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Clinical opinions of structured risk assessments for forensic child protection: The development of a clinically relevant device

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ABSTRACT

Structured risk assessments are well established and outperform unaided judgement in most forensic fields, yet there has been little uptake of structured assessments in Australian forensic child protection. The reasons for such limited uptake are unknown. To address this, this study trained five independent senior clinicians contracted by the Children's Court to use three structured approaches: 1) an Actuarial approach measuring static factors, 2) a Contextual/Dynamic approach measuring dynamic factors and, 3) a combination of the two measures via a proposed risk matrix model. Following training, clinicians applied the approaches to 30 vignettes (based upon actual restoration cases), and their perceptions of the clinical utility of the approaches were measured via questionnaires. Clinician's opinions of the three approaches were generally positive, suggesting that structured risk assessments have clinical utility for forensic child protection cases. Alternative explanations for the limited uptake are discussed. Of the three approaches the Combined was viewed most favourably, followed by the Contextual/Dynamic, and finally Actuarial.

1. Introduction

Risk assessments are highly influential in child-protection related Court proceedings (Jamieson, Tranah, & Sheldrick, 1999). They provide the Court with essential information, and help determine the most appropriate level of intervention to protect children from future harm.

Despite being influential and fundamental, there is no standard procedure as to how risk assessments are conducted. This is problematic as these matters are complex due to the nature of reportable behaviour, family systems, situations, and variation in available resources (DePanfilis & Scannapieco, 1994). This is heightened by the fact that in the child protection field there is a high level of staff turnover, inexperience staff, high workloads, and a growing demand on child protection services as more and more families 'in need' are being reported, particularly for both actual abuse and risk of possible abuse (e.g. Wood, 2008). Moreover, research consistently indicates that professional decision making in child protection is subject to bias (e.g. Arad-Davidzon & Benbenishty, 2008; DePanfilis & Girvin, 2005; Lennings, 2001; Pfister & Böhm, 2008; Wagner, 1999; Munro, 1999), and varies significantly even between expert clinicians (Rossi, Schuerman, & Budde, 1996).

Due to such problems, child protection decision making has been criticized as inappropriate and inconsistent (Children's Research Center [CRC], 2008). Inappropriate decisions can lead to an overuse of Out-of-Home Care, breakup and disruption to attachments, or injury to or death of a child. Such concerns have led many to exert the need for more efficient, consistent, defensible, and transparent decision making (i.e. clear decision rules) in relation to risk assessment and management (e.g. Lennings, 2001, 2002; Dalgleish, 2000; CRC, 2008).

In other fields of forensic psychology, such as the assessment of serious offenders for Court related purposes, similar concerns have resulted in the use of structured assessments. In other forensic fields such approaches are currently well established, accepted, and shown to be superior to unaided judgement (e.g. Boer, Wilson, Gauthier, & Hart, 1997).

In the child protection field, a few agencies (particularly in America) have begun developing and using structured approaches. Yet despite the documented benefits of structured approaches over unaided clinical opinion, there has been little uptake of structured approaches (e.g. Bromfield & Higgins, 2005; Bromfield & Holzer, 2008), particularly in the forensic child protection field. Unfortunately, it is unclear why such approaches have had little uptake. Thus, the overall aim of this study is to explore potential issues hindering the uptake of such approaches and to begin the development of a clinically relevant and accepted structured risk assessment approach for forensic child protection cases.

To do this, this study explores clinicians' responses to direct applications of three structured risk-assessment approaches to Children's Court restoration matters (i.e. matters where the issue of concern is whether or not to restore a child with a particular

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caregiver). This study utilizes an Actuarial, Contextual/Dynamic, and Combined (combining both the Actuarial and Contextual/Dynamic) approach to formulate an overall risk estimate.

In particular, this study focuses on 1) the empirically validated South Australian version of the Family Risk of Abuse and Neglect (FRAAN; Johnson, Wagner & Wiebush, 2000) for the Actuarial approach, 2) a revised version of the consensus-based Family Strengths and Needs Assessment (FSNA; e.g. CRC, 2008) — a substitute and potential starting point for the development of an appropriate contextual device as none currently exist in child protection, and 3) a Combined approach utilizing a proposed risk matrix model. These devices are discussed in greater detail below.

1.1. The Actuarial assessment

The Family Risk of Abuse and Neglect (FRAAN) is one of the very few actuarial devices that exist in child protection. It was developed by the Children's Research Center (CRC) in conjunction with various child protection agencies, and validated in jurisdictions such as South Australia (Johnson, et al., 2000), California (Johnson, 2004), Michigan (Wagner, Johnson, & Caskey, 2003), and Minnesota (Johnson, Wagner, Scharenbroch, & Healy, 2006). These represent slightly different, but inherently similar, versions. Today (to the best of the authors' knowledge), the only actuarial child protection risk assessment device used in Australia is the FRAAN (Undated, Department of Family Corrective Services booklet).

The FRAAN involves an 11-item Neglect and an 11-item Abuse scale. Scores are attached to each item and are tallied for a risk classification (i.e., "low", "moderate", "high", or "very high" risk) for abuse and neglect. The predictive ability of the FRAAN is reasonable. For example, within 12 months of the assessment, of those classified as low risk, only 6.8% received another notification for any type of abuse (with 3.4% confirmed), whereas 63.6% of those classified as very high risk received another notification (with 43.0% confirmed). Baird, Wagner, Healy, and Johnson (1999) calculated interrater reliability rates based upon four independent ratings of 80 vignettes. With 'high' and 'very high' combined to make three risk classifications (i.e. low, medium, and high), there was 100% agreement (i.e. all 4 raters agreed) for 57.5% of the cases, and >75% agreement (i.e. 3+ raters agreed) for 85% of the cases.

Actuarial devices alert us to the raised likelihood of risk, but cannot tell us much about specific individuals (Hart, 2003). If used in isolation, they may under-represent the complexity of child protection decision making (Fluke, 2004) due to a reliance on static factors. Static factors are historic in nature, and therefore are relatively fixed in their risk indication over time (e.g. Schwalbe, 2008). For example, someone who had drug or alcohol problems 10 years ago and someone who was currently experiencing drug and alcohol problems would receive the same risk score on the FRAAN measure. This measure excludes other important risk indicators such as dynamic, needs, protective and responsivity factors. Dynamic factors, both stable (change slowly e.g. substance abuse) and acute (change rapidly e.g. mood), are amenable to intervention (Hanson & Harris, 2000, 2001). Needs represent deficit conditions antecedent to an offence (Andrews & Bonta, 1994), such as a parenting skills deficit resulting in the application of inappropriate parenting. The 'need' is for the parent to be equipped with appropriate parenting skills. Protective factors decrease the likelihood of un-desirable target behaviours, such as the parents having adequate income (e.g. James, 2000). Responsivity factors are correlates of successful intervention, such as motivation (Andrews, Bonta, & Hoge, 1990). Thus, the most appropriate approach, at least theoretically, to conducting risk assessments involves complementing actuarial devices with clinical discretion of other identified contextual factors (e.g. Lennings, 2002), known as 'Structured Decision Making' (SDM; Hart, 1998).

1.2. Structured decision making assessment

SDM risk assessments consist of two components: an actuarial and a contextual assessment (Hart, 1998). Unfortunately, no contextual risk assessment device exists in child protection.

In other forensic fields, research consistently demonstrates that structured empirically-based methods outperform unaided assessments (e.g. Kroner & Mills, 2001; Quinsey, Harris, Rice, & Cormier, 1998). Thus, the second aim of this study is to begin an exploration into the development of an appropriate structured contextual risk-assessment device. A search was conducted for structural devices examining contextual factors in relation to child abuse. The Family Strengths and Needs Assessment (FSNA) fits this criterion.

1.1.2. FSNA

The FSNA was developed by the CRC in conjunction with child protection agencies in Californian and Virginia. Slightly different versions are used in various jurisdictions. It contains factors rated along a continuum from strength to severe need. Items are weighted to identify the three most critical needs and strengths. A field test report in California conducted by the CRC in 1998, as cited on the National Crime and Juvenile Review Service, 2001 website (see references for website details), found that for assessments of whether a need existed, without regard to the severity of the need, most items had interrater reliability rates above 80%.

1.1.3. Substituting and transforming the FSNA into a structured dynamic needs risk assessment

Shlonsky and Wagner (2005) argue that the FSNA is not a dynamic risk-assessment device. Rather, they view it as a separate component of the case planning process being directed towards informing service options and changes that might occur in families as a result of interventions. However, the FSNA fits the bill for a dynamic risk-assessment device through its emphasis on dynamic needs. Both needs and dynamic risks are inter-related concepts that focus upon offence-related factors amenable to change. Furthermore, the disengagement of risk from intervention is artificial, and begs the question: what is the point of intervention if not to reduce the risk of future offending?

The rationale for using the FSNA as a substitute for a structured dynamic needs risk-assessment (i.e. Contextual/Dynamic assessment) is as follows. First, it specifically examines contextual factors in relation to child abuse. Second, although it does not contain a comprehensive range of key dynamic variables (e.g. DePanfilis & Zuravin, 1999; Fuller, 2005), the item selection *does match* key dynamic risk variables (e.g. Fluke, Shusterman, Hollinshead, & Yuan, 2008; DePanfilis & Zuravin, 2002; Rittner, 2002). Third, dynamic risk assessments in other forensic domains are similar in format to the FSNA (e.g. the Dynamic Factors Identification and Analysis; Motiuk, 1997).

The FSNA's current form does not contain a process to derive a risk classification. In other forensic fields, as no optimal decision-making algorithm exists across contexts (Kropp & Hart, 2000), such processes generally avoid specific cut off scores for classifying risk. Instead, professional judgment is encouraged (Gray, Snowden, MacCulloch, Phillips, Taylor, & McCulloch, 2004) by posing key questions to aid judgment (e.g. Webster, Douglas, Eaves & Hart, 1997; Kropp & Hart, 2000).

The following four step process is proposed for the FSNA in order to convert it into a more appropriate contextual assessment. First, consider the ratio of strengths to needs. Second, identify critical risk factors. Third, consider a) the length of time the risk factors have been present, b) sustained reductions in risk, and c) the influence of risk factors on the situation. Finally, formulate a risk estimate (low-, moderate-, high-, or very high- risk) taking into consideration the above steps. These key considerations are based upon clinical