifiable, clearly demonstrated, amenable to change, causal in nature or symptomatic, but controllable. Client outcomes must be measurable, understandable, and pertinent to CPS intervention.

Presumably, an unlimited number of risk influences could be present in a family and could eventually be considered for translation to client outcomes. A few examples of risk influences that can be translated to client outcomes are chemical dependency, unrealistic expectations for a child, powerlessness and dependence, impulsiveness, and peer conflicts.

Using standardized client outcomes

A specific set of client outcomes can be identified and applied across all CPS cases. Standardized client outcomes should be suitable for individuals, parts of a family, or the entire family. The following five client outcomes represent a standard set of client outcomes that have been applied in CPS for a decade: self-sufficiency, communication skills, problem solving, parenting knowledge and skill, and developmental/role achievement (Holder & Corey, 1986).

Client outcomes such as those listed here are too general in themselves to be helpful in case planning. Another layer of specificity is necessary. Client outcomes such as self-sufficiency are made up of many characteristics or aspects. The whole (e.g., self-sufficiency) can be understood by its parts (e.g., self-care, independence). These parts or dimensions of client outcomes provide the substance for translating risk influences into outcomes. They give direction to case planning and case management. The authors have identified 32 dimensions across the five client outcomes. As an example, self-sufficiency is made up of seven dimensions: self-care, independence, defends self, sociability, coping, self-esteem, and self-control. Risk influences are actually matched with client outcome dimensions. Here is an example:

Risk influence: father is impulsive
translates to
Client outcome: self-sufficiency, self-control

In using this approach, ongoing CPS services do not focus attention on the negative, namely, on the impulse control problem. On the contrary, services and support are concentrated on the strength and positive functioning associated with building self-control. A father, for example, does not hear a message from CPS about what he must stop doing, but what he can do positively. The strengths perspective, used by social workers in mental health (Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1989; Sullivan, 1992; Weick et al., 1989), has recently been applied in the context of family preservation and support services (Kinney et al., 1994). Use of the strengths perspective rather than the deficit model reframes the nature of the intervention relationship from an involuntary and intrusive one to a partnership with the child and family.

Table 1. TRANSLATING RISK INFLUENCES TO CLIENT OUTCOMES

Process Step	Use of Risk Influence	Example
Intake	determine validity of report	bruises to face and shoulders
Initial assessment/ investigation	determine who is to be serviced	violent outburst with slapping and punching
Family assessment	understand the cause and define desired client outcome	father reacts impulsively when under pressure
Treatment plan	translate risks into client outcome, outcome dimensions, case goals	self-sufficiency—self-control
Case evaluation	evaluate progress toward client outcomes and risk reduction	increased self-control
Case closure	client outcomes achieved, risk influences reduced	rountinely demonstrates self-control; no record of additional abuse

Determining client outcomes

The translation of risk influences to client outcomes occurs as a natural part of a seven-step CPS intervention process (see Table 1). The decision to translate a risk influence to a particular client outcome is subjective. This is not a fault of the approach; clearly, during ongoing work much of decision making has a subjective component. This translation, or matching of risk influences to client outcomes, is based on the informed opinion of a caseworker and the expression of a family member's or the family's interests, needs,

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and level of acceptance. The translation actually begins to occur naturally during the family assessment. A caseworker launches into studying the family, analyzes the risk influences, identifies strengths, and engages the family in a change partnership. This results in an identification and understanding of risk influences that are more prominent and causal. A process of informal negotiation between the worker and the family begins to occur. Discussion focuses on what must change, what needs are apparent, and in what direction the family chooses to proceed. As a result of these discussions and the general family assessment work, the family and caseworker identify client outcomes that match the most problematic risk influences occurring in the family situation. Case plans are then formed with the family using the client outcome dimensions as the case goals. The accomplishment of the goals or outcome dimensions contributes to the achievement of the client outcome, or the desired result.

The process of understanding the risk influences and connecting them to outcomes affords time and opportunity for a relationship to form between the client and the social worker.

Measuring client outcomes

The difficulty of objectively measuring client outcomes is sometimes used as a rationale for concentrating on case status or program outcomes at the expense of client outcomes. To the extent that client outcomes can be reduced to specific characteristics (i.e., dimensions) and can be perceived as behavioral in nature, however, measurement is possible. Behavior is demonstrated and observable; it can be measured. Observers can report on it, or people can self-report. Using the example of the impulsive father whose client outcome is self-sufficiency and dimension is self-control, consider the following possible measurements:

- Exercises acceptable restraint in behavior
- Usually is able to manage emotions
- Usually is able to inhibit desires
- Generally is able to manage habits
- Acknowledges impulsiveness
- Demonstrates knowledge of impulsiveness
- Demonstrates impulse control

These measures are also influenced by subjective judgments, as they incorporate the opinions of all the essential parties involved. Judgments are based on observations, provider reports, family member self-reporting, and observations of others involved with the family. Subjectivity also occurs because of the need to consider meaning, feeling, expectations, and satisfaction.

Managing cases

The use of risk influences translated to client outcomes provides both a management framework and a practice perspective. It promotes a shift in focus toward strengths and positive intervention. It provides the worker-family partnership with greater clarity and understanding of what is to be expected on a daily basis as well as what final result should be expected. This approach is congruent with the traditional client pathway most CPS agencies apply, giving caseworkers and community service providers specific direction about treatment objectives and service activity. Finally, it focuses case tracking, progress evaluation, reporting, and record keeping as well as case decision making generally.

Case application

The following CPS case illustrates the structure and clarity provided by connecting risk influences to outcomes.

CPS began working with Mary, age 22, and her two sons, Mark, age 4, and Tim, age 3. Concerns included Mary's lack of supervision of her sons. Mary would routinely send the boys outside to play in the morning, locking them out of the apartment until late afternoon. When neighbors would bring to Mary's attention instances of the boys playing in the road or asking neighbors for food, Mary would respond by harshly disciplining her sons. Others had seen Mary screaming at the boys, grabbing each by the hair or throat, and slapping Mark across the face for not properly supervising his brother.

Mary's family of origin was alcoholic and Mary was frequently beaten by both parents. Mary left home at age 14, living on the streets. She abused alcohol since age 12. Mary is currently on probation for physically assaulting a woman in a bar during an argument over a dice game. She has been sober for the past eight months, attending Alcoholics Anonymous (AA) meetings and submitting to random urine screens as conditions of her probation. Never married, Mary had short-term relationships with the fathers of Mark and Tim. Mary keeps her distance from her mother and sister. She stated that they mostly say mean things to her and they are "more screwed up" than she'll ever be.

Mary described her sons as very smart and good at taking care of themselves, each other, and sometimes her. She also described them to be, on occasion, totally out of control, as if they had no brains at all. She becomes most frustrated with them when they act like "babies" and seem to hang on her and expect her to "do everything." On these occasions, Mary has felt so enraged with the boys that she has either locked them in their room or used a belt to put a stop to their behavior. Since the time Mary was placed on probation, she has told her sons that if they behave badly she might start drinking. Then she would go to jail and no one would take care of them.

The conclusion drawn by CPS in its initial assessment was that risk of future maltreatment was high based on the following risk factors:

- Harsh parenting/disciplinary techniques
- Unrealistic expectations of the children
- Mary's history of being abused
- Impulsive, angry behavior, including alcohol abuse

Mary agreed to continue working with a CPS social worker and accepted respite day care services. Throughout the following month, the focus of

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CPS intervention was on building a relationship with Mary. The social worker sought to develop a deeper understanding of the risk influences, and to engender a belief and hope in Mary that life could be different. This family assessment process, which seeks to probe beneath the previously identified symptoms, is a critical factor in the identification of the risk influences (e.g., behaviors, emotions, conditions) that must change for risk of maltreatment to be reduced. As the most critical or core conditions/issues that must change were discussed, Mary and the CPS social worker were able to identify how each of those issues could be different (i.e., identification of outcomes). Specifically, they discussed how the family's and its individual members' behavior/emotions would be different if those outcomes were achieved (i.e., identification of the dimensions of the selected outcomes).

Table 2. SAMPLE CASE OUTCOMES AND DIMENSIONS

Risk Influence	Outcome	Dimension
Impulsive, harsh parenting	parenting knowledge and skill	knowledge, emotional control, discipline
Inappropriate expectations of children		expectations of children
Feeling unloved; avoidance of pain, impulsive, angry	self-sufficiency	self-esteem, defends self, self control
Fear of expressing feelings, verbally abusive, doesn't recognize feelings of others	communication skills	verbal expression, verbal responses, empathy

The CPS social worker and Mary developed a treatment plan that identified the specific outcomes and dimensions (see Table 2). Within the first months of the treatment plan, the intervention focused on the dimensions of knowledge and expectations of the children (outcome: parenting knowledge and skill); self-esteem (outcome: self-sufficiency); and verbal expression (outcome: communication skills). Service providers included the CPS social worker, a parent aide, a social worker from Headstart, and a therapist with expertise in depression and substance abuse. All providers and Mary met every 90 days to discuss progress and future direction of the treatment plan. The CPS social worker, as the case manager, was able to measure the reduction of risk influences and evaluate the effectiveness of service providers in assisting with the achievement of the identified outcomes.

Table 3. MEASURING ACHIEVEMENT OF OUTCOMES

Dimension	Measure of Achievement
Knowledge	identifies age-appropriate behavior and needs of children
Expectations of children	correctly responds to capabilities of children; expectations don't affect safety of children
Emotional control	separates own needs from children's; controls emotions and behavior, resulting in nonaggressive responses to children
Discipline	discipline is planned, varied—not harsh
Self-esteem	demonstrates some confidence, maintains energy to carry out responsibilities even when level of self-esteem varies
Defends self	more aware when using avoidance or denial; seeks other ways to cope
Self-control	more able to delay gratification; generally able to control anger and impulsiveness
Verbal expression	more attempts to express feelings; usually able to get needs met by verbal expression of feelings
Verbal responses	responses don't result in aggressive behavior; increased recognition of when verbal responses aren't effective
Empathy	can identify the feelings of others and shows interest in them; improving in showing consideration for others

Approximately 14 months later, risk of maltreatment had reduced significantly, allowing for closure of the case by CPS. This decision was based on the fact that CPS and the providers observed outcomes and dimensions (see Table 3) being demonstrated at a minimally acceptable level.

Discussion

Would change have occurred in this family without the identification of client outcomes? Probably, given the mother's willingness to learn and grow. However, certain differences would have been likely. Behavioral change would have been more difficult to measure. Instead, measures might have consisted of 1) time passed without further instances of abuse/neglect; 2) time passed remaining free of alcohol; 3) attendance in counseling; and 4) cooperation with the social worker and parent aide. This lack of focus on specific outcomes would make it difficult to evaluate if and/or when the risk influences were reduced.

The process of understanding the risk influences and connecting them to outcomes affords time and opportunity for a relationship to form between the client and the social worker. In this case, the relationship that developed had a positive impact on the mother's willingness to change. The structured approach makes all providers accountable for relating their services to the identified outcomes. This accountability had a positive impact on the efficiency and effectiveness of services. In addition, the communi-

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cation among the providers regarding their observations of progress was clearer.

Implications

Establishing client outcomes from risk assessment information creates a treatment plan clear in its purpose. Service provision is less subject to a trial-and-error approach, where each "error" is a lost opportunity for a family. Working with maltreating families is often challenging and overwhelming. CPS workers and other providers have frequently lapsed into measuring compliance with services as their primary approach to case management and treatment provision. This practice has been ineffective in promoting or evaluating change.

Managerial and clinical benefits result from outcome-oriented case practice. Translating risk information to client outcomes establishes accountability to casework practice similar to outcome measures applied to agencies and programs. In addition, the approach enables CPS to more effectively carry out its responsibility: to seek ways to provide opportunities for change.

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SELECTED MULTICULTURAL GUIDELINES FOR CHILD MALTREATMENT RISK ASSESSMENT

—by Peter J. Pecora, Diana J. English, and Vanessa G. Hodges

Cultural competence in child welfare practice has received increasing attention over the past few years. A disproportionate number of children and families served in child welfare programs are people of color (Children's Defense Fund, 1978; Stenho, 1982; Jenkins et al., 1983). Competence in risk assessment requires knowledge of particular cultures and how those cultures affect the families within them. Failure adequately to understand and take into account cultural factors might result in errors in judgment of risk.

For example, CPS professionals may make value judgments about the level or effects of poverty in a community without sufficient knowledge (see Korbin, this issue). They may misinterpret certain customary practices (e.g., coin rubbing as an Indochinese healing ritual) as detrimental, causing unnecessary child placement because of a lack of experience with the particular ethnic group. Unless one is from a specific culture, however, the kind of knowledge necessary for competent assessment and intervention is difficult to obtain.

Numerous articles discuss cultural competence and cultural differences, but relatively little empirical research has addressed the issue of cultural factors associated with child abuse and neglect. Further, although literature on multicultural issues in social services delivery has been growing (for an excellent review, see Stevenson, Cheung, and Leung, 1992; for information about the use of "culturagrams" see Congress, 1994), relatively few resources have been developed that adequately summarize the critical multicultural issues that child protective services (CPS) professionals need to consider in assessing the risk of child maltreatment.

This article, based on practice guidelines from *Multicultural Guidelines for Assessing Family Strengths and Risk Factors in Child Protective Services*, summarizes selected practice principles for examining multicultural influences on risk factors. In addition to "Multicultural Guidelines," the project, which was conducted over several years by a committee of multi-ethnic social service experts, developed two other resources: 1) a strengths checklist for use in conjunction with the commonly used approaches to risk assessment in the United States; and 2) a risk assessment matrix that more explicitly addresses multicultural issues and family strengths.[1]

Specialized training and supervisory support

To improve their risk assessments, multidisciplinary professionals must first make a commitment to develop ethnically sensitive practice (Nguyen, personal communication, 1991). They can then improve their risk assessments by the following means.

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