



Predicting relapse of problematic child-rearing situations



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ABSTRACT

Background: The development and evaluation of risk assessment instruments for child maltreatment is still in its infancy, both in the Netherlands and internationally. The aim of this study was to examine the predictive validity of a structured clinical judgement instrument – the Check List of Child Safety (CLCS) – that is widely used in the Netherlands. The second aim was to examine the predictive validity of a newly developed actuarial risk classification that is based on variables measured with the CLCS.

Method: The sample consisted of 3963 Dutch families who were under the supervision of the Dutch Child Welfare Agency (CWA) between 2011 and 2013 because of problematic child-rearing situations. Relapse was defined as restarting treatment by the CWA because of newly substantiated problematic child-rearing situations. The actuarial risk classification was developed by means of a CHAID analysis. The predictive validity of the CLCS and the actuarial risk classification were examined by calculating several performance indicators (sensitivity, specificity, false positives, false negatives and AUC values).

Results: The predictive validity of the CLCS was poor, with a non-significant AUC of .530, meaning that the CLCS performed no better than chance. The predictive validity of the actuarial risk classification was moderate, with a significant AUC of .630.

Conclusion: The actuarial risk classification not only outperformed the CLCS, but is also time-saving in practice since it comprises only variables that are significantly related to relapse.

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1. Introduction

Child protection workers have to make extremely difficult decisions about whether to intervene in order to safeguard a child's welfare, and how best to do so (Arad-Davidson & Benbenishty, 2008; Baird & Wagner, 2000; DePanfilis & Girvin, 2005; Dorsey, Mustillo, Farmer, & Elbogen, 2008; Pfister & Böhm, 2008). Identifying risks of maltreatment should guide these decisions. In recent years, there has been a shift in the field of child protection from largely unstructured clinical risk assessment to the widespread use of standardized risk assessment instruments (Price-Robertson & Bromfield, 2011). Despite this shift, the development and evaluation of risk assessment instruments in the field of child protection is still in its infancy. Risk assessment instruments are frequently implemented without proper empirical evaluation, both in the Netherlands (Ten Berge, 2008) and internationally (Knocke & Trocmé, 2005), and thus limited knowledge is available about their validity and effectiveness (Barlow, Fisher, & Jones, 2010). Therefore, the first aim of this study was to examine the predictive validity of the risk assessment instrument most widely used in the Netherlands, namely the Check List of Child Safety (CLCS; Ten Berge & Eijgenraam, 2009). The CLCS was implemented with little or no

empirical validation and it is therefore important to find out how well this instrument actually performs.

The CLCS is based on clinical judgement, which is one of the major approaches to risk assessment in child protection, besides the actuarial approach. The main difference between the clinical and the actuarial approach is that in clinical approaches, conclusions are based on the judgement of a professional who combines and weighs information in a subjective manner, whereas in actuarial approaches, conclusions are based solely on empirically established relations between risk factors and child maltreatment (Dawes, Faust, & Meehl, 1989). Clinical instruments can be further divided into (a) unaided decision-making based on experience, knowledge and intuition (unstructured clinical judgement), (b) tools based on the opinions of experts, but often without an empirical basis (consensus-based instruments), and (c) empirically based tools that leave the final decision-making process to the professional (structured clinical judgement; SCJ).

Clinical approaches are most common in child protection practice, both in the Netherlands and internationally, despite the fact that studies indicate that most clinical methods, including unstructured clinical judgement and consensus based methods, perform questionably in practice (Arad-Davidson & Benbenishty, 2008; Baird & Wagner, 2000; Barlow et al., 2010; Camasso & Jagannathan, 2000; D'Andrade, Benton, & Austin, 2005; DePanfilis & Girvin, 2005; Dorsey et al., 2008; Knocke & Trocmé, 2005; Lyons, Doueck, & Wodarski, 1996; Munro, 1999; Pfister & Böhm, 2008; Wald & Woolverton, 1990). Validation studies have

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even shown that some widely used clinical instruments perform no better than chance, meaning that in many cases an incorrect judgement is made (Baird & Wagner, 2000; Barber, Shlonsky, Black, Goodman, & Trocmé, 2008). This leads to inappropriate decisions, resulting in the overuse of out-of-home placements or in possibly repeated maltreatment (Baird & Wagner, 2000; Gambrill & Shlonsky, 2000).

It is therefore surprising that actuarial methods are used so little in child welfare. Actuarial methods remain controversial in child welfare, despite the fact that studies have consistently shown that most actuarial methods perform moderate, whereas most clinical instruments perform poor (e.g., Baird & Wagner, 2000; Barber et al., 2008; Camasso & Jagannathan, 2000; Chaffin & Valle, 2003; Chan, 2012; Coohy, Johnson, Renner, & Easton, 2013; D'Andrade et al., 2005; Dorsey et al., 2008; Johnson, 2011; Van der Put, Hermanns, Rijn-Van Gelderen, & Sondejker, in press). Also in other disciplines, such as criminal justice and psychology, the evidence is clear that actuarial methods outperform clinical judgement in predicting outcomes of interest (Aegisdóttir et al., 2006; Meehl, 1954, 1986; Dawes et al., 1989; Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Hanson & Morton-Bourgon, 2009). Within these fields, actuarial methods are therefore frequently used.

There are two main reasons why actuarial instruments generally outperform clinical methods. First, the mathematical features of actuarial methods ensure that only variables with predictive value are part of the instrument and that these variables are weighed in accordance with their independent contribution to the outcome of interest (Dawes et al., 1989). This illustrates why it is very difficult for professionals to accurately predict an outcome of interest using their clinical judgement, because they are not able to select the most important factors or to properly weigh the observed risk factors (Dawes, 1994; Dawes et al., 1989). Second, the reliability of actuarial instruments is higher and hence the prediction is more accurate, because risk factors are scored according to a fixed algorithm, meaning that professionals use the same objective scoring rules, whereas in clinical methods the scoring of risk factors is done in a subjective way (e.g. Dawes et al., 1989; Gambrill & Shlonsky, 2000).

Given the above, it is remarkable that the actuarial versus clinical prediction controversy still exists within child welfare. One explanation for its persistence might be the confusion about the precise purpose to be served by risk assessment instruments. Assessment in child protection includes two distinct purposes: (a) to predict future child maltreatment (*risk assessment*) in order to establish intervention urgency and intensity, and (b) to identify targets of interventions in order to contribute to individualized case planning (*needs assessment*). It is generally understood that actuarial methods perform better than clinical judgement in risk assessment, but this is not clear for needs assessment. Needs assessment instruments are most often developed through expert consensus and are usually not subjected to empirical validation (Schwalbe, 2008).

The controversy between actuarial and clinical prediction seems therefore mainly to relate to the needs assessment function of instruments and concerns the question which method is better at identifying targets of interventions. Shlonsky and Wagner (2005) assume that actuarial methods are not suitable for needs assessment because these instruments do not identify the full range of risk factors relevant to intervention planning. Most actuarial instruments currently in use in child welfare are brief instruments based on multivariate statistical techniques and consist mainly of static risk factors. These instruments are therefore not suitable for needs assessment. However, in the field of juvenile justice, several actuarial risk instruments have been developed that are suitable for both risk and needs assessment (Schwalbe, 2008). As Schwalbe (2008, p. 1461) stated: "Actuarial risk assessment instruments can be constructed with a broad array of dynamic risk factors that could ground clinical hypotheses and could identify targets of intervention to reduce risk".

In the Netherlands, no actuarial risk assessment instruments for child maltreatment are available. Because the use of actuarial methods by child protection services may be promising, the second aim of this study was to examine the predictive validity of a newly developed actuarial risk classification that is based on variables measured with the CLCS.

2. Method

2.1. Sample

For the present study, we used copies of the CLCS completed in the period January 2011–December 2013. These CLCSs were completed for families who were under the supervision of the Dutch Child Welfare Agency (CWA) because of problematic child-rearing situations, which means that there was a serious threat to the development of the child from an abusive or unsafe domestic situation and/or from parents or caregivers who were failing to provide the child's basic needs.

The CLCSs were retrieved from the system of the CWA. We then only selected the CLCSs of cases for which the treatment was ended before January 2014. Relapse was measured from treatment ending until October 2014, so that the period in which relapse was measured was at least 10 months for each case. This procedure resulted in a sample of 3963 families with at least one child aged 0–18 years (M age = 9.19, SD = 5.32). The families all lived in one of the following cities in the Amsterdam Metropolitan Area: Aalsmeer (2%), Amsterdam (53%), Amstelveen (6%), Haarlemmermeer (10%), Purmerend (9%), Uithoorn (2%), Zaanstad (9%) and other small cities (9%).

2.2. Instruments

2.2.1. Check List of Child Safety

The CLCS – which is known as LIRIK (Licht Instrument Risicotaxatie Kindveiligheid; Ten Berge & Eijgenraam, 2009) in the Netherlands – is a checklist in which professional judgement is central (i.e. it is an SCJ instrument). The CLCS helps the professional to evaluate a case systematically based on the available information. It is not a structured questionnaire and provides no formulae or criteria to form an objective judgement. This means that the final assessment of child safety is based on a subjective clinical judgement.

The CLCS is based both on scientific literature on safety indicators and on risk and protective factors for child maltreatment (Ten Berge & Eijgenraam, 2009). The CLCS was designed for professionals who are experts in the evaluation of (severe) parenting and developmental problems. Before professionals can use the CLCS, they must be briefed on its purpose, use, possibilities and limitations. Completing the CLCS takes about 10–15 min. A first study into the reliability of the CLCS showed that the interrater reliability was low to moderate (Veenhuizen, 2013).

The CLCS consists of two parts: (1) the identification of suspected child maltreatment at present (safety assessment) and (2) the assessment of the risk of child maltreatment in the near future (risk assessment).

2.2.1.1. Safety assessment. The safety assessment part involves assessing the child's current situation. This relates primarily to the substantiation of suspected child maltreatment. The CLCS helps the professional to systematically assess whether (a) parents act in a threatening manner or fail to act (see Table 1, items 1–5), (b) the child shows signs of developmental problems (including inadequate psychosocial functioning and injury; see Table 1, item 6), or (c) there are risk factors in the parent(s), the child, the family and/or the environment that are indicative of child maltreatment (see Table 1, items 7–9). Based on an assessment of the identified concerns and risk factors, the professional concludes whether or not there is actual child maltreatment.

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