Risk assessments in child protection

Before the introduction of risk assessment methods in child protection in the 1980’s the assessment and prediction of children at risk from abuse was a capricious business: care workers had no theory, or methodology and no strategy by which to determine which children were more at risk than others – they worked almost in the dark. When risk assessment strategies were introduced their enormous advantage was to give some orientation and means of prediction to social workers in their efforts to determine which children were at the highest risk. Moreover, in pre-risk assessment days, decisions about child protection were taken individually by scattered organizations and institutions without any inter-communication. The desperate consequence of this lack of cohesion was often complete confusion about which authority should make the decision about whether to and how to protect a child from abuse. Risk assessment required much closer participation between various agencies and therefore more efficient and individualistic protection care for children. Risk assessment takes into consideration a number of risk factors that affect a child – parental, family, environmental etc., – and analyzes these collectively to produce a total risk overview. Risk assessment has evolved considerably since its introduction in the 1980’s and various methods and theories of risk assessment have been experimented with; this essay looks at several of these methods, analyzing the relative worth of each. It also examines the introduction of schemes such as child protection conferences and child protection plans and evaluates the improvements to child protection brought by these schemes. Finally, this essay will discuss the future or risk assessment and its influence upon government policy and direction.

Vulnerable children face five principal types of risk: sexual abuse, emotional abuse, institutional abuse, physical neglect, and non-organic failure to thrive. This essay now details and describes the implications for risk assessment of each of these types of abuse. The NSPCC gives the following definition of sexual abuse: ‘ *The sexual abuse of children may include sexual touching, masturbation, intercourse, indecent exposure, use of children in or showing children pornographic films or pictures, encouraging or forcing children into prostitution or encouraging or forcing children to witness sexual acts. Children and young people of all ages can be victims of abuse.’* (NSPCC). Children then are at potential risk from all of the types of abuse described in the above quotation; each of which, if undetected and unprevented causes a deep physical and emotional trauma for the child. *Physical abuse* is defined by the National Centre on Child Abuse and Neglect as *" The physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby...’.* Children may also encounter physical abuse by way of domestic violence, and this together with physical abuse is nationally one the most frequently experienced types of abuse against children. The *emotional abuse* of children is defined by the American National Committee for the Prevention of Child Abuse as ‘... *a pattern of behaviour that attacks a child's emotional development and sense of self-worth. Emotional abuse includes excessive, aggressive or unreasonable demands that place expectations on a child beyond his or her capacity. Constant criticizing, belittling, insulting, rejecting and teasing are some of the forms these verbal attacks can take. Emotional abuse also includes failure to provide the psychological nurturing necessary*

for a child's psychological growth and development -- providing no love, support or guidance (National Committee for the Prevention of Child Abuse, 1987). This definition then describes the myriad forms of emotional abuse that children can be subjected to – and thus the inherent difficulties of prediction and prevention in child protection. *Non-organic failure to thrive* is a further possible risk that children are exposed to. It is defined by the Lucy Packard Children's Hospital as *'... decelerated or arrested physical growth (height and weight measurements fall below the fifth percentile, or a downward change in growth across two major growth percentiles) associated with poor developmental and emotional functioning.'* Non-organic failure to thrive is often difficult to detect, and risk assessment is vital to guarantee this detection. *Institutional abuse* is also a broad term, but within its scope are included bullying, racial discrimination, disability discrimination and many others.

Risk assessment then has to draw together all of these potential risks and must consider factors that influence them. These factors include *parenting capacity* , *child developmental needs* , *housing* , the *child's family* and the *child's environment* . This essay now discusses each of these factors succinctly before describing the various methods used to assess them.

Parenting capacity and the *family environment* are intimately connected as factors for assessment of possible risks to a child. A healthy relationship between his/her parents and a stable family environment is extremely important for the physical and emotional welfare of a child. When this healthy environment deteriorates because of domestic violence, parental arguments, parental divorce, change of circumstances etc., the child is put

at a higher risk of abuse. The influence of extended family (grandparents, aunts/uncles, cousins etc.,) is likewise very considerable and must be considered as a risk assessment factor. *Child developmental needs* refer to the needs of a child for access to education and social development, and for children with learning disabilities to get access to professional help and services. If this development is negatively affected in some way, then the risk to a child increases significantly. Poor quality *housing* is clearly a risk factor for the welfare of a child, particularly those with disabilities. Children with disabilities require special facilities and equipment, and all children require basic amenities and utilities depending upon the age and development of that child. Interior and exterior conditions, hygiene, sleeping environment, and local surroundings can all become risk factors if neglected or abused.

This essay now examines the three dominant theories or methods of risk assessment in the past decade of child protection: the actuarial model and the theoretical-empirical approach.

(1) Theoretical-Empirical (Consensus-Based) Models. Within the theoretical-empirical model risk is determined according to a decided group of empirically grounded risk factors, and by these the social worker produces a total assessment of risk founded upon witnessed combinations of risk factors (Boer, Webster, 1997). Scientific research has demonstrated that the theoretical-empirical model achieves average predictive success. (Epperson, 1998). The inherent difficulty of this method is that the care worker must equate identified risk factors into a recidivism likelihood. The model can

therefore be argued to be undermined by its lack of integration of risk factors (Wolfe & McGee, 1994) -- so important in child protection.

Risk assessment for the theoretical-empirical model is founded upon theories about parental abuse of children. The classic model of this type was the Ecological Model of Maltreatment (Brofenbrenner 1979, Belsky, 1993). The idea within this model is that numerous factors and the identification of risk factors determine the likelihood of abuse. The Ecological Model of Maltreatment considers risks related to children themselves, to caregivers, caregiver and child interaction, the family, and wider social and institutional factors. According to the theoretical-empirical model potential risk is determined in the investigation and influences case-choice at the beginning of the assessment process, during investigations, decisions about beginning cases, service strategy, child placement, and at the closure of cases.

(2)PureActuarial Models. These models supply definite principles for integrating risk factors (identified by retrospective empirically founded case reviews) into certain probability figures. The difference with such models is that they are not tethered to any particular theory of child abuse, or theory of parental abuse of children, but instead make use of all factors that are empirically joined to a risk assessment decision and put these in the assessment scales nonetheless. An advantage of such models is that they give specific weights of scale to individual risk factors and so can be transformed into scales that show the important associations between risk variables and the resolution of interest. Thus these associations imply that a particular variable is present, so too is the concomitant variable – though one should not necessarily infer that one variable produces the other. Such a

distinction is vital when evaluating whether the aim of risk assessment should be short term or long term prediction and prevention, and intervention. Recent scientific investigation reveals that actuarial scales such as these are better at prediction of risk than clinical judgement usually is (Groove & Meehl, 1996). Nonetheless, several authorities and risk assessment theoreticians have implied that this actuarial superiority is based upon inaccurate research (Serin, 1995). Sjosted and Grann (2002) have further questioned the methodology of actuarial models.

(3)Clinically Adjusted Actuarial Models. The essential difference between *pure actuarial models* and *clinically adjusted actuarial models* is that the later use an actuarial method to ascertain risk factors as determined by a risk scale, but a medical or care practitioner can vary the actuarial level plus or minus depending upon the factor of his clinical judgement. Thus *clinically adjusted models* place are more individualistic since they permit the inclusion of possible individual risk factors that were unable to be documented empirically.

There is much debate and argument about the strengths and weaknesses of these various methods. Within the actuarial school of thought there is a separate question as to which of the *pure actuarial models* or the *clinically adjusted actuarial models* is superior. It is probably true to say that actuarial models (of both types) are now thought to provide greater accuracy of prediction of child risk than theoretical-empirically based models. Clinically adjusted actuarial models are argued to give the best results, combining the advantages of an integrated risk assessment scale with the experience of a clinician and his ability to spot the individualistic risks in particular case that

the model may not have noticed. The future of risk assessment perhaps lies then with a refinement of the clinically adjusted actuarial model. Important issues of methodology to be addressed include poor reliability, validity of measures, dilemmas of terminology, lack of base rate information, incorporation of individualistic risks and sensitivity of investigation.

In pre-risk assessment days a profound flaw of the child protection system was the failure of various independent agencies to pool together their skills and the knowledge they had acquired about the risk to a particular child; inter-agency communication was poor, and as a consequence many children were harmed, or even killed, who might otherwise have been saved. The advent of risk assessment in child protection improved the co-ordination of information between professional care services, and the recent introduction of *child protection conferences* have led to a far greater and more efficient sharing of information between agencies. Child protection conferences are convened after social services and the police have made initial inquiries about the health of a child and then seek to extend these enquires. A child protection conference brings together all professionals concerned with the welfare of a child, and thus has the enormous advantage of bringing all possible helpful information together at the same time. The purpose of such conferences is to determine the welfare of the child, to evaluate the risk of physical or emotional harm to the child, and to decide whether the child should be transferred onto the *Child Protection Register* . Conferences also consider whether legal proceedings ought to be brought on behalf of the child, and whether the police are required to investigate a crime against the child. If it is felt necessary to put a child on the Child Protection Register,

then the conference must also produce a *Child Protection Plan* for the future welfare of the child. Such plans are essential because they explicitly stipulate what the responsibilities and duties are of each agency involved in the care of the child. The usefulness and thoroughness of these conferences is enhanced by the practice of a follow-up conferences after three months to determine progress, and then further conferences after six month intervals if necessary. Moreover, the inter-agency dialogue introduced by child conferences greatly improves the chances of these professionals spotting a specific risk to a child that might be missed by individual agencies. Child protection conferences are vital then to ensure and maximise the accuracy of individual risk assessments.

In short, child protection conferences have improved enormously the co-operation and inter-communication of the various agencies involved in the care of a particular child and so reduced considerably the risk posed to that child.

A further area that needs to be investigated by risk assessment is parental capacity to care for children. It is usually assumed that parents have a right to care for their children in all circumstances; an idea influenced by the normal reluctance of British society to tolerate intensive state intervention into private family life. It is believed that the state should remain at a distance, stepping in only in emergencies or cases of dire need. Professional care workers now argue however that this attitude of non-intervention often ignores the actual capacity of some parents to care for their children, particularly those with intensive needs. Thus this attitude can frequently

threaten a child’s safety and security. Future risk assessment needs to develop a theoretical and practical model for possible state intervention in cases where parental ability to care for a child is suspect. The British government will be required to play a significant role here; updating existing legislation and creating new strong legislation to allow for intervention by care services in the most high risk cases of child abuse. This demand upon the government is an outcome of the philosophy of risk now prevalent in the United Kingdom, where it is assumed that the government has the ability to foresee and prevent abuse and maltreatment – and so the government is to be held to account when this does not happen.

In the final analysis, it must be seen that risk assessment for child protection has had an enormous success compared with the vacuum and capricious nature of prediction and prevention that existed before its introduction. Care workers and clinicians now have a theoretical, empirical and practical model by which to best determine the various risks that affect vulnerable children. The future progress and evolution of risk assessment seems to lie with an actuarial model – probably a clinically adjusted actuarial model. Such models at present appear to integrate risk factors most successfully and therefore to offer the best rates of prediction. This said, methodology needs to be thoroughly revised to evaluate and consider reliability of data, reliability of measures, integration of clinical opinion, individualistic risks etc., So too risk assessment needs to develop clear concepts and to push for government legislation to produce a model for state intervention into cases where parental ability to care for children is insufficient. Risk assessment theory must seek to modify the attitude of the British public that assumes parental

right to care is absolute; showing that in certain circumstances this is not the case.

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