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Issues in Risk Assessment In Child Protective Services

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In Child Protective Services

A Policy White Paper

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INTRODUCTION

In practice, if not in word, risk assessment has been a part of child protective services since its beginnings. The investigation and substantiation of child abuse and neglect have historically been the first steps in a process intended to determine the likelihood of future maltreatment, and to initiate protective measures, when needed. The assessment of the potential for future maltreatment has always been the cornerstone of case planning and case management. Among other things, the substantiation of prior or current maltreatment was presupposed to indicate a higher potential for future maltreatment, and was, therefore, the primary justification for child welfare intervention. Common sense suggested that if parents had recently maltreated their children, the children were at sufficiently high risk of further harm that society should intercede to protect them. Investigation and substantiation included objectives that were comparable to those in contemporary safety assessments. Post-substantiation assessments included estimating the likelihood of future serious harm, which is the primary objective of formal risk assessment models in use today.

Although, historically, risk assessment activities were less structured than many of today's models, they were, nonetheless, risk assessment activities, essential to case planning and case management in child welfare.

In spite of child welfare workers' best efforts, however, the shortcomings of risk assessment were evident in both theory and practice.[1] The unstructured and relatively informal nature of these assessments promoted error and bias. The lack of comprehensive preservice and inservice training on risk assessment contributed to inconsistent and often inadequate direct practice. And, because child maltreatment was such a complicated and diverse phenomenon, it was agreed that practitioners should not rely solely on substantiation of prior maltreatment as the basis of subsequent case decisions. These and other factors precipitated calls for more accurate and accountable strategies to identify and assess risk.

While formal risk assessment technology had existed for many years in other practice fields, it had not been formally applied to child welfare. Its promise and

appeal were its perceived potential to improve the accuracy and effectiveness of case decisions to promote safety and permanence for abused and neglected children, by assisting in the accurate identification of children at high risk of harm. During the early 1980s, several states began to explore risk assessment as a child welfare practice technology, and by the end of the decade, several states had developed and implemented formalized risk assessment technologies in their child welfare service systems.

In 1990, Wald and Woolverton published an article in the *Child Welfare* journal, entitled "Risk Assessment: The Emperor's New Clothes."[2] It was a seminal article that has since been widely distributed and frequently referenced in the child welfare literature. In this article, the authors articulated a broad range of conceptual and methodological problems that threatened to undermine the integrity of these nascent child welfare risk assessment models and technologies. While acknowledging that risk assessment had the potential to improve child welfare practice, they cautioned that considerable developmental work was needed before risk assessment technologies could fulfill this potential.

In the ensuing 13 years, formal risk assessment has become tightly woven into the fabric of child welfare practice. The majority of child welfare agencies in North America have adopted and institutionalized some form of conventionalized risk assessment to address a variety of case-specific and system-related practice problems.[3] Unfortunately, there is still little research to support the reliability and validity of many models, and the literature continues to raise provocative and disturbing questions about all aspects of risk assessment technology and implementation.[4] Child welfare workers may continue to make case decisions that have potentially harmful consequences for children and families, while believing their decisions have been greatly improved by the risk assessment technologies adopted by their agencies. Many policy makers, agency administrators, and practitioners remain unaware of the seriousness of the existing problems, or may not fully understand their nature or scope. And, while individual researchers and practice jurisdictions have worked to refine and improve risk assessment technologies, the child welfare profession has yet to reach consensus on a plan of action to incorporate the strongest and most promising of these into practice, or to confront the many remaining issues and challenges.

To address both policy and practice issues in risk assessment, the Center for Child Welfare Policy of the North American Resource Center for Child Welfare undertook an extensive risk assessment initiative. This initiative was comprised of several components: 1) an extensive review and analysis of the literature on risk assessment in child welfare; 2) a two-day colloquy attended by researchers, academicians, risk assessment system designers, child welfare managers, and direct service practitioners to identify and explore key issues in risk assessment theory, technology, and implementation; and, 3) a review of state, provincial, and agency risk assessment models. The goals of this initiative were: to provide a summation of the current "state of the art" in child welfare risk assessment; to educate policy makers and practitioners about current issues and potential solutions; and to make recommendations to promote and guide the development of risk assessment policy and practice.

This document sets forth findings and recommendations in an executive summary format.[5] It is hoped this information can help in the design, or more appropriately, the redesign of national strategies to promote more effective identification of children in need of protection, and to assure delivery of the most effective services to assure their safety and permanence.

PART I: ISSUES IN RISK ASSESSMENT IN CHILD WELFARE

This document outlines the principal issues affecting the development, implementation, and evaluation of risk assessment technologies in contemporary child welfare practice. A great many issues and concerns have been raised and discussed in the child welfare research and practice literature, underscoring the conceptual and operational complexity of risk assessment as a practice technology. However, these issues can generally be subsumed under the following major themes:

A) There is a lack of agreement regarding the proper scope and purpose of risk assessment technology in child welfare assessment and case planning activities.

B) Fundamental concepts, premises, terminology, and measures have not always been well defined or articulated, are often applied in an idiosyncratic manner, are highly inconsistent among risk models, and in some cases, are simply inaccurate. This creates ambiguity, confusion, and contradiction, and greatly increases the likelihood of error and bias in risk ratings and subsequent practice decisions.

C) There are serious methodological problems in the design and development of many risk assessment technologies and models, and also in much of the research designed to evaluate and validate them. This not only impacts the reliability and validity of the models, but results in the communication of inaccurate information about their methodological soundness to the practice field.

D) A variety of systemic, bureaucratic, and individual barriers impede the large-scale implementation of formal risk assessment technologies by child welfare agencies.

E) It is often expected that formal risk assessment activities should serve a variety of administrative, political, and systemic functions in child welfare

organizations that have little to do with making accurate protective decisions for children.

F) A number of ethical and legal issues related to risk assessment have not been fully addressed.

Each of these topics will be addressed individually. Recommendations for policy and practice change will be presented in Part II of this document.

Historical Framework

Risk assessment originated in other fields of practice.[6] It is often used in epidemiology and medicine to identify public health risks and factors associated with future illness, and in the corrections field to estimate recidivism after release from prison. It is also a well-tested and proven technology in many areas of science and industry, where it helps predict the likelihood of accidents and breakdowns in large, complex systems.

The classic theory of risk assessment is a venerable concept. Regardless of field of application, it always analyzes two factors when attempting to determine potential risk: 1) what is the likelihood that a harmful event will occur, and, 2) if it occurs, what is the potential severity of that harm. Any analysis that asks these two questions with respect to a factor or combination of factors can be called a risk assessment.

In child welfare, formalized risk assessments were intended to help practitioners more accurately determine the likelihood and potential severity of future occurrences of child abuse or neglect, based upon the presence of certain family characteristics or environmental conditions determined to be highly associated with recurrent child maltreatment. It was presumed that by more accurately identifying children at "high risk of serious harm," agencies could focus more of their limited energy and resources on children most in need of protection. It was also hoped that standardized risk assessment would promote an assessment and decision-making process that was more reliable, more accurate, less biased, and

therefore, more just for families and children than less structured and more informal clinical risk assessment by individual caseworkers.

Many child welfare agencies believe they have achieved this goal by implementing one of many available risk assessment models. Unfortunately, few of the risk assessment models currently in use in North America deserve the confidence we place in them.[7]

Summary of Critical Issues

A. There is a lack of agreement regarding the proper scope and purpose of risk assessment technology in child welfare assessment and case planning activities.

Risk assessment models are formal frameworks designed to help gather and organize information about families, and to guide the interpretation of this information.[8] All risk assessment models encompass four common components: 1) the broad categories (criteria) to be assessed; 2) behavioral descriptors that define and operationalize these criteria (also known as measures); 3) procedures and calculations for determining various levels of risk; and 4) standardized forms to uniformly capture and record this information.

However, risk assessment models differ greatly in their scope, their stated purposes, the relative importance or weight assigned to various factors, and the mechanics of gathering, organizing, and interpreting information.[9] Risk assessment models range on a continuum from a discrete, "point-in-time" assessment of the likelihood of future harm, to case management tools that promote an overarching attention to risk, and its reciprocal, safety, in a variety of contexts and at different decision-making points in the case planning and service delivery process. Because of this disparity in fundamental concepts, premises, and scope, it is often questionable whether professionals discussing risk assessment are even talking about the same thing.[10]

Formal risk assessment technology was originally intended to help workers estimate the likelihood of future recurrences of serious child maltreatment in families.[11] Some risk assessment systems, particularly actuarial models, still adhere to this discrete objective.[12] In this context, risk assessment's unique purpose is to evaluate families during the intake assessment, and to classify them into groups based upon the assessed likelihood of future harm. This information helps to determine which family cases will be opened and transferred within the agency for a more in-depth assessment and subsequent protective services. As only one component of a broader continuum of case management and safety assurance strategies, "point-in-time" risk assessments help assure that agencies focus attention on families in which a future recurrence of maltreatment is most likely. Lower-risk families who have service needs can then be referred to other community providers, with reasonable confidence that future child maltreatment is not likely to occur.

At the opposite end of the continuum are risk assessment models intended to serve as overarching systems of data collection, analysis, and decision making throughout the life of a case.[13] In these models, the stated purposes of risk assessment include prioritizing cases for services, identifying a family's individual service needs, informing case plan development, allocating services and resources, reassessing progress, documenting risk reduction, informing reunification decisions, guiding case closure, and establishing work load standards.

The evolution of some formal risk assessment models from a discrete, "point-in-time" evaluation tool to an umbrella case management strategy likely resulted from the recognition that, in child protective services, all contacts with families involve ongoing assessments of risk. As a result, many agencies attempted to develop risk assessment models, instruments, assessment criteria, and scoring methods that could be implemented at a variety of decision-making points throughout the life of the case. Often, a single standardized protocol was used for multiple assessments, even though very different criteria and assessment methods are needed to achieve different objectives at different stages of casework.[14]

It is extremely important to differentiate formalized risk assessment from the everyday, ongoing casework responsibility of recognizing children in need of protection. Health screenings for children offer a good analogy. All parents do many things to try to ensure that their children remain healthy. In all interactions with their children, regardless of purpose, parents are watchful for signs of illness, distress, or lack of well being. When they see something that concerns them, or perhaps because they recognize their own fallibility, they may seek additional, more scientific assessments, including medical tests, to supplement their own judgment and help guide their decisions about their children's health and development.

So it is in child welfare. Preventing child maltreatment is the essence of child protective services. Whatever else workers may do in their contacts with families, they continually assess risk – vigilant for indicators of current or potential harm. But, recognizing their own potential fallibility, they seek additional, more formalized and more scientifically valid assessments to enhance the information available to them, while concurrently reducing error and bias. Formalized risk assessments augment the ongoing assessment of risk embedded in all contacts between caseworkers and families. However, just as it makes little sense to call every parent/child contact a "health assessment," it is neither reasonable nor accurate to call every social work contact in which risk of maltreatment is considered, a formal "risk assessment."

The fact that the term "risk assessment" has been loosely and interchangeably applied to both ongoing caseworker watchfulness for signs of potential risk, and to formal, structured, and statistically-validated assessment tools, has created serious communication problems for the field. The psychology profession has sought to promote clarity by assigning different terms to represent these two different types of assessment. The ongoing process of eliciting and considering information about a client's emotional health is generally referred to as "clinical assessment" or "psychosocial assessment." The formal process of using standardized, normed, and validated instruments and protocols to gather and interpret information is generally called "psychological evaluation" or "psychological testing." The use of different terminology assists practitioners in more accurately communicating whether their data was derived from clinical

judgment, or from standardized protocols and instruments. The child welfare field lacks comparable clarifying terminology.

There is also considerable confusion among child welfare practitioners about the difference between risk assessment and family assessment.[15] While risk assessment is designed to accurately estimate the likelihood of future incidents of maltreatment, the purpose of family assessment is to identify and explore, in considerable depth, the unique complex of developmental and ecological factors in each family and their environment that may contribute to or mitigate maltreatment. Family assessment data should be used primarily for case planning purposes, to enable the identification and delivery of the most effective interventions to address maltreatment and to prevent its reoccurrence.

When formal risk assessment is used to classify families by level of potential risk and to drive decisions about opening cases, it is best completed during the intake assessment, generally after a few meetings with family members and collateral contacts. However, in so short a time period, it is usually not possible to gather sufficient family assessment information to develop a comprehensive case plan for services. In a collaborative, family-centered model, family assessment requires that sufficient rapport be established between workers and families to promote an open and honest dialogue and an exchange of accurate and relevant information.[16] Family assessment also requires sufficient time to explore unique family circumstances and dynamics in greater depth than is possible at the intake level.

Despite significant differences in purpose, scope, and depth between risk assessment and family assessment, many agencies attempt to use a single "hybrid" instrument to do both. In these jurisdictions, staff are often expected to complete the entire assessment process and develop a formal case plan at the time of intake. Several problems result. Truncating the family assessment to fit within required intake time frames contributes to superficial assessments and sparse, boilerplate case plans that fail to accurately delineate either service needs or family strengths and resources. Moreover, all families are subjected at intake to a level of scrutiny that may exceed the level necessary to simply determine the likelihood of future harm. This wastes caseworkers' time, and may also represent a presumptuous level of protective service involvement in families

where there is little or no risk of future maltreatment. Thus, intake assessment workers may shorten the family assessment process to fit limited time frames; leave out the assessment of certain factors or categories altogether, or complete an "intuitive" assessment of risk and divert families out of the child protection system before the risk/family assessment is completed, thus increasing the likelihood of error and bias in the assessment of risk. In such situations, neither standardized risk assessments nor in-depth family assessments are effectively completed, and a preponderance of casework decisions may continue to be made largely on the basis of individual clinical judgment.[17]

B. Fundamental concepts, premises, terminology, and measures have not always been well defined or articulated, are often applied in an idiosyncratic manner, are highly inconsistent among risk models, and in some cases, are simply inaccurate. This creates ambiguity, confusion, and contradiction, and greatly increases the likelihood of error and bias in risk ratings and subsequent practice decisions.

As indicated earlier, risk assessment models typically incorporate four primary components: 1) the broad categories (criteria) to be assessed; 2) behavioral descriptors that define and operationalize these criteria (also known as measures); 3) procedures and calculations for determining various levels of risk; and 4) standardized forms to uniformly capture and record this information.

As formal risk assessment models have been implemented into practice, and as organizations have modified risk models to meet their perceived unique circumstances, a confusing array of new language has been developed.[18] Idiosyncratic terminology has appeared in a variety of sources, including published journal and research articles, risk assessment instruments, risk model instruction manuals, formal resource papers, descriptive pamphlets, and marketing brochures. Novel language has been coined by child welfare agencies, national child welfare organizations, national resource centers, researchers, academicians, and marketing strategists. The wide discrepancy in language used to represent and describe equivalent phenomena increases the difficulty in understanding what is already an inherently complicated technology.

Examples of some of the terms used to represent risk include: "risk elements," "risk factors," "risk influences," "risk contributors," "safety threats," "present danger," "threats of serious harm," "imminent danger," "emerging dangers," "future danger," "immediate need for a safety intervention," "family concerns," "risk correlates," and "cluster elements." A variety of language has also been coined to represent the intervening factors that mitigate risk, including "family strengths," "safety factors," "protective capacities," "buffering factors," "positive factors," "compensating factors," "protective influences," and "factors offsetting risk."[19] Diverse terms are often used in an interchangeable or idiosyncratic manner, sometimes within a single model or document.[20] And, the fact that the term "safety factors" is frequently used to represent factors that *compromise* safety rather than factors that *promote* it further increases the confusion.[21]

In addition, the language used to describe risk assessment concepts and models is often unclear and confusing. Some models attempt to differentiate, for example, between risk "factors" or "influences," and risk "elements," suggesting that one is a subset or more discrete delineation of the other.[22] One model explains the rationale for this practice as follows: "Grouping risk elements within a set of risk influences facilitates a sharper focus on the specific elements within an influence, as well as a broader examination of the interactions of more diverse risk elements."[23] One source contends that the "risk field" is comprised of "forces," each force being a "complex assemblage of characteristics, factors, qualities, and aspects known as elements... harmful influences are recognized through the identification of these elements...."[24] Another source states, "... this results in an identification and understanding of risk influences that are more prominent and causal."[25] Another contends that "correlates for family concerns receive added weight because they reinforce cluster elements... because correlates interact with causal factors."[26] One risk model explains, "A child is considered to be safe when an assessment of available information concludes that children in the household or custodial setting are not in immediate danger of serious harm."[27] One final example – "Danger is present when there is a threat or likelihood of serious harm. What constitutes a threat? A threat may be a condition, behavior, thought, feeling, or perception."[28]

Possible reasons for this proliferation of idiosyncratic language include a lack of understanding of the importance of standardizing both concepts and language in

risk assessment models, as well as attempts by change agents to adapt a model for local use, or by developers to establish a market niche. Unfortunately, the lack of clarity in language creates unnecessary confusion, interferes with our ability to communicate fundamental concepts and principles, and compromises our ability to do comparative research between risk models. This also poses unnecessary obstacles at the practice level, since practitioners who implement risk assessment must first sort through the idiosyncratic language and contradictory terms to understand the concepts that underlie the technology. Often frustrated by their inability to make sense of the nonsensical, they give up and request training in "how to complete the form."

Criteria/Measures

There are equally challenging problems related to the criteria, or measures, used to assess risk and to quantify it at various levels. There is little standardization of assessment criteria among currently used risk assessment models.[29] One comparative study found that no factors were common to all the risk models examined, and about 40% of the criteria were unique to a single model.[30] Risk assessment models also have wide variations in their numbers of criteria, ranging from a low of about six to a high of about 50.[31] In some models, the primary criteria are further divided into more discrete sub-categories, thereby creating dozens of individual measures. Many models fail to differentiate between risk factors for physical abuse, neglect, and sexual abuse, even though contributors and dynamics are often different for these types of maltreatment.[32]

The literature repeatedly challenges the legitimacy of many of the measures used in risk assessment instruments. One source cites "a striking lack of attention to and concern with reliability and validity of measures used."[33] Most measures have not been empirically tested, or their reliability and validity are not supported by research findings.[34] One study of eight risk assessment models determined that fewer than half of the 88 measures in these models had been empirically tested, much less validated, before being implemented into practice.[35]

Most measures, particularly in consensus-based risk assessment models, were derived from one of two sources – descriptions in the social work research literature of common characteristics of families who have maltreated their children, or the judgments of experienced practitioners.[36] While the child maltreatment literature may identify factors that appear to be *associated* with child maltreatment, these factors are often not tested to determine their capacity to *estimate the likelihood* of future maltreatment. [37] One source suggests they simply represent the "best available guesses about which factors are most likely to be related..."[38]

The measures in many risk assessment models are also constructed in a manner that creates confusion, thereby undermining the instrument's reliability.[39] Measures are often poorly defined, nebulous and ambiguous, overly global, illogical, and very subjective. Some are quite simply inaccurate. These measures often leave considerable room for interpretation by different raters, and at times, the descriptors that delineate the various degrees of risk are virtually indistinguishable, making it possible to score the very same behaviors at more than one risk level.

One common practice is to develop measures that distinguish between levels of risk by creating a continuum with some variation of "none" or "a little" anchoring one end, and "a lot" anchoring the other.[40] Examples of such rating continuums include the following:

- minor, moderate, serious, severe, extreme
- safe, fairly safe, unsafe, very unsafe, extremely unsafe
- marginally, moderately, very, extremely
- has a history of, occasionally, sometimes, often
- superficial, significant, major
- mild, moderate, profound
- isolated, sporadic, repeated
- some gaps, significant gaps, gross deficits
- superficial injury, significant injury, major injury

These continuums are typically used to represent the following: different levels of severity of harmful behaviors or activities; the extent of an action's impact on a

child victim; the frequency or prevalence of an activity or behavior; and the degree to which a condition impacts parental functioning.

In another example of this practice, a set of measures to rate physical hazards in the home included a "minor gas leak" as a moderate risk and a "severe gas leak" as a high risk.[41] How would a rater determine how much gas escaping into a particular room, over what period of time, would warrant re-categorizing a leak from "minor" to "severe?" These measures also ignore the fact that in typical circumstances, gas leaks have the potential to kill and should be considered, de facto, high risk.

What is common to all these measures is that the descriptors used to differentiate risk levels are *quantitative* rather than *qualitative*. These measures assume that changes in the amount, extent, or frequency of a behavior or condition represent gradations of harm that are meaningful in determining the existence or potential of maltreatment. In other words, a little exposure is less risky than more exposure, and both are less risky than a lot of exposure. While this may be true in some instances, very often it is not. These measures also fail to designate exactly how much is "a lot" or "a little," and, instead, leave this differentiation to the discretion of the caseworker. Further, the words used to describe the behaviors and conditions at the various risk levels are often not easily differentiated and, in fact, some descriptors, such as "severe," "serious," and "extreme" are essentially synonyms.[42] It would be similarly difficult to determine exactly how many incidents would have to occur before "isolated" behavior became "sporadic."

Effective qualitative measures are difficult to construct and are, therefore, prone to error. In a measure of a caregiver's emotional and mental health, moderate risk is described as "Caregiver currently exhibiting behaviors which may be a sign of deteriorating mental health, and treatment is not being sought," while high risk is described as "Caregiver's current psychological state appears to pose a high level of risk to the child; caregiver is unwilling and/or refuses to seek psychiatric treatment and/or evaluation."[43] The intent is to describe qualitatively different parenting behaviors. However, both measures essentially describe the same parental dynamic, using somewhat different words. The only real differentiating factor is the clause "appears to pose a high level of risk to the

child." This requires workers to make a judgment about the level of risk before they can complete the rating, rather than relying on the measure itself to guide this judgment.

The following measure of "caretaker's acceptance" combines qualitative and quantitative descriptors, and also incorporates inaccurate content. In this five-point scale, "very accepting" represents no risk; "limited acceptance" represents low risk; "indifferent and aloof" represents moderate risk; "disapproves of and resents child" represents high risk; and "rejects child and is hostile" represents very high risk.[44] In addition to the ambiguity of quantitative terms such as "limited acceptance," it is difficult to discern a substantive difference between "disapproves of and resents" child and "rejects and is hostile." They are, again, different manifestations of the same parental behavior. The measure also implies that indifferent and aloof parenting strategies are not as potentially harmful as resentment and rejection when, in fact, parental indifference and aloofness inherently constitute rejection, and often cause significant emotional harm over time. Indifference is not a neutral mid-point somewhere between acceptance and rejection. Chronic parental indifference is a type of neglect that constitutes its own kind of continuing serious harm.

In another example, the measures developed to rate the risk of sexual abuse are not consistent with empirical data. In this set of measures, a child who is propositioned or pressured to have sex, but in which no sex occurs, is rated to be at moderate risk. Only if the perpetrator has physically involved the child in a sexual act or exploitation does the risk become high.[45] According to empirical data, both conditions may represent a high risk of recurrence of sexual abuse. Grooming behaviors by perpetrators typically include a sequence of escalating and more intrusive sexual involvement over time, any of which represent a significant threat of continuing and future harm, as long as the perpetrator has unhindered access to the child victim.[46]

The previous examples may appear extreme, but, in fact, reflect alarmingly common problems in risk assessment measures. They illustrate a critical point. Reliable and valid measures are the cornerstone of any effective risk assessment instrument. To promote accuracy and fairness in data collection and interpretation, measures must be clearly articulated and objective, and must

leave as little room as possible for misinterpretation. Well-constructed measures promote consistency and accuracy in ratings, whereas ambiguous and poorly defined measures promote individualistic, inconsistent, and potentially biased interpretations. It must be remembered that a primary goal of formalizing risk assessment was to standardize both assessment criteria and ratings to promote greater consistency and accuracy of assessments, and, hence, fairness to families. Poorly developed measures in many risk assessment models defeat this purpose.

Confusion Between Risk, Safety, and Substantiation

The recent national emphasis on child safety has spawned the development of a variety of new "safety assessment" instruments. Some of these are considered components of risk assessment, while others are promoted as related to, but not subsumed under the term "risk assessment."

Child safety is not a new concept in child welfare, nor are safety assessments a recent invention.[47] Child safety has always been, and remains, the mission and defining principle of the child welfare profession, and child welfare professionals have been assessing children's safety as long as there has been a child welfare profession.

The resurgence of national concern about safety is more likely a counter-reaction to recent changes in direct practice brought about by the philosophical shift toward family preservation and "reasonable efforts."[48] In many agencies, the increasing focus on family preservation had the unfortunate impact of de-emphasizing safety and protection.[49] Some family preservation language tends to reflect this "either-or" perspective. Examples include focusing on family strengths rather than family problems,[50] and completing assessments rather than investigations. Some advocates admonish against the substantiation of prior maltreatment[51] and emphasize preventing future harm rather than dwelling on past events. [52] Most family preservation concepts are sound, and were, themselves, implemented to counteract the child welfare field's tendency to compromise family integrity and stability in the name of child protection. However, child protection and family integrity are both important goals of child

welfare, and they must always be appropriately and concurrently balanced and integrated into direct practice.

The stated goal of recently developed safety assessments is the accurate and timely identification of children who are "unsafe" (i.e., who are currently being maltreated, have very recently been maltreated, or are in circumstances where they are likely to be maltreated in the immediate future).[53] Attention to safety issues allows agencies to develop very short-term plans, referred to as safety plans, to stabilize family situations, or to make alternative placement arrangements so children can be protected until a more in-depth family assessment and service plan can be completed.

Toward this end, the data collected in safety assessments tends to cluster around three fundamental questions.

1) *Has the child been recently maltreated, is the child currently being maltreated, or is the child at risk of imminent harm?*

   Safety assessments are intended to accurately identify children who have recently been or are currently being maltreated, or are at risk of imminent harm; and to determine the nature and type of harm, its severity, and its potential consequences for the child. By definition, these children are already at elevated levels of risk to their health, safety, and well-being.

2) *What additional family and environmental factors may increase the likelihood of harm in the near term?*

   Safety assessments attempt to identify family and environmental factors that could potentially escalate, resulting in imminent, continuing, or increasing harm to children.

3) *Are there strengths and protective factors in the family that can mitigate maltreatment and assure the child's safety?*

   Safety assessments were originally developed as a strategy to prevent unnecessary out-of-home placements.[54] If workers could identify and

support family and community strengths and resources that could stabilize volatile situations and provide support to families, many children could potentially be protected in their own immediate or extended families. The objective was to prevent emergency removal and foster care placement, which, themselves, can subject children and other family members to serious emotional trauma.

While the objectives of safety assessment are fairly clear, there remains considerable confusion about the relationship between safety assessment, risk assessment, investigation, and substantiation of maltreatment.

Abusis Inibi

Safety assessments are, in fact, a form of risk assessment. However, they are concerned only with risk of severe harm in the near term, or as the Latin appellation indicates, "abuse near at hand," rather than the likelihood of harm at some time in a more protracted future. Special emphasis on this subclass of risk assessment is not only justifiable, but a necessary correlate of risk assessment, since the two most important variables in defining risk – the likelihood of harm, and the potential severity of such harm – are both very high when children are "unsafe."

Safety assessments reflect the *a priori* assumption that we are most concerned with severe maltreatment that is "inibi" – that has just happened, is happening, or is imminent. However, while it is justifiable, even necessary, that we carve off this class of potentially severe and imminent risk for special and urgent consideration, to suggest that safety assessment is qualitatively different from risk assessment will only cause additional confusion and discontinuity.

Confusion Between Safety Assessment and Investigation/Substantiation

Upon close scrutiny, the objectives and activities of safety assessment appear to be equivalent to those of child protective services investigations, the

substantiation of maltreatment, and the assessment of imminent risk – albeit repackaged and renamed. In this context, substantiation refers to the formal process of determining whether an alleged incident of child maltreatment occurred, and the nature, severity, and circumstances of such maltreatment.

Safety assessment, stripped of ideology and rhetoric, essentially combines substantiation of maltreatment and emergency case planning. Items on safety assessments routinely probe for information about existing unsafe environmental conditions, negligent or abusive parenting practices, and conditions that currently compromise a child's health or well-being. The specific measures in safety assessments typically include the physical, emotional, and behavioral indicators of various types of maltreatment, descriptions of potentially harmful familial, environmental, and social conditions, and the extent and type of harm a child has already experienced.[55] While some proponents contend that safety assessment is categorically different from the investigation and substantiation of maltreatment, this rhetoric sends a contradictory message. Workers are admonished not to "investigate" nor to "substantiate," but the preponderance of data they are instructed to collect is designed to identify and document prior, current, and continuing abuse or neglect.

The current focus on safety assessment is a legitimate re-emphasis of the importance of child welfare's fundamental responsibility – child safety – and, it deserves the emphasis it has received from recent federal policy and action. However, it is problematic to suggest that the substantiation of abuse and neglect is not an important component of risk and safety assessment, safety planning, case planning, and documentation of outcomes. Moreover, in no way does the substantiation of maltreatment preclude a developmental, family-centered approach to practice.[56] The child welfare profession can strengthen and preserve families by assuring that information about precursor conditions to maltreatment, and associated risk factors, drive the development of service plans and interventions that enable and empower families to grow and change.

C. There are serious methodological problems in the design and development of many risk assessment technologies and models, and also in much of the research designed to evaluate and validate

them. This not only impacts the reliability and validity of the models, but results in the communication of inaccurate information about their methodological soundness to the practice field.

Effective formal risk assessment is based on sound scientific principles and statistical methods.[57]

Most practitioners contend, quite rightly, that the "science" of human behavior has its limitations, and that effective social work intervention involves "art" as well.[58] Fundamental social work constructs such as relationship, empathy, empowerment, and respect are very difficult to quantify or measure. Some of the resistance to actuarial models of risk assessment results from concerns about undermining these essential social work principles. A common criticism is "You can't reduce social work to a checklist. It's contrary to everything social work stands for."[59]

However, formal risk assessment is not fundamentally about social work, nor was it ever intended to serve all the casework purposes for which it is used.[60] The unique role of formal risk assessment in the larger context of child protection is to classify families accurately into groups, based on their likelihood of future maltreatment, thereby enabling agencies to target the most extensive services to the children and families who most need them. Formal risk assessment is only one component in a larger, more comprehensive process of family-centered casework which incorporates activities of engagement, individualized assessment, ongoing case planning, service delivery, and reassessment throughout the life of a case.

Formal risk assessment is most successful when it is possible to identify, measure, and statistically confirm the net effects of certain well-defined criteria or variables on specific outcomes.[61] However, the precursor conditions that lead to child maltreatment are a complex and poorly understood interaction of psychological characteristics, social and environmental stressors, parenting behaviors, family interrelationships, and, in some cases, the developmental and behavioral characteristics of children.

Considering this complexity, it is naive to believe we can always determine the potential for future maltreatment in families using only clinical skills.[62] While in some families, the likelihood of continuing maltreatment may seem apparent to a well-trained child welfare clinician, in the majority of referred families, things are not so clear. Moreover, data suggests that in a large percentage of families classified as "high risk," child maltreatment does not reoccur.[63] Thus, the ability to accurately "predict" maltreatment in most families remains elusive.[64]

It is because of this complexity, and the potentially harmful consequences to children and families when we're wrong, that the child welfare profession needs to underpin its safety and treatment decisions with the most rigorous scientific support.[65] And, while no human services profession can achieve the definitional clarity or empirical rigor that is possible in the physical sciences, we must still strive for the highest possible degree of consistency and accuracy.[66] To achieve this, formal risk assessment in child welfare must be based on scientific principles and must attempt to meet the same high standards that underlie risk assessment in other practice fields.

An understanding of these principles and standards is necessary to evaluate the methodological integrity of risk assessment technologies.

Reliability and Validity

Two fundamental research principles, reliability and validity, underlie any assessment of the relative effectiveness of different risk assessment models.[67] While there are different types of reliability and validity, and while these constructs can become complex in their implementation, in theory they are fairly straightforward.

Reliability can be broadly defined as the degree to which a particular measure yields consistent results. One type of reliability, known as inter-rater reliability, refers to the degree to which different people using the same criteria will reach the same conclusions from the same information. This aspect of reliability is most relevant in formal risk assessment, where the goal is to standardize the

collection and interpretation of case-related information by different workers in different places and at different times to reduce error and bias.

An example borrowed from medicine can illustrate reliability. A complete blood count is often used as a first-line intervention to screen for certain diseases, because it is a very reliable measure. The basic structure and function of blood cells are genetically determined and are, therefore, very consistent among humans. Further, because this measure is rigorously defined, easily quantified, normed, and standardized, physicians will typically interpret blood count results in the same manner. For example, with few exceptions, a red cell count of 10 signals anemia, while a high white count warrants further examination for illness or infection. In general, the more precise, well defined, objective, and clearly articulated a measure, the greater the likelihood that different raters will come to the same conclusions from the same data.

Validity in research is an inherently complicated construct, made more so by the fact that there are several different types of validity. The use of the term in risk assessment generally refers to the degree to which an instrument can *accurately* categorize or classify families into different levels of risk. Thus, for a child welfare risk assessment instrument to be valid, the families it has identified as "high risk" should, as a group, maltreat their children significantly more often than the group of families identified as "low risk," and the group of families identified as "moderate risk" should fall clearly in-between.

A formal risk assessment model's reliability and validity provide the "litmus test" of its effectiveness. The higher a model's reliability and validity, the more likely it is to promote the *consistent* collection of *accurate* information about the condition being examined, ultimately promoting *consistent* and *accurate* conclusions regarding potential risk.[68] Conversely, risk models that lack reliability or validity formalize and sustain the collection of inconsistent and inaccurate data, and result in faulty decision making using this data.[69]

Actuarial and Consensus Models

There are two primary types of formal child welfare risk assessment models: actuarial models and consensus models (sometimes referred to as matrix models.) There is a large body of literature describing both types of models, as well as some research that compares their respective reliability and validity.[70] There is also considerable confusion among child welfare professionals about the nature of these approaches, how they are developed, and their use.

Actuarial instruments are common in a variety of professional disciplines to formally estimate outcomes, such as who is most likely to have a heart attack – or survive one – or who is most likely to become involved in a traffic accident. Actuarial models are based on established statistical associations between certain criteria and a specific outcome of interest. The tables used by insurance companies to establish premiums for health, life, or accident insurance are an example of actuarial instruments. Actuarial instruments are typically used because comparative research has repeatedly demonstrated their superiority over clinical judgment in accurately estimating the likelihood of particular outcomes.[71]

Actuarial models use standardized statistical procedures to identify the specific criteria, and their combined effects, that have the greatest power to discriminate between groups of people in the future occurrence of a particular outcome. Criteria are formalized into standardized assessment protocols only *after* the relationships among the variables have been quantified and thoroughly tested. Further, the ratings of individual criteria and the scoring of an overall risk level are dictated by the previously determined statistical weighting of these previously identified associations.[72]

Actuarial risk assessment instruments in child welfare are an attempt to apply statistical methods to more accurately estimate the likelihood of a reoccurrence of child maltreatment. An actuarial risk assessment tool incorporates criteria or measures that have been demonstrated, through prior statistical assessment, to have a high level of association with reoccurrences of maltreatment. The presence of these variables in families in certain specific combinations can be said to increase the likelihood (but not to guarantee) that maltreatment will reoccur.[73] The greater the statistical association between the combined variables in the instrument and the presence or absence of future maltreatment, the greater the

capacity of the instrument to consistently and accurately classify families into various levels of risk.

Consensus models, by contrast, rely on a preponderance of professional agreement about which variables or conditions are most highly associated with recurrences of child maltreatment.[74] There is a rather large body of professional literature that describes the various types of individual, family, and environmental conditions found to be associated with child maltreatment. The presumption is that when these factors are present, the likelihood of maltreatment increases. Well-developed consensus models may improve the consistency and accuracy of data collection, largely because the individual criteria are backed by at least some research, and because these models standardize the assessment criteria used by different raters. However, the measures themselves are often not subjected to testing before being implemented, and there is usually no empirical data regarding how the various factors interact, or how they should be weighted and scored.[75]
Thus, consensus risk assessment models do not lend themselves to the use of numerical scoring systems.

Well-developed consensus instruments do have a role in child welfare practice. However, they should not be used to estimate the likelihood of future outcomes. Consensus-based instruments can be useful tools to guide and standardize the collection of pertinent information to inform a variety of case decisions. As examples, consensus-based tools could guide data collection for a safety assessment or a comprehensive family assessment; could provide information to help select services that best meet a family's individual needs; or could help identify the strengths and developmental needs of prospective adoptive and foster families. However, consensus instruments must still strive to achieve the highest possible levels of reliability and validity (although the type of validity required for these purposes is different from that sought in formal risk assessment.) Measures developed for consensus instruments must be based on sound empirical data, clearly defined and articulated, pretested, and validated for their intended purpose.

Consensus-based instruments can be used in conjunction with actuarial instruments, albeit for different purposes. For example, consensus-based tools

might be used to assess a family for indicators of drug abuse, or to assess a foster family's capacity to care for a child with special needs. By contrast, actuarial instruments could be used to estimate the likelihood of recidivism after drug treatment or the likelihood of placement disruption, based upon a family's present characteristrics and circumstances.

The Fallacy of "Consensus"

There is considerable confusion in the child welfare field about what constitutes consensus. Many people incorrectly interpret consensus to mean the negotiated opinions of whatever group of professionals is convened to develop or revise a risk assessment model. Ad hoc committees of practitioners are asked to present and discuss their judgments and opinions, and try to reach agreement on which criteria, definitions, and rating methods "work best for them." Referring to this process as "generating consensus," "further refining the model," or "addressing our unique circumstances" gives apparent validity to a process that is notoriously subject to error and bias.[76] Even as the child welfare profession espouses the necessity of evidence-based practice, critical case decisions continue to be made using risk assessment instruments based not on evidence at all, but on the personal opinions of a variety of informants with differing degrees of expertise.

It is troublesome that many jurisdictions adapt risk assessment models, in whole or in part, without assuring that their changes are empirically based, and without testing for reliability and validity. The literature delineates a variety of potential reasons that substantive adaptations of risk assessment models are so prevalent.[77] Many users don't grasp the complexity of the technology, and they revise it to make it simpler or more understandable. Some users want a shorter protocol that takes less time to implement. It is often believed that staff's "buy-in" to a model depends on their participation in its development, and their agreement with the final product.[78] Some administrators believe their agency's circumstances to be so unique as to warrant an individualized model. And some practitioners equate any form of standardization as a rigid mandate that undermines individuality and creativity. While the majority of idiosyncratic revisions in risk models are presumably well intentioned, these changes often further undermine a model's reliability and validity.

Comparative Research of Risk Assessment Models

During the past 50 years, extensive research has been conducted in a wide variety of practice fields on both actuarial and consensus-based decision-making models. These studies have repeatedly demonstrated the superior reliability, validity, and performance of actuarial models over consensus-based models.[79]

Since the mid 1980s, there has also been considerable research intended to evaluate the risk assessment models used in child welfare. Some of these studies have examined the reliability or validity of individual risk assessment models, while other studies have concurrently compared the performance of more than one model. In studies assessing the relative performance of actuarial versus consensus models used by child welfare agencies, the findings are consistent with the research from other practice fields – actuarial models have demonstrated higher levels of reliability and validity than have consensus models.[80]

The preponderance of research literature continues to raise serious questions about the reliability and validity of most of the risk assessment models and instruments currently used by child welfare agencies.[81] In practice, many child welfare professionals are making decisions about children and families with little more accuracy than flipping a coin, while believing they are using technologies that reduce subjectivity and bias, and that increase the quality of their decisions. As discussed earlier, this is at least partially the result of a prevalent but inaccurate belief that group consensus is an accurate means of selecting criteria and constructing measures for assessing risk.

There is also skepticism among researchers about the soundness of much of the research conducted to test the reliability and validity of risk assessment models.[82] A first principle of research taught to graduate students in all professions is, "All research is not equal." The accuracy of a study's conclusions depends on the researcher's adherence to rigorous procedures for study design, definition of measures, sampling, data collection, statistical analysis, and data interpretation. Evidence-based practice stresses that research should be competently constructed and executed, reported findings should be supported

by the data, and research methods should be accurately described. It also calls for full disclosure of methodological problems or other constraints that potentially skew the results or limit the generalizability of findings and conclusions.[83]

Risk assessment research often does not adhere to these guidelines, and studies may claim to be sound even though they are poorly designed and implemented. Their conclusions are, therefore, suspect. Some research studies make claims of reliability or validity without having been subjected to careful and objective scrutiny to confirm that they were well designed and implemented, their data was appropriately analyzed, and their conclusions were fairly and honestly represented.[84] Unfortunately, child welfare practitioners may believe a study's claims of "reliable" or "valid" whether or not this conclusion is warranted.

Not all child welfare practitioners have had sufficient training in research methods to independently evaluate the quality of a study or a model – nor do they always have time to do such an evaluation. Unfortunately, many risk assessment research studies and models do not stand up to rigorous scrutiny, and their developers and marketers cannot always be expected to present disinterested critique. However, child welfare administrators and policy makers should have ready access to accurate information about the relative strengths and limitations of risk assessment models and their related research. To achieve this, researchers and developers must be willing to subject their work to critical appraisal by other researchers, and administrators and policy makers should have access to resources to help them evaluate research methods, conclusions, and claims.

Finally, child welfare practitioners should not presume that because a risk assessment instrument was found to have high levels of reliability or validity under certain circumstances, it would be equally reliable or valid if used for a purpose other than that for which it was developed.[85] A finding of "reliable" or "valid" should not be interpreted as a universal pronouncement of an instrument's integrity regardless of how it is used.

D. A variety of systemic, bureaucratic, and individual barriers impede the large-scale implementation of formal risk assessment technologies by child welfare agencies.

As is true with any large-scale change initiative, system-wide implementation of a formal risk assessment model can be fraught with challenges. It requires a significant allocation of time, work, and resources, and its success depends on strong organizational commitment to support and sustain the change process over long periods of time, despite a variety of deterrents and barriers.[86]

The literature has identified multiple problems related to implementation of formal risk assessment at the local agency level.[87] In some organizations, workers vary greatly in their use and interpretation of risk assessment models, even though the models ostensibly standardize decision-making.[88] While many workers do use standardized risk protocols to help guide their decisions, many others use risk rating instruments simply to record conclusions and decisions they have already made by other means, including personal clinical judgment.[89]

Many caseworkers consider formal risk assessment a burdensome increase in an already heavy workload. When time constraints combine with multiple distractions and competing priorities, risk assessments are often quickly and superficially completed.[90] Further, many caseworkers and their supervisors are discouraged from implementing a risk assessment model because they believe it interferes with, rather than enhances, practice, particularly when they don't recognize a need to improve the quality of their assessments or decisions. Many staff perceive formal risk assessment as an administrative mandate, rather than a necessary intervention to promote unbiased, accurate, and relevant decisions.

At times, workers view formal risk assessment as an unnecessary and unwarranted intrusion into families, particularly if it is a lengthy assessment that borders on a comprehensive family assessment. Workers may abandon or shortcut the assessment when they encounter resistance from family members, or when they find policy loopholes that allow them to bypass administrative requirements to complete risk assessment at intake. A common practice is to classify cases at intake into service categories other than alleged abuse or neglect,

and to divert these families into less intrusive service streams. While diversion of low-risk children and families into alternative services is a legitimate objective, this decision should be made only *after* the level of risk has been determined by a reliable and valid risk assessment tool - not before.

Another prevalent barrier to implementation is lack of training in the prerequisite clinical competencies for effective assessment.[91] Assessment in human services is a very complicated activity. It requires high levels of skill in critical thinking, observation and listening, interviewing, information gathering, and data analysis and synthesis. Caseworkers must also master the specialized knowledge needed to recognize and assess certain conditions. For example, caseworkers who are unable to recognize indicators of substance abuse, or who don't understand its behavioral dynamics cannot accurately assess its presence or extent in families. Assessments can also be rendered inaccurate by a lack of cultural knowledge, or by workers' inability to recognize how their personal culture, values, and beliefs can obscure their interpretations and conclusions about families. Caseworkers without thorough training can produce assessments with frighteningly inaccurate conclusions, even when they appear to be asking the right questions and properly recording the information.[92] Finally, many workers are better at collecting information than at synthesizing it, using it effectively to inform casework decisions, or documenting it accurately to enhance both planning and accountability.[93]

Yet, in spite of the inherent complexity of assessment in human services, risk assessment training often consists primarily of policy briefings, a description of the risk model, an explanation of its criteria and measures, and instruction in how to complete the protocol and record the data. Many staff do not receive sufficient training in fundamental, and significantly more important core assessment skills. Much risk assessment training has been likened to teaching airline pilots how to complete a pre-flight checklist before taking off, without ever having taught them navigation, meteorology, or even the essentials of flying the plane. Yet, many jurisdictions continue to expect two or three days of training on a risk assessment model to fully prepare staff to implement it consistently and accurately.

Coaching and supervision are also essential to the effective implementation of risk assessment.[94] Even skilled professionals experience what adult learning theory calls a "performance dip" when implementing a new skill or technology. This performance dip is more pronounced when a new skill is complicated, or when learning it requires modifications in well-entrenched habits. Skill mastery only occurs over time. It requires ongoing practice, feedback, support, and personal perseverance. This rarely occurs in organizations unless educational supervision, coaching, peer support, and individualized professional development are integral parts of the organizational culture.

Of course, problems in the construction of risk assessment instruments and their measures will also impact their implementation. Anything that makes a model harder to understand, to master, or to integrate with other casework activities can undermine its use. This includes ambiguous and confusing criteria, idiosyncratic language, overlapping categories that obscure differences between the various risk levels, and complex rating and scoring procedures. Moreover, risk assessment models are often superimposed on pre-existing case management systems without thoughtful consideration of their "fit." This contributes to repetition, duplication, and even contradiction in procedures and forms for the collection, recording, and management of case related information.[95]

A variety of common organizational barriers can also interfere with effective risk assessment implementation.[96] Many are the same barriers that undermine other change initiatives, as well as compromise the quality of child welfare practice in general. They include excessive workloads, shifting and competing priorities, poor time management, a reactive rather than planful approach to management, too few resources, poorly designed and implemented change initiatives, an unsupportive political environment, and a generalized resistance to change that helps maintain the status quo in many bureaucratic organizations. The literature contends that as a result of these and other barriers, complete and successful implementation of formal risk assessment at the local level has proved to be elusive.[97]

Finally, standardized risk assessment models, criteria, forms, and scoring protocols are frequently "hard coded" into computerized child welfare

information systems. This practice is intended to increase accountability in the child welfare system by standardizing data collection and recording activities. However, when a risk model's criteria, measures, instructions, algorithms, and forms are programmed into the software's code, it is often time consuming and extremely costly to make changes. This creates incentives for organizations to continue to use obsolete, untested, or even invalid risk assessment models rather than reprogram their entire information system to accommodate necessary changes. Given the infancy of risk assessment technology, and the amount of ongoing research and developmental work, it is essential that agencies maintain sufficient flexibility in their software programs to allow easy redesign and updating of input screens, criteria, and scoring protocols whenever it is needed.

Large-scale system change is complicated and challenging, and the implementation of formal risk assessment generally involves significant system change. Even the most reliable, valid, and best-formulated risk assessment model will fail to achieve its objectives if it is not fully and properly implemented.

E. It is often expected that formal risk assessment activities should serve a variety of administrative, political, and systemic functions in child welfare organizations that have little to do with making accurate protective decisions for children.

The child welfare literature describes a variety of ways formal risk assessment is expected to improve child welfare practice. Among these are: improving workers' decision-making at all stages of casework; improving the quality and consistency of services to families; improving the case referral and case management process; providing a forum for case discussion and supervision; delineating child welfare practice standards; increasing agency accountability; demonstrating agency accountability to the public; reducing agency liability; improving court presentations; compensating for inexperienced staff and the effects of turnover; helping manage workloads; and providing a framework for case documentation. As such, formal risk assessment protocols are variously expected to serve as case planning and case management tools, public relations tools, quality assurance tools, communication tools, monitoring and recording

tools, supervision tools, and workload management tools, as well as a means of promoting the safety of maltreated children.[98]

This last expectation is the most troublesome. Even in the best of circumstances, no single technology can ever fully protect children from maltreatment.[99] Child safety is the mission of the child welfare field – the desired outcome, the ultimate reason for its existence – and a variety of sophisticated and integrated technologies and resources are necessary to approach this goal. Formal risk assessment is a single technology with the limited purpose of estimating, with acceptable accuracy, which children in our communities are most likely to be maltreated. Maintaining unrealistic expectations for formal risk assessment can actually deter policy makers, administrators, legislators, and potential funders from seeking and developing more appropriate strategies to address the many organizational, community, and direct practice problems that plague contemporary child welfare, thus ultimately increasing, rather than decreasing, the potential of future harm for high-risk children.[100]

F. A number of ethical and legal issues related to risk assessment have not been fully addressed.

Our society has clearly and correctly determined that, in the vast majority of circumstances, parents should retain the authority and responsibility to make decisions regarding their children's physical, social, educational, and psychological development and well-being. Society has also correctly determined that the state must support this parental authority and must not interfere unnecessarily in family life. However, the state also has a legitimate moral interest and obligation to protect the absolute rights of children to a safe environment and to certain levels of care and nurturance.[101] Generally, these social, moral, and legal norms do not conflict. However, in situations of child abuse or neglect, children's rights to safety supersede parents' rights to self-determination. The legal doctrine of *parens patriae* conveys the legal authority and moral responsibility to the state to assure that children are not maltreated by their caregivers. The bottom line, however, is that without parental consent, child protective services cannot intrude or interfere in family life except in situations of serious child abuse or neglect.[102]

This raises the question of how child protection agencies, as agents of the state, can morally and legally use formal risk assessment data to fulfill their mandated responsibility to protect children from maltreatment without inappropriately interfering with parents' civil and parental rights. In essence, can child protective services agencies intervene in families against their wishes, based solely upon risk assessment findings that estimate a high likelihood of maltreatment, even when no maltreatment has yet occurred?

There are currently no risk assessment technologies that can predict with certainty that child maltreatment will reoccur, even in families identified as potentially high risk.[103] Some formal risk assessments can accurately categorize families into high risk, moderate risk, and low risk groups, based on the statistical likelihood of a reoccurrence of maltreatment at some time in the future. This is the best that current research and technology have to offer. Given these realities, it is difficult to see how one could justify opening a non-voluntary protective services case, in the absence of substantiated abuse or neglect, based entirely upon risk assessment findings.

Even so, there has been serious discussion in some states and agencies about shifting the focus of child protection from the investigation and substantiation of a past incident of child maltreatment in favor of risk assessment, which is "future-oriented" and not "aimed at proof or disproof of specific allegations of past maltreatment."[104] Common arguments to support this action include: substantiation isn't family friendly; it focuses attention on pathology rather than strengths; it dwells on a family's past behaviors rather than growth and change; in many families, maltreatment never reoccurs; substantiation is too subjective a concept to be meaningful; and substantiation sets up a confrontational rather than collaborative relationship between families and the agency.

However, there are also convincing arguments for maintaining the substantiation of maltreatment as a policy requirement. The process used to substantiate abuse or neglect examines many of the same variables and dynamics addressed by today's safety assessments – the variables and dynamics correlated with severe and immediate harm. As suggested earlier, the current national imperative to develop safety assessment protocols may owe its urgency to this trend of

abandoning investigation and substantiation in favor of systemic risk assessment.[105]

A clear and well-documented indication of child maltreatment may be the only legal and ethical justification for intrusion by child protective services into the private dynamics of family life. Without such documentation, intrusion into families may violate parental rights legislation and federal civil rights law.

It must also be understood that even reliable and valid risk assessment technologies serve a limited purpose in the broader context of child protective services, and there are ethical and potential legal liabilities if these limitations are not acknowledged. Claiming, either by design or ignorance, that formal risk assessments will achieve what they cannot creates potential liabilities the child protection system can ill afford. The stakes increase greatly when risk assessment protocols used by agencies are neither reliable nor valid. Agencies place themselves in a precarious legal position by claiming their decision-making is based on standardized, validated risk assessment protocols when it is not.[106] A state or provincial child protective service system that endorses or mandates a formal risk assessment model that it knows, or should know, is potentially harmful to children and families is at risk of significant legal liability. If children are harmed as a result of faulty decisions based on these models, agencies may be subject to legal remedies.[107]

Summary

The child welfare profession faces mounting moral and political pressures to improve its effectiveness and accountability, and to demonstrate its public value. Most child welfare professionals understand that the accurate and timely identification of children at high risk of maltreatment is the cornerstone of effective child protection. To achieve this end, child welfare organizations throughout North America have expended millions of dollars to develop, implement, and institutionalize formal risk assessment systems. The question remains whether the results have been worth the investment.

In many jurisdictions, estimates of future risk are still being made based largely on personal opinion and judgment. We continue to rely on tools that lack reliability and validity, while believing that these tools standardize and greatly improve decision making. We create idiosyncratic adaptations of existing models for our own use, and we support large-scale and costly implementation initiatives without sufficiently managing their overall impact on the service system. We conduct studies to validate models that were fundamentally flawed at the outset. We mandate the use of protocols that make little sense to the work force, and that are often abandoned in frustration by the staff who must use them. Striving for improved accountability, we "hard code" entire risk assessment models and instruments into child welfare information systems, further cementing our reliance on this technology, and creating potentially insurmountable challenges when changes are needed. And, since large-scale change has historically been so difficult for many organizations, it may ultimately be easier to support ineffective, even potentially harmful technologies rather than change them, both because of the financial investment already made, and because an overburdened work force cannot sustain another large-scale change. Unfortunately, perhaps because of the many other seemingly intractable problems facing the child welfare field, we appear to have a collective vulnerability to the promises of untested and unproven risk assessment models and technology.

The net effect may have been that, despite all good intentions and hard work, formal risk assessment may not have significantly improved services to children and families and, in some cases, it may actually have had a harmful impact. It is

imperative that we collectively re-evaluate our options, identify and capitalize on our strengths, and implement strategic measures that will promote the most ethical and effective use of risk assessment technologies to assure equitable and legitimate protective decisions for abused and neglected children and their families.

PART II: RECOMMENDATIONS

Recommendations are presented for each of the six issue areas identified and discussed in this document.

*A) **There is a lack of agreement regarding the proper scope and purpose of risk assessment technology in child welfare assessment and case planning activities.***

1) Formal risk assessment should be considered one tool in a broader, structured process of safety assessment and safety planning, family assessment, case planning, decision making, and ongoing risk analysis throughout the life of a case.

2) Formal risk assessment should be used by intake assessment caseworkers to guide decisions about whether children and their families should receive ongoing protective services from the agency; whether they should be diverted to other community service providers; or whether they should be closed at the intake level.

3) Agencies should not attempt to use hybridized instruments as both a formal risk assessment and a family assessment. Formal risk assessment requires measures that can estimate the likelihood of future occurrences of child maltreatment. Family assessment requires measures that guide the collection of data to identify family needs, strengths, and dynamics. These goals, criteria, methodologies, and uses of data are sufficiently different to warrant two different instruments and processes.

4) The child welfare profession should establish uniform terminology to clearly differentiate between formal "point-in-time" risk assessment using validated and standardized protocols, and the ongoing clinical process of observation and monitoring for indicators of potential harm. One possibility is to use the term, "risk evaluation" to represent formal, point-in-time, normed, statistically valid protocols

as a distinct sub-class of broader child welfare risk assessment activities.

5) Checklists and other clinical assessment tools should be developed to guide family assessment and decision making throughout the life of the case. These tools should be as empirically sound as possible, based on current research, and standardized to promote clarity, objectivity, and consistency among users. These tools should also incorporate the specific criteria and measures that have the greatest degree of relevance to the type of decision being made.

6) As there are often differences in the family dynamics associated with physical abuse, sexual abuse, and neglect, both risk assessment and family assessment protocols should incorporate and assess those criteria that are most relevant for each type of child maltreatment.

7) Formal risk assessment models and instruments should be developed only in collaboration with professionals who have specialized expertise in the construction, evaluation, and validation of such instruments. This responsibility should not be delegated to ad hoc committees of practitioners and administrators without such support.

B) Fundamental concepts, premises, terminology, and measures have not always been well defined or articulated, are often applied in an idiosyncratic manner, are highly inconsistent among risk models, and in some cases, are simply inaccurate. This creates ambiguity, confusion, and contradiction, and greatly increases the likelihood of error and bias in risk ratings and subsequent practice decisions.

1) The child welfare field should establish standardized and consistent terminology to represent all components and facets of the formal risk assessment process. All models should utilize the same terms for the same concepts and elements, including risk factors, protective factors, criteria, and measures.

2) The identification and substantiation of recent or current maltreatment, and the assessment of risk of imminent maltreatment should be clearly stated objectives for all safety assessments.

3) Safety assessment should not replace formal risk assessment. Both are essential components of a structured continuum of decision making, but their purposes are different, and the data is used toward different ends. Safety assessment evaluates both *abusus inibi,* (i.e. the presence of recent or current maltreatment and the potential for imminent maltreatment,) and factors in the family and community that can help mitigate maltreatment. With this data, children at risk of imminent harm can often be protected within their own families and communities, thereby minimizing family disruption and placement trauma. Formal risk assessment should follow safety assessment to discern the likelihood of a future recurrence of maltreatment. This data helps agencies determine which families should receive ongoing protective services from the agency, and at what level of intensity.

4) Safety plans should be developed for all children found to be recently or currently maltreated, or in volatile and unstable situations where they are at imminent risk of severe harm. Safety plans should focus only on assuring children's protection in the immediate term. Safety plans should not substitute for formal case plans. Case plans should be developed after completion of a comprehensive, individualized family assessment which provides relevant information to guide the selection and provision of ongoing services.

C) There are serious methodological problems in the design and development of many risk assessment technologies and models, and also in much of the research designed to evaluate and validate them. This not only impacts the reliability and validity of the models, but results in the communication of inaccurate information about their methodological soundness to the practice field.

1) National child welfare and social work organizations should establish strict and consistent standards to guide the development, administration, evaluation, and utilization of formal risk assessment technologies. In other practice fields, such as medicine, psychology, and education, evaluation and assessment instruments are standardized, extensively pre-tested, normed, have strict administration and scoring protocols, and require well-trained staff to administer and interpret them. The child welfare field should commit to the same high standards. Standards should also be adopted for research designed to evaluate the reliability and validity of formal risk assessment models.

2) All formal risk assessment protocols should be empirically derived – developed on the basis of findings and conclusions of well-designed and implemented research. All criteria and measures should be pre-tested and determined to have the requisite levels of reliability and validity prior to being used in any risk assessment protocol. The structure for data analysis, scoring, and ranking should also be based on scientific and statistical procedures that promote the highest possible levels of reliability and validity.

3) To promote accuracy and consistency in data collection and fairness to families, criteria and measures in risk assessment instruments must be clearly defined and measurable, and must leave as little room as possible for bias and misinterpretation.

4) Considering the current state of formal risk assessment technology, child welfare agencies should use reliable and valid actuarial risk assessment models for formal risk assessment in all child protective service cases.

5) Local jurisdictions should not typically attempt to adapt or modify the structure, criteria, or scoring of reliable and valid formal risk assessment models for their own use. Doing so can undermine the model's reliability and validity. If an organization is interested in enhancing and improving these models through further research and

development, or revising and/or re-validating a model for use with a specific target population, this should only be attempted with assistance from skilled researchers and statisticians who are well versed in the development and validation of actuarial decision-making models.

6) Consensus decision-making models that are based on credible empirical data, and that include relevant and clearly-articulated measures, may be appropriate tools to guide the ongoing clinical assessment of safety and risk, family assessment, and service planning. However, consensus-based models should not be used to estimate the likelihood of future occurrences of maltreatment in place of actuarial decision-making technologies, which have higher reliability and validity.

7) Child welfare administrators and policy makers should have access to resources to help them critically and objectively appraise research methodologies and claims. A centralized research clearing house which maintains the highest standards of scientific objectivity and disinterest[108] should be utilized to review published and unpublished research findings and to evaluate the study design, methodology, and conclusions of risk assessment research. The clearinghouse should also provide technical assistance in the design and implementation of risk assessment research.

D) A variety of systemic, bureaucratic, and individual barriers impede the large-scale implementation of formal risk assessment technologies by child welfare agencies.

1) System-wide implementation of formal risk assessment should be viewed as large-scale system change and should be guided by fundamental principles of change management. This includes educating local managers and practitioners regarding the model's utility and effectiveness, designing the most efficient and least disruptive implementation strategies, and reducing or eliminating

organizational barriers to successful implementation. Mandating formal risk assessment without considering its full integration with other casework and decision making processes will undermine its acceptance and effectiveness. Agencies must also make the commitment to support and sustain the use of risk assessment technologies over time.

2) Because of the inherent complexity of assessment in human services, and the high level of skill needed to gather and interpret assessment information, safety and risk assessments are best performed by highly skilled caseworkers with specialized training and prior child welfare experience. While these functions are typically, and appropriately, performed by intake caseworkers, many agencies assign newly hired caseworkers who have little training or practice experience to work in intake units. A lack of worker skill in interviewing and assessment will undermine even the most reliable and valid of protocols. It would be helpful if job classifications and salary levels for assessment caseworkers were upgraded to reflect these higher prerequisite qualifications.

3) Comprehensive training in prerequisite core-level assessment and interviewing competencies should always precede training in the use of specific risk assessment models or protocols. Training should also be provided for supervisors who are assigned responsibility to monitor their staff's assessment activities. Coaching and educational supervision should be supported by all local agencies to promote the transfer of learning and skill mastery.

4) Risk assessment models and forms should not be "hard coded" into computerized child welfare information systems. Information systems must be sufficiently flexible in their programming to accommodate rapid changes in risk assessment criteria, measures, and scoring protocols, as these are being continually developed and improved.

E) ***It is often expected that formal risk assessment activities should serve a variety of administrative, political, and systemic functions in child welfare organizations that have little to do with making accurate protective decisions for children.***

1) Agencies should not use formal risk assessment instruments for purposes other than that for which they were developed – to estimate the likelihood of a future recurrence of child maltreatment in families. More appropriate technologies must be developed to address other organizational and systemic needs, including case planning, public relations, quality assurance, communication, supervision, workload management, and monitoring and recording. Risk assessment cannot substitute for formal systems of data collection and recording to assure accountability.

F) ***A number of ethical and legal issues related to risk assessment have not been fully addressed.***

1) The child welfare profession must acknowledge and address the potential legal and ethical liabilities of continuing to use untested or unproven formal risk assessment models.

2) Considering the limitations of even the most well developed, reliable, and valid risk assessment technologies, agencies should not rely on risk assessment as the sole or even the primary resource to justify their casework and child placement decisions. Investigation with confirmed findings of abuse and neglect must remain the primary justification for opening non-voluntary cases for child protective services.

Sources and Notes

1. Cicchinelli (1995); English & Pecora (1994); Wald & Woolverton (1990).

2. Wald & Woolverton (1990).

3. Tatara (1996); Berkowitz (1991).

4. Macdonald (2001); Pecora, Whittaker, Maluccio, & Barth (2000); Baird, Wagner, Healy, & Johnson (1999); Milner, Murphy, Valle, & Tolliver (1998) as cited in Macdonald (2001); Schene (1996); English & Pecora (1994); McDonald & Marks (1991); Wald & Woolverton (1990); Cicchinelli & Keller (1990).

5. ***Note*** *A more in-depth discussion in monograph form is in press and slated for publication in spring, 2004.*

6. Nash & Bowen, 2002; English & Pecora (1994).

7. Camasso & Jagannathan (2000); Gambrill & Shlonsky (2000); Pecora, Whittaker, Maluccio, & Barth (2000); Lyons, Doueck & Wodarski (1996); Wald & Woolverton (1990).

8. Schene (1996); Cicchinelli (1995); English & Pecora (1994); Keller, Cicchinelli, & Gardner (1988) as cited in Baird (1999).

9. Cash (2001); Pecora, Whittaker, Maluccio, & Barth (2000); Cicchinelli (1995); Wells (1995); English & Pecora (1994); Doueck, English, DePanfilis & Moote (1993); Wald & Woolverton (1990).

10. Cicchinelli (1995); Wells (1995); Cicchinelli & Keller (1990).

11. Baird, Wagner, Healy, & Johnson (1999); Schene (1996); Curran (1995); English & Pecora (1994).

12. Baird & Wagner (2000); Johnson (1996).

13. Pecora, Whittaker, Maluccio, & Barth (2000); Doueck, English, DePanfilis, & Moote (1993); Cicchinelli & Keller (1990).

14. Cicchinelli (1995).

15. Pecora, Whittaker, Maluccio, & Barth (2000); Schene (1996); Wells (1995); Cicchinelli (1995); English & Pecora (1994); Doueck, English, DePanfilis, & Moote (1993); Wald & Woolverton (1990).

16. ***Note*** *See Rycus & Hughes (1998), Field Guide to Child Welfare for definitions and descriptions of a family-centered practice model for child protective services.*

17. Gambrill & Shlonsky (2000); English & Pecora (1994); Rossi, Schuerman, & Budde (1966) as cited in Baird, Wagner, Healy & Johnson (1999).

18. Wells (1995); Pecora, Whittaker, Maluccio, & Barth (2000).

19. English & Pecora (1994); Schene (1996); Holder & Morton (1999); Wagner, Johnson & Caskey (1999); Gambrill & Shlonsky (2000); Holder & Lund (1995); Pecora, English & Hodges (1995).

    Note *This list is not intended to be exhaustive, but simply sufficient to make the point.*

20. ***Note*** *The following 18 terms, all synonyms for either risk factors or protective factors, are used, often interchangeably, in the document, "Designing a Comprehensive Approach to Child Safety" (Holder & Morton, 1999): "safety concerns, "safety threat," "imminent danger of serious harm," "threat of harm," "threat to safety," "current danger," "current threat," "present danger," "impending danger," "emerging danger," "present-danger threats," "jeopardy," "threat to child safety," "threats of present danger," "threats of impending danger," "protective factors," "protective capacities," "control of threats."*

21. ***Note*** *Common sense would suggest there would be less confusion if the term, "safety factors," was used to describe factors that promoted safety, and "risk factors" was used to describe factors that increased risk. Using terms to represent the opposite of their customary meaning is unnecessarily confusing.*

22. Ohio Department of Job and Family Services, Family Risk Assessment Model (1995); New York State Risk Assessment and Services Planning Model (1994).

Note *New York State replaced its consensus-based risk assessment model with an actuarial model in the late 1990s. (Falco & Salovitz, 1997).*

23. New York State Risk Assessment and Services Planning Model (1994).

24. The *Child At Risk Field* (CARF) model, developed by ACTION for Child Protection, referenced by Cicchinelli & Keller (1990).

25. Holder & Lund (1995).

26. Ohio Department of Job and Family Services, Family Risk Assessment Model (1995).

27. New York State Risk Assessment and Services Planning Model (1994).

Note *This represents one of many examples of tautologies found in the risk assessment literature. A tautology is a phrase that simply repeats the same concept in different words in different parts of a sentence, rather than providing any new or clarifying information. Examples are: "A child is safe when free from harm;" or, "A child is unsafe when exposed to harmful circumstances." In both cases, we learn nothing new about the subject from the explanation in the remainder of the sentence.*

28. National Resource Center for Child Maltreatment (2002).

29. Lyons, Doueck, & Wodarski (1996); Cicchinelli & Keller (1990).

30. Lyons, Doueck & Wodarski (1996).

31. Lyons, Doueck & Wodarski (1996); Cicchinelli & Keller (1990).

32. Gambrill & Shlonsky (2000); Schene (1996); English & Pecora (1994).

33. Gambrill & Shlonsky (2000).

34. Pecora, Whittaker, Maluccio, & Barth (2000); Johnson, (1996); Doueck, English, DePanfilis, & Moote (1993); Cicchinelli (1995); McDonald & Marks (1991).

35. McDonald & Marks (1991).

36. Baird (2000); Gambrill & Shlonsky (2000); English & Pecora (1994); Doueck, English, DePanfilis, & Moote (1993).

37. English & Pecora (1994).

38. Wald & Woolverton (1990).

39. Pecora, Whittaker, Maluccio, & Barth (2000); Wells (1995); Cicchinelli (1995); Wald & Woolverton (1990); Selltiz, Wrightsman, & Cook (1976).

40. ***Note*** *Measures developed in this manner were found in all the consensus-based risk assessment models reviewed for this study.*

41. Ohio Department of Human Services, Family Risk Assessment Worker Manual (1997).

42. Webster's New Universal Unabridged Dictionary (1983).

43. Los Angeles County, Family Assessment Risk Variables (1996), adapted from (1989) Illinois Department of Children and Family Services, Risk Assessment Training Manual.

44. New York State Risk Assessment and Services Planning Model (1994) and derivatives: Risk Assessment Model for Child Protection in Ontario (2000), and New Brunswick Department of Health and Community Services Risk Management System (1999).

45. Ohio Department of Job and Family Services, Family Risk Assessment Model (2000); Washington State Department of Social and Health Services (2001).

46. Salter (1988, 1995).

47. DePanfilis & Scannapieco (1994).

48. ***Note*** *The evolution of confusing and contradictory language is illustrated by the use of the phrase, "reasonable efforts." The phrase was coined in 1980 in P.L. 96-272, the Adoption Assistance and Child Welfare Act, to describe the level of effort expected of child protective service systems to prevent placement and to promote permanence for abused and neglected children. As concern grew that many child welfare systems were compromising child safety in their efforts to meet the "reasonable*

efforts" requirements of P.L. 96-272, subsequent legislation, The Adoption and Safe Families Act (ASFA) was passed in 1997 to more clearly define "reasonable efforts" and to delineate specific circumstances of child abuse and neglect in which no effort was necessary to prevent out-of-home placement of children. Suddenly, in professional literature and conversation, it was declared that "reasonable efforts were no longer required in severe cases of abuse." The phrase "reasonable efforts" had evolved to become idiomatic for "unreasonable efforts."

In fact, it has always been a child welfare responsibility to make reasonable efforts to prevent placement and to reunite children with their families. Post-ASFA, it is still our responsibility to always make reasonable efforts to avoid placement. It is just that sometimes no effort is the most "reasonable" effort.

49. Schorr (1977) as cited in Baird, Wagner, Healy & Johnson (1999)

50. Rycus & Hughes (1998); Leung, Cheung, & Stevenson (1994); Hutchinson, Lloyd, Landsman, Nelson & Bryce (1983).

51. Schene (1996); Doueck, English, DePanfilis, Moote (1993); Cicchinelli & Keller (1990).

52. Doueck, English, DePanfilis, Moote (1993); Cicchinelli & Keller (1990) as cited in DePanfilis & Scannapieco (1994).

53. Wagner, Johnson & Caskey (1999).

54. DePanfilis & Scannapieco (1994).

55. Wagner, Johnson & Caskey (1999); Salovitz (1993); Ontario Association of Children's Aid Societies (2000); Ohio Department of Job and Family Services, Office for Children and Families (2003); New Brunswick Department of Health and Community Services (1999).

Note *It may be that the movement to do away with substantiation of maltreatment was precipitous. The factors investigated and confirmed to arrive at a finding of substantiation are basically the same as those necessary to register a safety concern in a safety assessment. The safety assessment instruments used by many states and provinces (including Michigan, Alaska, Ohio,*

Georgia, Indiana, Wisconsin, New Brunswick, New York, and Ontario) incorporate essentially the same assessment criteria. All were modeled after a safety assessment developed by New York State (1992). While there are minor differences between protocols in language and order of items, the criteria themselves are largely identical. The common criteria are listed below. The majority of these require identification and documentation (i.e. substantiation) of prior or current abuse or neglect, including acts of commission (has harmed a child) or omission (has failed to protect a child.)

1) *Caretaker caused serious physical harm to the child and/or made a plausible threat to cause serious physical harm.*
2) *Caregiver has previously maltreated a child in their care.*
3) *Caretaker's behavior is violent or out of control.*
4) *Caretaker fails to protect child(ren) from serious physical harm or threatened harm.*
5) *Caretaker describes or acts toward child in predominantly negative terms, or has extremely negative expectations.*
6) *Child's whereabouts cannot be ascertained and/or there is reason to believe the family is about to flee or refuse access to the child.*
7) *Caretaker has not, or will not, provide sufficient supervision to protect the child from potentially serious harm.*
8) *Caretaker has not, or is unable, to meet the child's immediate needs for food, clothing, shelter, and/or medical care.*
9) *Child's physical living conditions are hazardous and may cause serious harm to the child.*
10) *Child sexual abuse is suspected and circumstances suggest that child safety is an immediate concern.*
11) *Caretaker's drug or alcohol use seriously affects his/her ability to supervise, protect, or care for each child.*
12) *Child is fearful of caretakers, other family members, or other people living in or having access to the home.*
13) *Caretaker's explanation for an injury is unconvincing.*

In Michigan's validation study of their safety assessment instrument, 9 of the 14 factors were found to have a statistically significant relationship with subsequent harm. The five factors that could not be validated empirically included: "caretaker is violent or lacks control;" "caretaker refuses access to child;"

"child is fearful;" "suspected sexual abuse;" and "mental health problems." While the researchers identified the small sample size as warranting caution in generalizing conclusions, the majority of factors found to have a statistically significant association with subsequent harm were those that described conditions reflecting prior or current abuse or neglect. (Wagner, Johnson & Caskey, 1999.)

56. Rycus & Hughes (1998).

Note *The identification and substantiation of maltreatment is often viewed as contradictory to a family-centered approach to practice. However, the fundamental issue is not whether workers collect and document information about prior maltreatment, but how they do it. Clearly, in some cases, our ability to protect children requires that we complete a formal investigation, sometimes followed by prosecution, which are by necessity, both objective and adversarial in nature. However, in the majority of families, prior maltreatment can and should be discussed within the context of a collaborative and supportive relationship between workers and families. The goal is to explore the history and impact of precursor conditions and stressors that led to maltreatment, and to develop an intervention plan to prevent recurrences of maltreatment. Acknowledging and discussing maltreatment in an open, supportive, and nonjudgmental manner is ultimately more humanizing, sensitive, and effective than ignoring, denying, or discounting it. Such open dialogue gives families permission to discuss and deal with their issues constructively and to seek help when they need it, rather than feeling a need to hide or deny their distress. (Refer to the Forrester Family Case Example in the Field Guide to Child Welfare, Volume II,"Case Planning and Family-Centered Casework" for illustrations of methods to discuss maltreatment with family members in a sensitive and empowering manner.)*

57. Ruscio (1998); Johnson (1996); Blenkner (1954).

58. Cash (2001).

59. Macdonald (2001); Johnson (1996); Grove & Meehl (1996).

Note *There is a fallacy in characterizing actuarial models as cold, unfeeling, or compromising a client's dignity. Actuarial models are used to compile, record and analyze data -- not to collect it. They do not require replacing caseworkers with robots or computers, nor do they require caseworkers to gather the data in an impersonal, disrespectful, insensitive, or confrontational manner. In fact, the more empathetic, respectful, supportive, and empowering the caseworker completing the assessment, and the better the caseworker's clinical assessment skills, the more likely the data will be accurate, truthful, and thorough. The fact that we rely on statistical models and standardized "checklists "to record and analyze data to produce the most accurate conclusions doesn't imply it needs to be collected by interrogation.*

60. Wells (1995); Curran (1995).

61. Wollert (2002); Macdonald (2001); Ruscio (1998); Dawes (1993).

62. Macdonald (2001); Gambrill & Shlonsky (2000); Cicchinelli & Keller (1990).

63. Baird & Wagner (2000).

64. Gambrill & Shlonsky (2000); Doueck, Lyons, & Wodarski (1996).

65. ***Note*** *There are two ways an invalid risk assessment can be harmful. The most evident is its failure to identify children at high risk of harm, resulting in their serious injury or death. However, the identification of high risk when it does not exist subjects children and their families to unnecessary, disruptive, and often traumatic levels of authoritative intervention.*

66. Macdonald (2001); Johnson (1996); Cicchinelli (1995).

67. Ruscio (1998); Johnson (1996); Cicchinelli (1995).

68. Macdonald (2001); Johnson (1996).

Note *According to Johnson (1996), consistency and accuracy are relative terms. Accuracy means a statistically significant, better-than-chance accuracy, rather than perfect accuracy. The higher the statistical levels of accuracy, the more effective the*

instrument. The concept is comparable when applied to reliability (i.e. consistency).

69. Macdonald (2001); Gambrill & Shlonsky (2000); Ruscio (1998); Wald & Woolverton (1990).

70. Baird & Wagner (2000); Baird, Wagner, Healy & Johnson (1999); Lyons, Doueck, & Wodarski (1996); Camasso & Jagannathan (1995); English & Pecora (1994); Marks & McDonald (1989).

71. Macdonald (2001); Gambrill & Shlonsky (2000); Baird & Wagner (2000); Baird, Wagner, Healy, & Johnson (1999); Ruscio (1998); Grove & Meehl (1996); Dawes, Faust, & Meehl (1993); Dawes (1993).

72. Macdonald (2001); Gambrill & Shlonsky (2000); Ruscio (1998); Johnson (1996).

73. ***Note*** *Baird & Wagner (2000) contend that a designation of "high risk" does not equate with a "prediction" that a family will, in fact, have a reoccurrence of maltreatment. Actuarial risk assessment systems are designed to categorize or classify families into groups based upon the probability that maltreatment will reoccur. While the words "prediction" and "classification" are often used interchangeably in the literature, they connote different expectations. Prediction implies a dichotomous outcome -- either maltreatment will occur, or it won't. Most risk assessment models assign cases to more than two categories -- and some have used as many as six levels. In actuarial risk assessment, it is recognized that cases will "recidivate "at different rates – some higher, some lower – and then classifies them into groups accordingly. Classification of a family as "high risk" is not an assertorial of future maltreatment. However, it does indicate that these families may require more attention and services, because they tend to have subsequent incidents of child maltreatment at higher rates than families in lower-risk classifications.*

74. Pecora, Whittaker, Maluccio, & Barth (2000); Wald & Woolverton (1990).

Note *Consensus models are sometimes referred to in the literature as "matrix" approaches to risk assessment. Consensus models*

include Illinois, Washington, New York's original model, and their many derivatives. These are contrasted to actuarial or "empirical predictors" models. A third type of model is based on the Child Well-Being or Family Risk Scales (Magura & Moses, 1986,1987). Although sometimes called "risk assessments," these are actually assessments of child and family functioning rather than assessments of risk, and are more appropriately used to gather data for family assessment and case planning purposes.

75. Lyons, Doueck, & Wodarski (1996); English & Pecora (1994).

76. Macdonald (2001); Gambrill & Shlonsky (2000); Ruscio (1998); Dawes, Faust, & Meehl (1989); Meehl (1992) as cited in Ruscio (1998); Cicchinelli & Keller (1990).

Note *A comparable scenario would be to ask each local chapter of the American Psychological Association to periodically convene some of its members to revise the assessment criteria on the Child Behavior Checklist, a standardized screening tool used to identify children with emotional disturbance. Changes in the test would depend solely on the opinions and personal practice experiences of committee members. Mental health treatment programs would then use these revised instruments to determine which children would receive mental health services. Most of us would, quite justifiably, protest. Yet, we implicitly sanction this same process when we delegate the development of risk assessment protocols to ad hoc committees, or even to individual "experts," without exploring empirical data on which to test their assumptions.*

Gambrill & Shlonsky (2000) list a variety of factors, including errors in information processing and personal attitudes and biases, that can negatively impact the objectivity of decision makers. They include:

- *Selective perception (not necessarily seeing what is there)*
- *Sequential rather than contextual processing of information*
- *Faulty memory*
- *Lack of knowledge*
- *Lack of use of knowledge that is available*
- *Preconceptions*
- *Day-to-day mood changes that influence judgment*

- *Selective attention - attending to events that are vivid, and ignoring less vivid (but perhaps more important) data*
- *Influence by primacy - undue influence by what is first heard or considered, and the resistance to change initial beliefs in the face of challenges of new evidence*
- *Wishful thinking*
- *Seeking control*
- *Lack of interest in having a carefully thought out position*
- *Wish to appear decisive*
- *Disregarding data that do not support preferred beliefs*
- *Assigning exaggerated importance to data that supports preferred beliefs*
- *Using different standards to criticize opposing evidence than to criticize supporting evidence*
- *Attitudinal mind set in which client deficiencies are more strongly considered than client assets*
- *Focus on the role of personal pathology over environmental or other factors*
- *Inappropriately assuming that events that occur concurrently have causal relationship*
- *Time pressures and distractions may encourage a mindless, mechanical approach in which decisions are made without due consideration.*
- *Values and policies of agencies and the broader community may create pressures that bias decisions*
- *Pressure to conform*
- *Neglect of alternative views in a group that is focused on attaining agreement*
- *Tolerating feeble inferences, rewarding gold and garbage alike, and the buddy-buddy syndrome (a reluctance to criticize friends)*

Cognitive biases and errors in information processing highlight the importance of developing risk assessment measures that minimize their influence. Actuarial models, which are based on empirical relationships between certain variables and outcomes, are designed to reduce the impact of these biases.

77. DePanfilis (1996); Johnson (1996); Cicchinelli (1995); Cicchinelli & Keller (1990).

78. Cicchinelli & Keller (1990).

79. Macdonald (2001); Gambrill & Shlonsky (2000); Baird & Wagner (2000); Baird, Wagner, Healy, & Johnson (1999); Ruscio (1998); Grove & Meehl (1996); Dawes, Faust, & Meehl (1989); Dawes (1993).

Note *The following quote by Dawes (1993) reaffirms the superiority of actuarial models in decision making.*

"In the last 50 years or so, the question of whether a statistical or clinical approach is superior has been the subject of extensive empirical investigation; statistical vs. clinical methods of predicting important human outcomes have been compared with each other, in what might be described as a 'contest.' The results have been uniform. Even fairly simple statistical models outperform clinical judgment. The superiority of statistical prediction holds in diverse areas, ranging from diagnosing heart attacks and predicting who will survive them, to forecasting who will succeed in careers, stay out of jail on parole, or be dismissed from police forces... objections (to using statistical models) ignore the data from well over 100 studies, almost all of which show the superiority of prediction based on statistics rather than on experts' intuition... The objections to using statistics also ignore the ethical mandate that, for important social purposes such as protecting children, decisions should be made in the best way possible. If relevant statistical information exists, use it. If it doesn't exist, collect it."

80. Baird & Wagner (2000); Baird, Wagner, Healy & Johnson (1999); Falco & Salovitz (1997) as cited in Gambrill & Shlonsky (2000).

Note *The literature is clear; clinical judgment is not as accurate as statistical decision making, even when the judgments are made by persons with considerable experience and training (Meehl, 1986). Perhaps the hallmark of true "experts" is not the unwavering conviction of their professional knowledge and beliefs, but the full recognition of their potential fallibility, acknowledging their limitations when making life-altering decisions for families and children, and relying on whatever tools are available to minimize the impact of bias and information processing errors on their decisions.*

81. Macdonald (2001); Pecora, Whittaker, Maluccio, & Barth (2000); Gambrill & Shlonsky (2000); Baird, Wagner, Healy, & Johnson (1999); Lyons, Doueck, & Wodarski (1996); Schene (1996); Camasso & Jagannathan (1995); English & Pecora (1994); McDonald & Marks (1991); Wald & Woolverton (1990); Cicchinelli & Keller (1990).

82. Pecora, Whittaker, Maluccio, & Barth (2000); Camasso & Jagannathan (2000); Gambrill & Shlonsky (2000); Baird, Wagner, Healy, & Johnson (1999); Schene (1996); Lyons, Doueck, & Wodarski (1996); Curran (1995).

83. Gambrill (2000); Gambrill & Shlonsky (2000); Lyons, Doueck, & Wodarski (1996).

Note *The frequent publication of poorly constructed and executed research studies, and a prevalent tendency to misrepresent them as stronger than they really are, prompted Dr. Eileen Gambrill, incoming editor of the Journal of Social Work Education to write an editorial entitled, "The Honest Brokering of Knowledge and Ignorance"(2000). In this editorial, she called for methodological soundness, reporting accuracy, and full disclosure in social work research. She contended that caution was warranted in trusting conclusions due to problems found in many published studies. Among these problems were: vague definitions of key concepts and methodology; lack of information regarding reliability and validity of measures; the use of inappropriate statistical analysis; underplaying or not mentioning study limitations; inflated claims, or claims with no evidence provided; disguising weaknesses; ignoring alternative views or data that contradicted preferred positions; reliance on secondary sources which may misrepresent primary sources; and ignoring pertinent scholarly work outside of social work. She further suggested that many of these problems were "classic propaganda strategies."*

84. Gambrill & Shlonsky (2000).

85. Wollert (2002); Ruscio (1998); Johnson (1996); Dawes, Faust, & Mehl (1989).

86. DePanfilis (1996); Cicchinelli (1995); English & Pecora (1994).

87. DePanfilis (1996); Curran (1995); Cicchinelli (1995); Cicchinelli & Keller (1990).

88. Gambrill & Shlonsky (2000); Cicchinelli (1995).

89. Gambrill & Shlonsky (2000); Schene (1996); English & Pecora (1994); Fluke (1993) as cited in Lyons, Doueck, & Wodarski (1996) and in Johnson (1996); Cicchinelli & Keller (1990).

90. Doueck, English, DePanfilis & Moote (1993).

91. Pecora, Whittaker, Maluccio, & Barth (2000); Schene (1996); Curran (1995); Cicchinelli (1995); Doueck, English, DePanfilis & Moote (1993); Cicchinelli & Keller (1990); Wald & Woolverton (1990).

92. ***Note*** *Complicating this issue is a movement in child welfare staff development to discount or dismiss the relevance of knowledge competencies in favor of behavioral or "outcome-based" skill competencies, as if knowledge and skill were not inextricably linked. It must be recognized that child welfare as a practice field, and social work as a profession, are based on a large body of specialized knowledge, and that sufficient knowledge of a specific content domain is necessary to the effective application of any skill. Both knowledge and skill competencies must be fully integrated into training needs assessment and training delivery.*

93. Schene (1996); Fluke (1993) as cited in Lyons, Doueck, & Wodarski (1996); Cicchinelli & Keller (1990).

94. Pecora, Whittaker, Maluccio, & Barth (2000); Schene (1996); Cicchinelli (1995); English & Pecora (1994); Cicchinelli & Keller (1990).

95. Cicchinelli (1995); Doueck, English, DePanfilis & Moote (1993); Cicchinelli & Keller (1990).

96. Ruscio (1998).

97. English & Pecora (1994).

98. Schene (1996); DePanfilis (1996); Wells (1995); Cicchinelli (1995); Doueck, English, DePanfilis & Moote (1993); Cicchinelli & Keller (1990).

99. Lyons, Doueck, & Wodarski (1996); Curran (1995); Wald & Woolverton (1990).

100. Cicchinelli (1995); Wald & Woolverton (1990).

101. Rycus & Hughes (1998).

102. English, Wingard, Marshall, Orme, & Orme (2000).

103. Gambrill & Shlonsky (2000); Lyons, Doueck, & Wodarski (1996); Dawes, Faust, & Meehl (1989).

104. Schene (1996); Doueck, English, DePanfilis, Moote (1993).

105. ***Note*** *Over the past decade, there has been a movement within child welfare to discontinue the substantiation of abuse and neglect in child protective service cases. Reasons identified for the need to eliminate investigation and substantiation include:*

1) "Investigation and substantiation are not foolproof. CPS is unable to substantiate many cases of actual abuse and neglect, and some cases are substantiated inappropriately." While these concerns are legitimate, it is also true that past maltreatment remains highly associated with future maltreatment. If CPS investigation and substantiation are our best means of identifying prior maltreatment, it should be improved with appropriate training and tested technologies, not abandoned.

2) "We should seek other methods of identifying cases in need of protective services; we should move philosophically away from emphasizing past experiences to focusing on the future of the child through risk assessment." In fact, focusing on the child's future may require revisiting the child's past.

3) "It is more difficult to engage families in social work intervention when we are seen by families as intrusive investigators trying to assign guilt and even criminal responsibility for abusive and neglectful behavior." Yes, it is more difficult, but perhaps it is also necessary. Parents who perpetrate child abuse and neglect are a diverse group, with a varied mix of problems, strengths, and socio-economic challenges. Because of this diversity of possible need,

child protective service workers must investigate and assess each family situation, must retain a continuum of intervention strategies ranging from casework engagement to authoritative intercession, and must have the capacity, responsibility, and authority to make these important decisions regarding the best interventions for each case. Child protective services is one of the most difficult fields of practice in the social work profession, requiring a considerable arsenal of intervention knowledge and ability, and the expertise to differentially apply these interventions.

106. Curran (1995).

107. Personal conversation (2003), M. Freundlich, attorney, Children's Rights, Inc., New York.

108. ***Note*** *The term, "disinterest," does not mean "uninterested," but rather, "impartial, without selfish motive or interest, and gaining no personal advantage or benefit from the outcome."*

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