



## Risk assessment in care and protection: The case for actuarial approaches

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### Abstract

The assessment of abuse is a highly emotionally charged activity. The requirement to provide an accountable and transparent assessment process requires the development of actuarial devices and clearly enunciated decision rules. Risk assessment requires the application of ecologically valid, evidence-based approaches. Such approaches, commonly transcribed into actuarial systems, are usually incorporated into a clinical reasoning approach. Whilst academic debate tends to highlight actuarial approaches as superior to approaches based on clinical experience, both common sense and the demands imposed on practitioners via cross examination demand that best practice incorporate triangulated assessment utilising both actuarial and clinical approaches to assessment. This article outlines a triangulated assessment and reporting strategy and its application to a case study.

### Keywords

*developmental psychology, child protection, psychological assessment, actuarial approaches, decision making*

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### Introduction

Decision making in psychology is generally an uncertain process and in forensic psychology is oriented towards identifying, assessing and quantifying risk. Risk can be defined as a social construct invented to cope with change and the uncertainties of life (Mellers, Schwartz & Cooke, 1998). Risk refers to both the likelihood or occurrence of a specific event, and the severity of that event.

The rationale for risk assessments is based on the observation that child abuse assessments have to walk a tight line between the fear they are over-pathologising 'problematic' behaviours as abusive, managing perceptions of an increase in child abuse in the general population, and moderating the political reality that resources are scarce (Budd, 2001; Budd, Poindexter, Felix & Naik-Polan, 2001; Herbert, 2000; Spencer,

2001). The type of strategy an agency adopts to establish abuse may determine the perception of it. For instance, an investigative agency that seeks confirmation of abusive behaviours is more likely to over-represent abuse (the self-fulfilling hypothesis) than a risk assessment strategy that seeks to exclude families on the basis of specific indicators that must be present for a decision to intervene. The current article reviews two kinds of assessment strategies – an actuarial approach and a structured clinical reasoning approach based on the development of an expert system - and applies them to a case study.

### Why we need actuarial approaches

At the heart of the criticisms of parenting assessments is the problem of what constitutes an 'adequate' level of parenting. It is necessary to have some understanding of what are our

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'bottom lines' in this area. However, Budd et al. (2001) have suggested that parenting assessments, where they are used to determine if a child should return home once removed, often involve a higher definition of parenting than do assessments of parents in the original assessment to identify if a child is at risk. In other words, the definition of what constitutes an appropriate level of parenting competence is often variable. This problem is often reflected in the term 'good enough parenting' (Winnicott, 1964). Budd (2001) refers to it as 'minimal parenting' and criticizes many parenting assessments for focussing on 'optimal' parenting rather than minimal parenting. Associated with this concentration on optimal parenting has been a failure to focus on parent strengths as well as weaknesses.

Decisions about outcomes not only reflect judgements about the client/family, but also judgements about what are the decider's best interests (Daniels, 2000), or as Dalglish (2000) terms it, their 'threshold for action'.

Organisational allegiances, ideological preferences, prior experience, and the focus of the assessment (client-based, family-based, worker-based, systemic etc) can be used to predict the threshold for action and the judgements that flow from it about whether or not the report is 'sound' and the recommendations 'fair'. The 'threshold for action' is not much more than the expert opinion or recommendations a psychologist makes. In fact, of course, decisions are made by balancing allegiances and the product of good decision making means making explicit what the priorities are.

Daniels' (2000) study demonstrated Dalglish's 'threshold for action' within a group of 128 experienced British social workers by identifying the differing value systems that a worker might have. Depending on whether they prioritised emotional closeness, risks of sexual abuse, attachment, or management support for their actions, differing outcomes from the same investigation were likely.

Arad (2001) also undertook a study in which child protection experts were asked to complete a questionnaire in which they identified the kinds of variables or themes underlying decisions to remove a child. Essentially, Arad

asked, does the decision to remove a child depend more on the assessment of the parent's abilities to provide a good psychosocial developmental environment for the child, or upon the kind of abuse suffered by the child (risk assessment)? His research supported the contention that the kinds of variables identified by workers as indicating risk to a child are different from the variables that are linked to a decision to remove a child. In a sense this is not surprising. Decisions about moving a child out of a family incorporate the likely response of a parent to supervision, the interventions available, and other resources, as well as the evaluation of the immediate risk to the child. In the absence of hard data about what the relative outcomes are for various risk assessments, it remains an open question as to what is the best fit between parenting assessments and risk assessments in the decision to remove a child.

### **Case study: The Dan Family**

In 1997 I was requested to provide a report on whether a child (seven year old Chloe) should be returned to middle class parents with otherwise few risk indicators. However, they had so abused their second (and youngest) child (18 month old Robert) that he was now functionally blind and developmentally delayed. The baby had been shaken, and bone scans had revealed a pattern of abuse. Both parents resolutely opposed the diagnosis of shaken baby syndrome and denied their involvement. There were no markers of abuse regarding Chloe.

The family was unusual in that there were no obvious markers of difficulty other than the notification. Both parents presented as intelligent, articulate people with good jobs, no anti-social backgrounds and no history of substance abuse. The parents were well integrated in the community, had the same general practitioner for all of the children's life, and the general practitioner had never noticed any problems. The children had a wide circle of friends (both peer and adult) and good school attendance records. The extended family was closely involved and supportive of the family. Following the abuse of the child, the older girl was removed and placed with an aunt, and the Department of Community Services sought to have the child remain out of the home for the foreseeable future.

My report utilised a literature review as a component of the investigation. The advantage of this case being controversial is that I continued to hear about the progress of the case up until 2001, effectively providing a 5 year follow-up period. The names and details (including those in Table 1) have been changed to protect the identity of the family.

*Level of risk to Chloe. It is not possible to reliably assess the level of risk that Chloe might face if returned to her parents. This is because the parents are emphatic in the denial of any charge of child abuse, and attempts to adequately measure the potential level of hostility were thwarted by their deliberate manipulation of information to appear virtuous.... To the best of my knowledge there is no proven allegation of abuse in regards to Chloe. However, the very severe abuse directed towards Robert is a major concern. Further, the inability of the family to accept that abuse is a most worrying factor. Explaining why Robert has been abused, and Chloe apparently not, would seem to be important, but no such explanation can be obtained from the parents due to their denial of abuse in the first place.*

*American research suggests that some parents 'selectively' abuse children, that is, children possess 'triggers' to which parents respond. One such trigger often mentioned is the notion that one child will have some kind of pre-existing problem (such as a developmental delay or physical disability) and that this leads to a crisis point in the parent, with abuse resulting. If such a scenario can be invoked, then it may be possible to assess risk factors for Chloe that may be qualitatively different to Robert....*

*Conventional research suggests that separation from family of origin can produce trauma at two specific levels. The first is a problem of breaking firm attachments that would seem to have been established, not only to the parents, but also to the extended family system. Children tend to interpret such breakages not as something bad the parents have done, but as something they, the child, have done. Such beliefs can become entrenched and injurious to the development of self-esteem as the child matures. The second is in being able to guarantee a stable foster placement for the child.... (It is) my opinion that, on balance, more harm could be generated by removing Chloe from the family than from returning her.*

My report and its conclusions were not accepted by the Department of Community Services, who sought to treat me as a 'hostile witness' in the procedures after this. The difficulty appeared to be a result of the clash that occurs between 'gut

feeling' that these were 'bad' parents who should not get their children back, and analytical thinking that needed to identify established risk factors before the decision to take a certain course of action could be followed. Five years later I am informed that there are not only no further problems with the daughter, but that the son had been restored to the family. At the time I undertook this assessment I was unaware of any tools that would help quantify the risk assessment process, or provide a means for making the process of assigning risk a more transparent process than relying on my clinical opinion buttressed by reference to the literature.

### **The problem of accountability**

In the real world decisions involve uncertainty and conflict, and hence are much more likely to be affected by arousal (psychologically we experience arousal as anxiety). Accountability for making decisions increases both loss aversion (minimisation of potential negative consequences) and decisional avoidance (e.g. procrastination). As a result, accountability enhances conservatism. Similarly, anticipating regret can lead to inaction. Interestingly, procrastination will occur even when the negative consequences of inaction (e.g. child suffering abuse) is greater than the likely consequences of the action (e.g. significant disruption in attachments to a loved parental figure).

If we refer to the Dan case we can see how these factors might operate. Firstly, there is a fear of severe abuse. Even though research suggests that such a fear is a low probability event, the tendency to reduce one's risk of a loss may lead to a decision that over-emphasises the chance of the risk occurring (Rose, 1998). On the other hand, it can also be construed that my opinion was based on a desire to avoid regret. That is, having prioritised the strength of the attachments of the daughter to her parents, my concern was to minimise the unintended consequences of acting on a fear of child abuse. But, whilst I can present my recommendation in terms of adherence to the literature, it can also be construed as a reaction to the anticipation of regret (over the decision).

The assessment of risk differs according to the selection of outcome. For instance people who

prioritise loss over gain will make more conservative assessments of risk. In general, people tend to prioritise losses over gains, but differences occur whether they are prioritising the probability of a loss or the magnitude of a loss.

In relation to the Dan case, the probability of abuse occurring to Chloe is very low. This can be emphatically stated in that there is no evidence of any abuse ever having occurred to this child. However, given the dramatic and tragic abuse to her younger brother the fear is that this child could be hurt. The 'loss' in this case is harm to the so far non-abused child. An assessment of risk will depend on whether one is assessing for the probability of abuse (will it occur) versus the magnitude of the abuse if it occurs (severe injury based on the history of the other child). Conservatism (in this case retaining the management decision of safety first or not reuniting the child with her parents) is clearly more influenced by magnitude of the loss (if it were to happen) than probability, as the most likely probability is extremely low.

### **Decision making in the clinical context: Actuarial approaches**

Actuarial methods, by definition, require research to identify the variables that are of use in the specific population you are examining. In essence, actuarial approaches assign beta weights (derived from multiple hierarchical regression) to variables that have been established by empirical studies as likely to predict the target behaviour. An individual is assessed on each of these variables, his or her score 'weighted', and the resultant variable string added. Should a specific cut-off score be obtained a suitable risk rating is applied.

The information to complete the actuarial device could be available on file now and simply need analysis, or it may require dedicated data gathering exercises. When obtained, the data is coded and entered into a regression equation that predicts the variable of interest (likelihood of re-abuse). For any new case, we can achieve a prediction of likely outcome by simply measuring these aforementioned variables, assigning the weight and adding them up.

Whilst the literature consistently prioritises the superiority of actuarial approaches (see Taylor, 1998) there is considerable doubt about the real

world validity and ability of actuarial methods to respond to changing circumstances (see Goddard, Saunders, Stanley & Tucci, 1999; Mellers et al., 1998). Recent research in the child protection field has begun the process of developing potential actuarial devices. The work of Baird and colleagues (Baird & Wagner, 2000; Baird, Wagner, Healy & Johnson, 1999) has established an actuarial assessment structure. Their research, utilising over 1300 cases has identified that of all methods tried, actuarial assessment provided both the most reliable assessment (highest inter-rater reliability) and highest validity (accurate assignment of cases to high, medium and low risk categories).

This research has been translated into an Australian jurisdiction (Johnson, Wagner & Wiebush, 2000). The South Australian study is based on 674 families for which actual outcome data is known over a 12 month period. This study also provides some good data on re-occurrence rates of child abuse. It found that for a sample of all families recorded over a 12 month period in the Departmental data base and meeting specific abuse criteria, one third were re-notified within 12 months with 21.8% reporting a substantiated re-abuse incident.

Table 1 outlines the specific variables utilised in the actuarial assessment for emotional abuse and physical abuse, and their application to the Dan case. Note that some variables have a built in weighting, allowing for more importance to be attached to some variables than to others.

Table 2 reports the various cut-off scores developed for assigning risk, based on the 11 items for each abuse category in Table 1. The important findings of the South Australian study were the correct classification rates. That is, how many low risk families went on to a subsequent notification? The percentages in Table 2 show firstly, the notification outcome from the 12 month follow-up for the sample of 674 cases on the data base meeting the requirements for the study. The second percentage represents the actual confirmations of abuse. As can be seen, overall there is strong support for the use of the classification system despite a number of false positive (e.g. families identified as high risk for which no subsequent notification is confirmed), and more importantly missed cases (number of low risk cases for whom a subsequent notification does occur).

**Table 1. Risk assessment items and application to the Dan Family case study**

<b>Emotional abuse</b>	<b>Physical abuse</b>	<b>Dan Family case assessment</b>
Current investigation is for neglect or emotional abuse <i>Emotional abuse =; Neglect =2</i>	Current investigation is for abuse <i>Neglect = 0; physical, sexual or emotional abuse = 1</i>	<b>Score 1</b> Based on injury to Robert
Prior investigation reports of neglect or emotional abuse <i>None = 0; One or more = 1</i>	Nature of prior intakes. (score highest) <i>No prior intakes = -1; Prior intakes – non child protection =1; Prior child protection notification = 2; Prior confirmation of physical, sexual or emotional abuse = 3</i>	<b>Score -1</b> No prior intakes
Number of prior intakes (child protection and other) <i>None = -1; One = 1; Two or three = 2; Four or more = 3</i>	Child characteristics (check all that apply and <i>add</i> for score) <i>None = 0; Yes – special needs = 1; Yes - history of offending = 1</i>	<b>Score 1</b> Robert has special needs as a result of injury, but probably before injury as well <b>Score 0</b> Chloe has no history of, or current special needs
Family with one caregiver only <i>No = 0; Yes = 1</i>	Number of children confirmed for abuse or neglect in the investigation <i>One = 0; Two plus = 1</i>	<b>Score 0</b> Robert only notification
Age of youngest child in family at the time of investigation <i>13 or older = -1; 8 to 12 = 0; 7 or younger = 1</i>	Prior alternative care placements of household children <i>No = 0; Yes = 1</i>	<b>Score 0</b> None recorded prior to removal of Robert
Number of children confirmed for abuse or neglect <i>One = 0; Two plus = 1</i>	Age of youngest child in family at the time of investigation <i>13 or older = -1; 8 to 12 = 0; 7 or younger = 1</i>	<b>Score 1</b> Robert is still an infant
Current investigation found child to be physically harmed <i>No =0; Yes = 1</i>	Age of youngest child in family found injured or physically harmed <i>No injury = 0; 13 or older = 0; 8 to 12 = 1; 7 or younger = 2</i>	<b>Score 2</b> Robert is an infant
Care giver has history of domestic violence <i>No =0; Yes = 1</i>	Caregiver(s) has alcohol or drug abuse problem that contributed to the incident <i>None= 0; Alcohol only =1; Drug only or mixed alcohol and drug =2</i>	<b>Score 0</b> No drug or alcohol history identified
Adult caregiver(s) has a current or prior assessment history of alcohol and drug abuse <i>No =0; Yes = 1</i>	Caregiver(s) has a history of domestic violence <i>No =0; Yes = 1</i>	<b>Score 0</b> No DV/AVO history
Adult caregiver(s) has current or prior assessment history of significant parental skill deficits <i>No = 0; Yes = 1</i>	Adult caregiver(s) has current or prior assessment history of significant parental skill deficits (enter highest) <i>No = 0; Yes, other than discipline related = 1; Yes, excessive or inappropriate discipline =2</i>	<b>Score 0</b> Note there are no <i>prior</i> assessments of skills deficits despite the fact that clearly the abuse identifies some kind of self-regulatory deficit.
Family has received financial assistance prior to the investigation <i>No = 0; Yes = 1</i>	Caregiver response to the investigation <i>Caregiver(s) cooperated with investigator = 0; One or more caregiver(s) did not cooperate = 2</i>	<b>Score 2</b> Whilst both parents cooperate with the Department over ongoing care, they fail to provide information about what actually happened. However, this is a very hard to score item.

**Total score: Robert 6; Chloe 5. Medium risk rating.**

**Table 2. Risk ratings for actuarial items from the South Australian Risk Study (Johnson et al. 2000)^.**

Rank	Total score	% Neglect*		% Physical/ sexual abuse		% At risk of any abuse	
		Notification %	Confirmation %	Notification %	Confirmation %	Notification %	Confirmation %
Low	-2 to 2	8.0	4.3	5.9	2.5	6.8	3.4
Medium	3 to 7	22.7	13.9	21.5	8.8	31.0	18.2
High	8 to 10	36.9	21.3	31.9	11.9	48.4	27.7
Very high	11 or more	63.9	42.6	37.1	25.7	63.6	43.0

^Notification rates and confirmation rates are shown within each of the risk categories.

\*Items for neglect are not shown in Table 1.

Applying this process to the Dan case, I use the second column (assessing risk of physical abuse), but we need to consider whether risk is being assessed for Chloe or for Robert (Table 1). Expressed another way, I can argue that Robert or Chloe have a 1 in 5 chance of being re-notified for physical abuse but a 1 in 3 chance for notification for any abuse, but probably only a 1 in 10 chance of actually being physically re-abused and a 1 in 5 chance for any abuse.

On the basis of the actuarial risk the finding of a moderate risk of abuse probably vindicates the recommendation to return Chloe. It seems that the risk of harm associated with removing the child is greater than the probable risk of harm of leaving the child in the family. It raises issues about how to interpret risk ratios when a child is as vulnerable as Robert, and the objections raised in court to the conclusion of my report can be understood in terms of accountabilities. Despite the greater vulnerability of Robert, his risk rating remains 'moderate'.

At the human level, there is little doubt that emotion continues to play a role in the decision making process. A year after my initial assessment, a re-assessment of the child was ordered, and the magistrate requested I conduct it. The supervising office refused to allow me to conduct the assessment. Within two years Robert had been returned to his family, the family had no further notifications and was cooperating well with Departmental supervision. A further two years on there were still no re-notifications.

In reality, the most likely outcome of any assessment is a need to use actuarial methods but then to carefully use clinical discretion to complement the assessment. Blackburn (1993) refers to this alternative as 'theory building' in

which the focus of the assessment is to build up a picture of the client and to develop a theory or rationale for accounting for the behaviour and hence a predictive map for future behaviour.

### **Decision making in the clinical context: The expert system**

Expert systems act to synthesise previous cases and provide a decision tree along which new cases can be decided. Expert systems can be rigid, or they can be updated to include new information as it becomes available. There have been some attempts to establish decision trees leading to automated decisions in the child abuse area, but at this stage no system has revealed good predictive validity (Little & Rixon, 1998). Expert systems owe considerably to the field of artificial intelligence and model decisional pathways by the use of decision structures. Their advantage in forensic fields is that they allow the rule driven application of clinical variables to arrive at a consistent or reliable decision. A decision tree in this context represents a graphical depiction of the questions that must be asked, and answered, to arrive at a specific outcome. Since 'small is beautiful', the task is to produce the smallest tree that produces the best outcome (yet see Dalgleish, 1998, for a criticism of this approach). Without reproducing the decision tree here, it is important to understand the decision rules that follow from the application of the reasoning process.

Little and Rixon (1998) presented an attempt at establishing a 'demonstration' tree with 20 cases to show how such a system might look. A number of elements make up this decision tree. The output is the judgment of risk, quantified as high, medium or low. It remains, of course to assign actions to those ratings, and this

ultimately remains both a political and clinical decision at one and the same time.

A context element is included in the heuristic. The context refers to whether the tree is being generated on physical, emotional or neglect types of abuse. In practice these abuse types co-exist, and thus a decision tree might have to be generated for each context, and results from each application aggregated according to some, as yet undefined, rule. Decision elements in this study were:

***Attitude of carers to child*** (coded as positive, ambivalent, negative, strongly negative). Modification of the value can occur depending on the possible mitigation of the most negative carer by positive attitudes of other available carers. In addition, it is recognised that the value of their elements may vary for each child in the family. As the Dan case shows, children are not necessarily all equally at risk.

***Ability of carers to do caring*** (coded as positive, adequate, negative, very negative). A number of variables are utilised to define the loading on this element. Weaving together these variables can be subjective, and in true expert systems each of the sub-variables would have a loading and a weighting (recognising that some variables may be more important than others). Examples of such variables include substance abuse, maturity, isolation, and carers' relationships to each other. Carers may moderate each other's loading.

***Impact on the child's behaviour*** (coded strong, weak, none). This variable recognises the 'victim characteristics'. The behaviours of the child may or may not interact with the abuse situation (e.g. attention deficit disorder type behaviours, excessive crying, and so forth).

***Previous record of instances of abuse*** (coded as highly negative, negative, none, positive, unknown). This history or static risk variable takes into account previous notifications, coding for both frequency and severity. Positive ratings are given if a negative event was followed by positive (and successful) attempts on the part of the parents to correct problems.

***Seriousness of actual or potential abuse*** (coded as high, medium, low, no evidence). Seriousness of injury is rated, as is the deliberateness category. Deliberate injuries that might not be very serious can gain a higher rating than

accidental very serious injuries. Rating neglect and emotional abuse in this scenario requires considerable subjectivity.

***Vulnerability of child*** (coded as high, medium, low). Another child characteristic, this refers to static risk factors of being a victim (e.g. disability, age). The reasoning here is the younger the age the more vulnerable the child.

***Abuser's current immediacy and impact for child*** (coded high, medium, low, none). This is a proximity measure, conceptualised as the amount of access the abuser has to the child. Immediacy values could be modified by the presence of a supervisor, for instance.

Prior to considering the application of this system an important definitional issue has to be considered. There is confusion about what constitutes attitudes and behaviours in parenting skills. Dalgleish and Drew (1989) define 'aspects of parenting' as essentially behaviours and experiences of the parent that prevent them from recognising and meeting the needs of their child. Meyers and Battistoni (2003) suggest that parenting attitudes are based on their current self-esteem, social support, domestic violence victimization, and substance abuse, as well as their childhood history of physical and sexual abuse. Yet, much the same definition appears to be incorporated in parental abilities as well (Little & Rixon, 1998). For the purpose of the current review, parental abilities represent the behaviours parents do as operationalised in meeting their child's need, whilst attitudes reflect the experiences parents have had that might have left bias or problems in acting on the behaviours necessary to meet their child's needs, or to recognise them. Thus substance abuse as an experience may have prevented a parent from developing empathy, thus affecting parental attitude, whilst current substance abuse may prevent the parent from actually caring for the child, hence reflecting its impact on parental abilities. In essence, it proves difficult to operationalise the difference between parenting attitudes and parenting abilities.

The essence of an expert system is to detect the rule that links all these elements in the cases provided. Once the rule has been learnt, and shown to be applied successfully, it can be generalised to new cases. In Little and Rixon's

(1998) system, two variables (ability and attitude) appear most capable of classifying cases against the criterion of actual classification. Essentially this system arrived at the following rule for the classification of cases:

1. If the carer's ability is positive then the risk is low.
2. If the carer's ability is very negative, then the risk is high.
3. If the carer's ability is negative, then the risk depends on the carer's attitude towards the child. If this is negative or worse, then the risk is high. Ambivalent carer's attitude was further modified by seriousness and vulnerability. High serious/vulnerability loadings turned ambivalent attitude to high risk, otherwise risk was medium.
4. If the carer's ability is adequate, then the risk is dependent on the carer's attitude. If this is negative or worse, then the risk is medium, otherwise a positive carer's attitude results in a low risk rating.

These rules then can form the basis for decision making.

We can see how this might apply in the Dan case. I might rate the carers' ability to care as high. Risk should, consequently, be low. This is so, even if the abuse we are concerned about is serious and non accidental. However, such a judgement only applies to Chloe. Ability to care for Robert would be judged as negative given the evidence of bone scans that showed old injuries. Decision rule 3 states that if ability is negative (but not very negative), we assess for attitude. A positive carer's attitude leads to either a low or medium risk rating, irrespective of level of seriousness of the abusive act. Clearly, in relation to Robert, high vulnerability and high seriousness moderate positive carers' attitude and lead to a conclusion of medium risk.

Comparing the two systems, the actuarial scale results in an equivalence between risk assessment for Robert and for Chloe, whilst the expert system method identifies a medium risk factor for Robert but low risk for Chloe. The principle of triangulation in assessment requires multiple assessment strategies using multiple assessment data. The best practice model would be to combine differing assessment strategies - where the results cohere, confidence in the outcome can be gained. Where the various

outcomes differ, less confidence in the risk rating occurs. In the current case the decision to return Chloe to her parents can be confidently stated. There is more range in the estimate of risk for Robert, hence a more conservative decision (not returning him until further review of the family has taken place) appears to be warranted.

### **Criticisms of actuarial approaches**

Problems with actuarial approaches are that they can be considered to limit the flexibility available to the clinician through specific personality, behavioural or contextual factors unique to that individual; that such approaches undermine the personal quality of the practitioner that is acquired through experience; that the data upon which such measures rest are not necessarily generalisable to the person or population under study; and that such assessment strategies are ideologically driven and promote a false 'scientism' at worst, and at best, are a product of reductive empirical principles (Hollin, 2002).

Actuarial methods also suffer from another significant problem. Data collection (in the main, the assessment) is not standardised (Goddard et al., 1999). Different interviewees and psychologists will go about their assessment in different ways, thus making it difficult to assume the data collected is equivalent (see for instance, Davey & Hill, 1999). On one hand, risk assessment instruments and check-lists seek to standardise these different assessment strategies, but do so at the risk of lowering or reducing the skill of some workers towards the 'lowest common denominator'. Such a process can end up with a bureaucratic rather than a clinically acceptable decision (see Goddard et al., 1999).

The Australian jurisdiction also has to grapple with not only multicultural approaches to parenting, but also with the issues surrounding the political and social justice issues raised in intervening in indigenous families (D'Souza, 1993). The cross-cultural assessment of risk and how one weights the special circumstances involved in such situations is yet to be formally examined or quantified in Australia or elsewhere. Such difficulties represent a limitation on the confidence we can hold about evidence-based approaches for groups where

there is, as yet, little or no evidence about what the key variables are for predicting abuse and response to interventions.

## Conclusion

The discussion has centered around the relative advantages of formalising risk assessment in child protection, despite the recognition of the inherent dangers in so doing. However, the need to increase accuracy and transparency of the assessment process, and to respond efficiently to potential risks whilst at the same time avoiding over-pathologising behaviour, are genuine requirements in the child protection arena. Actuarial based assessments provide one means to do this. The current discussion utilised a case study to demonstrate how such decisional mechanisms could be applied. Whether agreement with the outcome is achieved or not, it provides for transparency in the data collection and reasoning process, and hopefully a fairer decision than simply relying on clinical judgment. Clearly, evaluation of such systems can only occur if they are used, and the relevant authorities make available the data necessary for their evaluation.

## Note

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