Constructive Uses of Risk: The Promise and Peril of Decision-Making Systems in Child Welfare

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Introduction

Child Protective Services (CPS) agencies are charged with investigating allegations of child maltreatment and, finding that such maltreatment has occurred or is likely to occur in the future, must choose a course of action that protects children from future harm. The former task requires an accurate assessment of the risk of future maltreatment, and the latter requires a comprehensive assessment of family dynamics and functioning (Shlonsky & Wagner, 2005; Hughes & Rycus, 2003). At both of these stages, organizational, environmental, and individual factors create multiple barriers to accurate decision making (Gambrill & Shlonsky, 2001). Organizational and environmental challenges include heavy caseloads, time pressures, chronic stress, the presence of incongruent and often conflicting case information, public scrutiny, and restrictive agency policies (Regehr et al., 2000). Individual factors, such as limited processing capacities, ineffective critical appraisal skills, and personal biases, also complicate accurate decision making (Gambrill & Shlonsky, 2001). Given the complex and multifaceted nature of decision making in a child welfare context, the unassisted clinician is unlikely to be able to accurately estimate the threat of harm in either the near or long term. In fact, there is a substantive body of research spanning diverse disciplines which suggests that workers are able to more accurately determine risk levels using a statistically-driven risk assessment tool rather than relying solely on clinical judgment (Dawes, Faust, & Meehl, 1989; Grove & Meehl, 1996).

Consensus-Based Tools Versus Actuarial Tools

In an effort to minimize the shortfalls of unassisted clinical decision making, researchers and other professionals have developed formal risk assessment tools, which generally fall into two categories: consensus-based and actuarial. Both are intended to improve clinical judgment by identifying specific characteristics to examine when one is assessing future risk of harm. Consensus-based models are derived from agreement among experts about a set of characteristics that contributes to future risk of maltreatment, whereas actuarial models are statistically driven and based on empirical relationships between risk factors and outcomes (Baird & Wagner, 2000). By and large, actuarial tools predict at least as well as, and usually far better than, unassisted clinicians (Grove & Meehl, 1996) and consensus-based tools (Dawes, 1994).

Few comparisons have been made among the various risk assessment instruments used in child welfare services. A notable exception is the Children's Research Center (CRC) study of the reliability and predictive validity of three commonly-used risk assessment instruments: one actuarial tool and two consensus-based tools (Baird et al., 1999; Baird & Wagner, 2000). These included Michigan's Family Risk Assessment of Abuse and Neglect (FRAAN)—an actuarial tool; the Washington Risk Assessment Matrix (WRAM)—a consensus-based tool; and the California Family Assessment Factor Analysis (CFAFA)—a consensus-based tool. The three tools were rigorously compared using a retrospective review of cases in California. Not surprisingly, FRAAN's actuarial approach substantially outperformed the other two tools in terms of both reliability and validity, more often consistently and accurately classifying high-risk families who later maltreated their children. In addition to being data-driven, the FRAAN largely comprises simple (yes-no) questions (making it easy to score reliably), separately estimates recurrences of both abuse and neglect (an acknowledgement that these are two very different forms of maltreatment with potentially different risk factors), and calculates an overall risk rating rather than relying on caseworker judgment to assign a level of risk.

Nonetheless, even the best risk assessment instruments do not estimate maltreatment well enough for use as the sole basis of decision making. Rather, these tools can be used to classify families into escalating degrees of risk (low, moderate, high, very high) with the greatest possible precision, and this information is then combined with clinical assessment skills to formulate a service plan (Shlonsky & Wagner, 2005). The hope is that actuarial approaches to such classifications will provide greater consistency and enhanced predictive validity of decisions through the optimal weighting of statistically valid risk indicators. Actuarial instruments and accompanying decision-making tools have been developed by the Children's Research Center (CRC), and these have been put into operation with some degree of success (Johnson, 2004; Wagner & Johnson, 2003; Wagner, Johnson, & Caskey, 2002)

However, the literature suggests that workers tend to rely more heavily on clinical judgment, which may be indicative of a general distrust of risk assessment instruments. Schwalbe (2004) pointed to a persistent belief in the efficacy of clinical judgment, a tendency for people to be more heavily influenced by narratives than numbers, and the depersonalized nature of statistical tools as the primary reasons for worker resistance to risk assessment instruments. Munro (2005) suggested that this resistance may stem from differences in human reasoning. Front-line workers have traditionally shown a preference for intuitive reasoning, whereas actuarial tools tend to be derived from an analytic reasoning model. Against this backdrop, the implementation of standardized, risk assessment instruments is wrought with many challenges, despite their greater predictive capacity, and training child protection workers to think differently is eminently more difficult than training them to use a tool. Most important, risk assessment (estimating the likelihood that a child will be reabused) is not so easily separated from clinical assessment (observing and understanding the many factors that contribute to and sustain maltreatment), and both are needed to make a viable service plan.

Study Background

In 2000, Ontario implemented the Ontario Risk Assessment Model (ORAM) to ensure a more comprehensive, standardized assessment process (Tuyl, 2000) and to "promote and support a structured and rational approach to case practice, without replacing professional judgment" (Ontario Association of Children's Aid Societies, 2000, p. 1). The ORAM was derived from an older system developed in New York and includes three major components: a screening in-

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strument to ascertain whether allegations should be investigated, a safety protocol designed to indicate cases where children are at risk of immediate harm, and a risk assessment tool (RAT) designed to predict both long-term risk of maltreatment recurrence and to gather important case information at several points in time. None of the instruments contained in the ORAM was statistically derived. Rather, these are consensus-based or expert-driven tools and have not been empirically validated.

The RAT comprises five-risk assessment domains, including the caregiver, the child, the family, the intervention (caregiver motivation and cooperation), and abuse/neglect circumstances. Within these domains, the RAT contains 22 individually rated risk elements that are thought to be associated with child maltreatment. Each of the 22 risk elements is evaluated on a scale of severity, ranging from 0 to 4. The risk assessment scales are defined using "anchors," narrative descriptive statements to help workers determine which rating (0–4) best fits the characteristics of the family they are investigating (Leslie & O'Connor, 2002). Space is provided at the end of each risk element for workers to expand upon or justify their selected rating in narrative form. After completing the risk assessment, workers consider all the risk elements present in a case and how these risk elements interact with one another (accounting for the presence of protective factors that may mitigate risk to the child), and then they choose an overall risk rating for the family based on a five-point severity scale (Leslie & O'Connor, 2002). The determination of the overall risk rating is based exclusively on the clinical judgment of workers, though supervisor input is encouraged. The RAT is completed for cases to be opened for ongoing services, every six months, and when a case is to be closed. The RAT is used as both an assessment of risk and a structured clinical tool, and the same set of risk factors is assessed repeatedly for the life of the case.

The three tools were rigorously compared using a retrospective review of cases in California. Not surprisingly, FRAAN's actuarial approach substantially outperformed the other two tools in terms of both reliability and validity, more often consistently and accurately classifying high-risk families who later maltreated their children.

Since the implementation of the RAT, professionals have raised questions about its predictive value, workload implications, and impact on casework. These concerns center on how the tool is used in practice and whether the data produced are informative and useful (Leslie & O'Connor, 2002). Confirming concerns expressed in the field, initial outcomes from the RAT evaluation study conducted at the University of Toronto suggest that it is neither a reliable nor a valid tool for estimating whether children will be reabused (Trocme et al., 2007). More specifically, the tool was deemed unreliable due to low internal consistency within categories, low inter-rater agreement for individual risk factors, and low inter-rater agreement for the Overall Risk Score. The study also suggests that the RAT has low predictive validity for almost every item, including the overall risk rating.

In light of these findings, the Ontario Ministry of Children and Youth Services (MCYS) partnered with the University of Toronto to investigate alternative risk assessment and contextual assessment tools for use in CPS. The Ministry researched a battery of tools used in the United States, the United Kingdom, and Australia as part of its movement toward a differential response system (i.e., diverting low-risk cases into preventive and family support programs and serving high-risk cases with core child protective services) that relies upon quickly and accurately classifying cases into varying levels of risk. Given the problems experienced by workers using the current risk assessment system and the difficulty of implementing new decision-making protocols, the MCYS decided to obtain input from the field prior to restructuring the current system. The Ministry chose eight tools to "test-drive" with intake and ongoing services workers from an array of Children's Aid Societies (CAS) in Ontario. Ninety-two child welfare workers and supervisors volunteered to review the tools, use them to assess a set of closed cases, and participate in focus groups held across the province.

The California Structured Decision-Making Model

As a result of its literature search and consults with several academic sources, MCYS concluded that the California Structured Decision-Making (SDM) system developed by Children's Research Center of Wisconsin represented the current best risk assessment system. California's SDM contains, as its centerpiece, a reliable actuarial risk assessment instrument with high levels of predictive validity in estimating the likelihood of subsequent child maltreatment reports, subsequent substantiated maltreatment, and child injury resulting from abuse or neglect (Wagner & Johnson, 2003; Johnson, 2004). This tool is used at the close of maltreatment investigations to help workers make difficult service decisions (e.g., whether and how to serve these families and long-term placement decisions). The risk assessment tool encourages the provision of more intensive services, mandated when necessary, to high-risk cases and less intrusive, voluntary services to lower-risk cases. Clinical skills are still of paramount importance for gathering the case-specific information required by the risk assessment form, understanding the issues that resulted in the family being investigated, and determining a reasonable course of action given this contextual information and the risk rating produced by the tool.

The risk assessment tool is accompanied by a safety assessment (which is completed within 24 hours of seeing the children) and, for families having continued involvement with the child welfare system, a structured clinical assessment tool (completed by the ongoing services worker), a risk reassessment, and a family reunification assessment. Risk assessment and clinical or contextual assessment are deliberately separated. That is, instruments designed to produce a risk rating are entirely distinct from instruments designed to gather critical case information that drives the case plan. The risk assessment tools are viewed as decision aids, simply to be used as another piece of information at key milestones during a family's involvement with child protection services (CPS). The SDM clinical assessment tool, the California Family Strengths and Needs, is designed to provide detailed, individualized information about the issues that brought the family to the attention of CPS, and it is structured in a way that facilitates case planning (see Table 1 for detailed descriptions of each tool in the California SDM system).

Methods

Intake and family service workers and supervisors from a wide range of Ontario's Children's Aid Societies (CAS) were solicited through the Ontario Association of Children's Aid Societies' Web site and mailing list to participate in what was called a "test drive" of risk assessment and clinical assessment tools that were being considered for use across the province. Participating workers were asked to com-

plete mock risk assessments using their own closed cases, examine of set of potential clinical assessment tools, and participate in a day-long focus group to gather feedback about each instrument.

Sample

There are 53 Children's Aid Societies in Ontario, varying in size and population. To maximize inclusion and variation, participation was limited to two volunteers from each agency. Focus groups were held in three locations: Ottawa (East); Sudbury (North); and Toronto (South and West). These locations were chosen to minimize travel for participants and to garner a sample that was representative of the province. The clear distinction in job description and types of decision-making needs between intake and ongoing services workers necessitated conducting separate focus groups for intake (Component I) and ongoing services (Component II) workers and supervisors. In all, 92 workers and supervisors from 34 Children's Aid Societies participated in the focus groups.

Procedures and Instruments

Prior to the focus groups, participants in both components were asked to volunteer to spend a day at their own offices familiarizing themselves and "testing" the two assessment instruments on three cases they had recently closed to insure that families with open cases were not affected by reevaluation of their case files. Participants were also asked to review four clinical or contextual assessment tools designed to structure information gathering for use in case plan development. These ranged in level of complexity, knowledge needed about the family, and time to complete. Volunteers then participated in focus groups centering on the instrumentation and viability of the risk assessment tools they had completed (morning session) and on their opinions about the clinical assessment tools they had been asked to review (afternoon session).

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Intake workers and supervisors in Component I began by reviewing the California Safety Assessment and the California Risk Assessment. Ongoing workers and supervisors in Component II began by reviewing the California Risk Reassessment Tool and the California Family Reunification Assessment. All volunteers were then asked to select and review the charts of three of their own cases that had been closed in the last six months. Component I participants reviewed at least one case that had not been opened and one case where the child had been taken into care. Component II participants reviewed at least one case where the child had been reunified and one case where the child had received ongoing services without having been placed in foster care.

After participants had refamiliarized themselves with the cases, the volunteers from Component I were asked to complete a California Safety Assessment and a California Risk Assessment for each selected case. Volunteers for Component II completed a California Risk Reassessment Tool and a California Family Reunification Assessment. For each case, volunteers used only information that would have been available to them at each respective decision point. While completing this task, they were asked to take notes in relation to the following:

- Ease of use
- Availability of requested information
- Utility as a decision aid
- How the tool compared with the equivalent instruments in the ORAM
- Potential of the tool to work in concert with other, more detailed assessment tools
- Strengths of the tool
- Weaknesses of the tool
- Unintended consequences of its implementation

Volunteers then summarized their comments and turned in their completed instruments to the principal investigator.

Although the Ministry of Children and Youth Services had decided to pursue the risk assessment portions of SDM unless serious objections were raised in the field, there was considerable debate about which clinical assessment tool would be most beneficial for Ontario. The Ministry chose four clinical assessment tools, representing a range of depth and complexity, as potential candidates for use in the province. These included the Ontario Revised Risk, Strength, and Needs Assessment; California Family Strengths and Needs Assessment; Looking After Children Initial Assessment—Ontario Version; and Bristol Core Assessment Form.

The Ontario Revised Risk, Strength, and Needs Assessment is a tool derived largely from the RAT. This instrument was constructed and used so workers could, essentially, evaluate and ultimately choose a tool with which they were familiar. The California Family Strengths and Needs is a structured clinical assessment tool covering eleven caregiver and nine child domains. Each item is anchored and scored, but the scores are not summed to indicate risk. The tool also includes a prioritization of these strengths and needs as well as a section for additional elements not covered by the tool.

The initial assessment module of the Ontario Looking After Children (ONLAC) assessment system is a detailed, largely narrative assessment tool geared toward ascertaining children's developmental needs, a caregiver's parenting capacity, and family and environmental factors, all of which are used to develop a case plan that drives service provision. While the ONLAC is defined as a "brief" assessment tool, the level of detail is far greater than the previous tools and requires a relatively long period of time to complete, as well as substantial knowledge of the child and family being assessed. This tool was chosen since it is fairly comprehensive, includes an assessment of child developmental functioning, is used widely in the United Kingdom, and is already in use across the province (primarily for children residing in long-term foster care).

The Bristol Core Assessment Form is a more detailed and time-intensive version of the Looking After Children Initial Assessment, and it also includes a scale for each domain. Similar to the ONLAC, the domains comprise child developmental needs, parenting capacity, and family and environmental factors, but the anchors and discussion points are far more numerous and detailed. Also included are parent and young person perception of individual and family strengths and needs, as well as a detailed analysis of these strengths

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and needs by the assessor. Again, this information is used to develop a case plan that drives services provision. This tool was chosen because it is comprehensive and detailed, is used widely in the United Kingdom, and represents the high end of the continuum in terms of required training for use and the length of time and amount of client information needed to complete it (see Table 1 for further descriptions of each tool).

One week prior to the scheduled focus group, participants in both components received a package containing these four clinical assessment tools for their review, and the afternoon session of each focus group gathered the participants' opinions of these four measures.

Data Analysis

The principal investigator and research team reviewed the notes and completed risk assessment forms filled out by study participants. They analyzed the content of the notes and forms to identify commonly expressed concepts, including concerns or strengths of the tools and opinions regarding their possible implementation in the field. Research assistants coded and labeled these responses and identified themes that were common across participants. In the focus groups, the facilitator explored with child welfare staff members their perceptions about how these tools would enhance or detract from their ability to provide high-quality services to the children and families with whom they work. In addition, their opinions were elicited regarding their experience with the current decision-making system (ORAM).

The transcripts and recorder notes were initially reviewed using discourse analysis. Open coding was used to identify broad concepts and themes that emerged in each group. This was followed by axial coding to establish interconnections among the themes and create a coding framework (Strauss & Corbin, 1990).

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Results

Overall, the participants favored the instruments in the California SDM system. Although they had not been trained on the proper use of these tools, caseworkers, by and large, appeared to understand their function and how to complete the tools. Nevertheless, there was some confusion around the separation of risk assessment and clinical assessment. The California Risk Assessment was well received by the vast majority of participants. They cited its ease of use, the speed with which it could be completed, and the consistency of its ratings as major benefits over the RAT in the ORAM. However, understanding how the contextual tools functioned with the risk assessment tool presented a challenge.

The contextual assessment tools sparked some discussion around the need to have a tool that would allow workers to effectively meet the needs of families while reducing, or at least not adding to, their paperwork. With this in mind, caseworkers tended to prefer the California Strengths and Needs Assessment. Participants expressed concern that the Ontario Revised Risk, Strength, and Needs Assessment was too deficit-focused and contained the same problematic issues present in the ORAM. Overall, participants perceived the ONLAC and Bristol assessment tools to be comprehensive and thorough but not feasible for use in daily practice. Although workers believed they had the skills to complete the tools, time constraints and high caseloads prohibited their use, and this was particularly true for investigation caseworkers. Some participants also pointed out that such detailed assessment tools may be too intrusive to engage families. That is, the generally intrusive and investigative nature of child protection work may not allow caseworkers to engage families sufficiently to complete a comprehensive clinical assessment tool.

Conceptualizing Risk and Context

The RAT in the ORAM required that workers use the ratings on the individual risk elements to inform their decision of the overall risk rating. In other words, workers use a combination of the risk ratings and their clinical judgment to determine the overall risk rating, which is then supposed to help determine an appropriate service plan for each family. In the California SDM model, risk and context are clearly separated, representing a paradigm shift that many workers struggled to grasp. The perceived disconnect and lack of integration between the risk rating and the more thorough family assessment posed the largest conceptual hurdle. Workers seemed skeptical about the predictive value of the California risk assessment tool because it did not include all of the 22 factors contained in the RAT, nor did it contain its narrative components (despite the fact that they did not trust the RAT either). They consistently highlighted that certain variables, such as a family's visibility in the community and a caregiver's mental health, seemed to be "missing" from the tool. The RAT framework appeared to bind workers mentally, limiting their ability to conceptualize risk without also completing a corresponding narrative that was generally used to provide a rationale for the risk rating and to more fully understand the family. Many participants expressed that the risk rating seemed meaningless, like a hollow number, because it was devoid of theory or context within which to situate it. This challenge speaks to one of the potential shortfalls of actuarial risk assessment instruments identified in the literature, namely, that they "indicate risk level without explaining the dynamic processes that might explain their findings" (Schwalbe, 2004, p. 573). That is, the risk assessment instruments use only the most predictive factors, and those factors may not be located at the beginning of the causal pathway leading to maltreatment.

A substantial portion of the focus groups was devoted to explaining how the tools functioned together because workers were not given any prior training in the use of the tools. After a more thorough discussion of SDM, they began to grasp that the California Risk Assessment tool is not meant to be a narrative tool; it is merely designed to trip an alarm bell that signals to workers that some families have a higher likelihood of future maltreatment than others, and it helps them make decisions about whether and where the family would best be served. Clinical expertise is still crucial in deciding how to use the risk rating to inform case planning. In other words, the actuarial risk assessment tool was not intended to help workers fully assess family functioning, understand clients' percep-

tions of their behavior, develop case plan goals, or choose treatment interventions. The SDM model generated a significant amount of confusion among workers primarily around the purpose of the risk rating and how it was intended to guide workers' decision making. For example, one worker's comment that "now if we have a high-risk case, we would transfer the file, but this is a different kind of tool" signals a lack of understanding of what to do with a risk rating. Another worker expressed that she was "having a hard time switching…maybe [use] a different name, like risk checklist?" Workers didn't understand when the risk assessment tool was meant to be filled out. Once workers understood that the risk assessment tool works in concert with a contextual assessment tool intended to capture family functioning and family dynamics, it was easier for them to process this new way of thinking.

The Perceived Relevance and Utility of the Risk Assessment Tool

Many workers expressed concern about the utility of the risk assessment tool as a decision-making aid. Even when it was communicated that numerous research studies have shown that actuarial models outperform clinical judgment and consensus-based tools in terms of estimating future harm to a child, workers remained skeptical. Probing around this issue revealed that many workers were dubious about the predictive value of the RAT in the ORAM and this, coupled with the length of time it took to complete, had made the RAT into a "recording tool" rather than a decision aid. One of the workers stated matter-of-factly that "most of these tools are completed when they have to be used and until then, they are a useless tool...this will not be a decision aid." That is, their assessment of overall risk, while informed by some of the general categories contained in the instrument, was clearly made after the workers had decided the risk level and made most of their casework decisions.

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In terms of a clinical tool, the RAT also did not seem to meet the needs of workers. One worker explained that trying to show family functioning using the RAT "was like putting a square peg in a round hole. It just didn't fit." In other words, with the ORAM, workers had become accustomed to relying chiefly on their clinical judgment because they did not believe in the merit of the tool. Other studies of decision making in child welfare echo that workers tend to use risk assessment instruments to merely verify, document, or justify decisions; in some cases, workers deliberately inflated risk ratings to ensure that families were classified as high enough risk to be given the services the worker thought appropriate (English & Pecora, 1994; Lyle & Graham, 2000).

Managing Risk Versus Promoting Child Well-Being

An ideological debate emerged among workers about the very nature of their role as child welfare workers and whether the pendulum had swung too far in the direction of risk management over more holistic approaches to child well-being. Some participants were concerned that relying on risk assessment tools intended to assess risk of physical abuse and neglect exclusively may encourage workers to minimize the importance of, or completely overlook, other kinds of maltreatment, such as emotional abuse or exposure to domestic violence. Critics of risk assessments in the field similarly argue that inadequate attention is afforded to the needs of the majority of children that come to the attention of child welfare who are "not likely to be physically endangered, but who are, nonetheless, at risk for a variety of long-term social, emotional and behavioral problems" (Knoke & Trocme, 2004, p. 37).

It became clear that workers' distrust of the ORAM as a useful decision-making aid had forced them to rely more heavily on their clinical judgment to make critical case decisions. For example, workers openly shared that they would frequently adjust risk ratings on the RAT if it did not match their intuitive reasoning. An unintended and unfortunate consequence of workers using the RAT, a tool with limited reliability and validity, was an erosion of their confidence in the ability of any tool to accurately estimate future maltreatment. The literature suggests this distrust may be attributable to a general perception among child welfare workers of risk assessment tools as mechanisms for controlling, monitoring, and formalizing their work to promote accountability, rather than as sources of consultation and support (Munro, 2004). In light of these findings, implementation concerns are of paramount importance lest good tools are used incorrectly in practice.

Discussion

The focus group participants' struggle to understand and appreciate the separation of risk and context in the California SDM and their resistance to risk assessments in general (as a result of bad experiences with the prior tool and the perceived incursion into clinical territory) signals the need for standardized, targeted, and comprehensive training prior to implementing new tools in the province.

Implementation Challenges

Training. For risk assessments to produce desired results, child welfare workers need to be trained to use the range of tools in the decision-making system correctly and consistently. Unnecessary risk can result from both the use of invalid instruments (as was the case with the RAT) and the misuse of a valid risk assessment tool (Gambrill & Shlonsky, 2000). More specifically, workers need to understand the accuracy and limitations of risk assessments. Knowing that risk assessments can produce two kinds of errors—false positives (where nondangerous families are determined to be at high risk) and false negatives (where dangerous families are determined to be safe)—will hopefully help remind workers to keep a critical mindset about the level of risk determined by a tool (Munro, 2004).

Furthermore, workers need to understand the intention of risk assessment tools and how they can function in harmony with clinical tools. Many workers expected the risk assessment instrument to provide guidance about the intensity and type of services that would help prevent future maltreatment. Training is necessary to explain that clinical judgment and expertise are needed to tap into these critical areas, and clinical tools can help workers structure this more detailed information. Perhaps, over time, more dynamic assessments can be developed that address both cause and consequence (Schwalbe, 2004), but these are not yet available for use in child welfare.

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Training needs to highlight specific ways in which the implementation of the California SDM system will add value to workers' daily responsibilities. Emphasizing that the tools in the California SDM are streamlined to enhance efficiency in recording will likely promote worker buy-in. Focus group participants were very vocal about their disdain for excessive and redundant paperwork that ultimately robs them of critical time that could be spent building relationships with families. Workers need training to help them better understand how front-end tools (e.g., screening, safety assessment, and risk assessment) fit into Ontario's new differential response initiative. Understanding these distinctions will not only help workers appreciate the merits of each tool but also help them understand the interaction among tools, which will minimize duplication in recording.

Accessibility. Accessibility may pose the greatest implementation challenge because the California SDM system represents a new paradigm for workers. The successful implementation of SDM will be thwarted if workers fail to fully conceptualize how risk and context are separated in the approach and how the different tools function in concert. The implementation of the California SDM model is an opportunity for trainers to dialogue openly with workers and supervisors about the strengths and limitations of the model and to jointly develop ways to address challenges faced by workers.

Organizational Culture. There is enormous pressure on child protection agencies to be accountable for errors made in their efforts to protect children from harm (Kanani, Regehr, & Bernstein, 2002). Munro (2004), in her examination of the organizational pressures in child welfare, argued that the pressure to be accountable for errors can lead to defensive practices, in which workers may be tempted to place an unwarranted amount of confidence in the results of risk assessment instruments as a means of escaping blame. She underlined that child welfare workers must be mindful that a risk assessment does not represent a certain truth; it is merely an informed hypothesis that may need to be changed in the presence of new information. She advocated that child welfare agencies, and supervisors in particular, foster an organizational culture that encourages workers to be self-reflective and critical of their reasoning.

Conclusion

Currently there is a dearth of empirical research exploring how risk assessment tools influence decision making. The viability of actuarial risk assessment systems in child welfare practice remains somewhat controversial. Accordingly, it is crucial that actuarial risk assessments are not presented as a panacea for the problems faced by the field. No instrument can determine with 100% certainty that maltreatment will recur. We are limited to finding the best predictive tool among many and then understanding and working within the limits of that tool. Actuarial risk assessment tools, while far from flawless, are the most predictive instruments of future maltreatment to date and, as such, can be useful decision-making aids (Shlonsky & Wagner, 2005). However, their predictive capacity, like many empirical measurements, is hindered by methodological issues, such as variations in definitions of child abuse and neglect (Gambrill & Shlonsky, 2000; Zuravin, 1999) and the fact that substantiation may not be the most valid measure of recurrence of harm (English, Marshall, & Orme, 1999).

As a rule, the actuarial tools should be developed and validated in the same jurisdiction to ensure that they are sensitive to the populations in which they will be used. Unfortunately, political and organizational needs may preclude such a long-term approach, as was the case in Ontario. Since one cannot determine in advance how the SDM tools will be used by workers and how they will interact with other factors (Munro, 1999), the risk assessment tools will be prospectively validated and recalibrated based on locally-specific findings. Given the complex and difficult nature of introducing new tools into any existing system, the tool developers have been, and will continue to be, consulted frequently and extensively to insure model fidelity. Interim data analyses and consultation with pilot agencies will also be conducted to ensure that the implementation of the tools is not causing dire unintended consequences.

Risk assessments and contextual assessments will be useful as decision-making aids only if implemented in a child welfare environment that supports transparency, consistency, constructive criticism, and accountability (Gambrill & Shlonsky, 2001, p. 830) and in which child welfare workers perceive the tools to be directly helpful and relevant to their daily work. The mere addition of new tools to child welfare agencies without sufficient training and organizational support is unlikely to improve workers' capacity for accurate decision making or increase the safety and well-being of children and their families. With the presence of conditions that support the effective use of these new tools, workers should be better equipped to use their clinical skills to assess, plan, and manage their cases.

Table 1. Risk and Clinical Assessment Tools

Instrument	Which Cases	Purpose	Description
California Safety Assessment	For a new referral For open cases in which family circumstances have changed	To assess the immediate safety concerns that may place a child in danger of imminent serious harm To provide structured information to guide workers' decisions about whether immediate protective interventions are necessary	Consists of safety items, safety interventions, and safety decisions
California Risk Assessment	Prior to a referral being opened for services	To assesses whether or not a family has a high likelihood of a future reoccurrence of child maltreatment Risk level helps guide case decisions about whether to close a referral, or open it as a child protective services case, or refer the family to alternative service providers.	Actuarial risk assessment tool consists of an abuse index and a neglect index
California Risk Reassessment	For cases in which children have remained in their own homes or been reunited with their families	Evaluates a family's progress toward case plan goals of risk reduction and child safety	Combines items from the original risk assessment tool with additional relevant items
California Family Reunification Assessment	For cases in which children are in placement and reunification with their families is being considered	To assess the family's readiness for reunification and to structure case management decisions around reunification to promote continued child safety and placement stability	Consists of reunification risk assessment, a visitation plan evaluation, a reunification safety assessment, guidelines for placement, and a recommendation summary.
Ontario Revised Risk, Strength, and Needs Assessment	For all cases open for services	To evaluate a family's presenting strengths and needs and to develop an effective service plan	Largely derived from the RAT contained in the ORAM. Each child is rated on 22 items arrayed in five subdomains (caregiver factors, child factors, family factors, intervention factors, and abuse/neglect factors). A space is provided for narrative explanation each factor.
California Strengths and Needs Assessment	For all cases open for services	Helps workers systematically identify and evaluate family strengths and needs and plan service interventions using this information.	11 caregiver factors and 9 child factors are rated on scales that identify and prioritize areas of need and identify relevant areas of family strength
Bristol Core Assessment	For all cases open for services	Gathers information useful for developing a case plan that drives services	Similar to Looking After Children (see next) but with more numerous and detailed anchors and discussion points
Looking After Children Initial Assessment — Ontario Version	For all cases open for services	Gathers information useful for developing a case plan that drives services	Largely narrative tool geared toward ascertaining children's developmental needs, caregiver's parenting capacity, and family and environmental factors

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