

ACTUARIAL RISK ASSESSMENT AND ONTARIO CHILD WELFARE TRANSFORMATION:

A PARADOX OF PURPOSE

**ACTUARIAL RISK ASSESSMENT AND ONTARIO CHILD WELFARE TRANSFORMATION:
A PARODOX OF PURPOSE**

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ABSTRACT

When Ontario Child Welfare Transformation was initiated a new risk assessment document was implemented. This study explored the opinions of protection staff on the present risk assessment. Participants' negative opinions about the document contrast sharply with their enthusiasm over transformation initiatives and illustrate a paradox between the document and transformation goals. Their concerns for the document and the standardized approach of the document centre on the theme of what is lost in the approach. In particular, they spoke to the present risk assessment missing assessment of the strengths and protective factors, which could mitigate risk and that it fails to capture the spirit and goals of transformation. They expressed concern that it misses the whole picture, social context and ambiguity of many situations. It fails to account for progress, adaptation and flexibility and instead focuses on static, fixed and unchangeable factors. They expressed concern for a lack of written or area for workers to explain context. Workers noted that the families' views are absent in the fixed categories, as well they questioned claims for the documents accuracy. Workers also noted that the standardized and rigid approach of the document failed to take into account structural and anti oppressive considerations. As a result, workers felt much was lost from the document.

Workers found ways to resist their assessments being constrained. Their attempts to assess risk outside the box were varied and creative and made use of a wide range of tools, paradigms and experiences. Workers own assessments of risk, were more consistent with transformation initiatives than that of the document. Workers offered suggestions as to how they would improve risk assessments in child protection.

The shifts in paradigms in child protection, the debate over the "how to" assess for risk, and the factors presently absent on the risk assessment, highlight possibilities of other ways of assessing risk and intervening. This study offers an interpretive account of the present actuarial risk assessment document from the perspective of protection staff. The concerns raised with the document, infuse the paper with critical questions regarding the objectivity and validity of positivistic approaches, the utility and futility of standardized approaches, and existence of competing claims and discourses regarding risks to children. Their concerns beg the question, could there be other possibilities to assess risk and intervene in a manner more consistent with transformation initiatives and anti oppressive practice?

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CHAPTER 1

Introduction

Throughout the 1990s, the insecurities and fears of in the globalized economy were reflected in social work, which shifted toward the “individualization of responsibility” for social difficulties and preoccupation with risk (Parton, 1996, p. 100). Coinciding with cuts to social services in the mid 1990s, several children died while receiving services from Children’s Aid Societies. Trust in social workers diminished and “moral panic” emerged (Dumbrill, 2006; Parton, 1996). In this period of insecurity and fear, concern arose over the different approaches to child welfare. Following the Coroner reports and child death inquests, the Risk Assessment Model¹ was initiated in 1998. The development of a standardized risk assessment model and new computerized systems offered surveillance like ability to monitor both family and worker compliance (Dumbrill, 2006).

Audits increased as emphasis on risk increased (Krane and Davies, 2000). Individual workers were held responsible for deaths and charges for criminal negligence causing death were laid. Charges against individual workers served “as a stark reminder of workers’ vulnerability in relation to assessment of dangerousness and risk” (Krane and Davies, 2000, p. 36). Increasing numbers of children came into care during this period of time (Todd and Burns, 2007, Dumbrill, 2006). A disproportionate number of children investigated and brought into care were from racial minority, aboriginal and poor families (DeMontigny, 2003). The cost of the system spiraled as more and more children were seen to be in need of protection under the new legislation and standards (Todd and Burns, 2007).

By 2005, a comprehensive evaluation of the child welfare system in Ontario was initiated. The Child Welfare Program Evaluation recognized there were unintended consequences from ORAM, including less clinical engagement with families, an inordinate amount of time spent on paperwork, rising numbers of children being apprehended and a recognition that the system was not financially sustainable (Todd and Burns, 2007; Ministry of Children and Youth Services, 2005). In 2006, the Child Welfare Transformation was initiated. A series of new changes were made to the standards and

¹ Herein, I will use the acronym ORAM, to refer to the Ontario Risk Assessment Model.

legislation to address these unintended consequences (Todd and Burns, 2007). These included open adoption, kin placements, alternate dispute resolution, community capacity building initiatives, a new focus on evidence based practice and differential responses to investigations. The former risk assessment *document* was replaced with an actuarial risk assessment *document* that is statistically driven and empirically tested.

Differences between the Risk Assessments used in ORAM and Transformation

The risk assessment under ORAM was the first standardized mandatory risk assessment document required for all workers to use in Ontario. It was a consensus model, where workers rate factors that have originally been identified by consensus among experts. Workers then assess these factors according to their professional judgment (Barber et al., 2007). The former document contained a set of standardized factors, each factor contained a likert type scale with written descriptors ranging from positive elements to very concerning. The worker chose the most appropriate rating for each factor, based upon information obtained in their investigation (from the family, collaterals, file history) and the worker would provide some written explanation of why they rated each factor in a certain manner. At the end, after considering all of the relevant information the worker would assess the interaction of factors, assign a rating of low, moderate or high risk and provide a summary explanation for their overall rating. These assessments would be reviewed and approved by a supervisor.

The risk assessment used under ORAM was based on the New York Model. It was referred to as “state of the art” at the time of implementation (Ministry of Community and Social Services, 2007a; Ministry of Community and Social Services, 2007b). However, its psychometric properties were not examined prior to implementation (Barber et al., 2007). As the risk assessment was being implemented under ORAM some researchers began to conclude that actuarial models perform better in the field than consensus models (Barber et al., 2007). Coinciding with Transformation initiatives, Barber et al (2007) conducted a study to measure the reliability and validity of the risk assessment used under ORAM and found the results were generally unsupportive of the continued use of the document.²

² Interestingly enough, the original investigating worker had better scores for reliability of ratings during this study than the case readers. I would hypothesize meeting face to face with the actual family gives ratings more reliable than a review of case facts.

As stated, when Transformation was introduced one of the many changes implemented was the introduction of a new risk assessment document. The present risk assessment document used across all child welfare agencies in Ontario is now an actuarial model³. Actuarial assessments are referred to as “the gold standard for risk assessment” (Schwalbe, 2009, p. 205). The objective of an actuarial model is to identify factors which are known to be “statistically predictive of future maltreatment and to use this information in the construction of an instrument that can be scored in a purely mechanical fashion” (Barber et al., 2007, p. 1). The worker is prompted on the computer to click a box for each factor to identify if the factor is or has been an issue. The computer generates the risk rating based on the presence or absence of factors and the document calculates a final numerical score and risk rating. “Due to the actuarial base of the tool, the assigned weights cannot be changed” (Ministry of Community and Social Services, 2007b, p.24). There is little clinical judgment used in the present model, with as much as 75% of the factors rated, being fixed (historically occurring, unchangeable factors) (Schwalbe, 2008). The document can be completed in less than ten minutes (Children’s Research Centre, 2004).

The actuarial risk assessment document that is presently being used in Transformation is part of a Structured Decision Making Model, developed by the Children’s Research Center in Wisconsin (Ministry of Community and Social Services, 2007b). There is also a strength and needs assessment and risk reassessment if the file opens up to ongoing service. However, these assessments are not completed as part of the intake assessment so will not be discussed in this paper. This paper will focus on the actuarial Ontario Risk Assessment presently used in intake.

The present risk assessment was adapted from the California Risk assessment tool. Researchers initially sought opinions from protection staff about factors they believed had a relationship to future maltreatment. The workers reviewed research, identified many of the factors on the present risk assessment and collaborated with researchers to develop instructions for scoring (Shlonsky and Wagner, 2005). This field research was then used by researchers to develop a data collection tool which examined a random sample of families investigated and then risk factors were drawn from information in the case files. “Risk factors were identified that had a statistical relationship to case outcomes

³ There are two main kinds of risk assessment models, consensus based and actuarial. Some models contain elements of both.

measures in a construction sample” (Ibid, 2005, p. 415). Items were then drawn from multivariate analysis and then weighed for inclusion on the present risk assessment. The results were then “validated in a second sample of cases that was not used in the construction sample” (Ibid, 2005, p. 415). The assessment yields a four level rating scale (low, moderate, high and very high).

Johnson (2004) conducted a revalidation test and “found that the instrument maintained its psychometric properties” (as cited in Shlonsky and Wager, 2005, p. 421). It was found that each increase in risk level was associated with an increased likelihood of recidivism across all four measures of low, moderate, high and very high (Johnson, 2004; also see Children’s Research Centre, 2004; Regehr, Bogo, Shlonsky and Leblanc, 2010). However, while the instrument distinguishes between levels well, “there are still a high level of misclassifications” (Shlonsky and Wagner, 2005, p. 419).

Prior to being implemented in Ontario, the present actuarial risk assessment underwent a review process in Ontario. Testing was conducted by the Bell Canada Child Welfare Research Center, Faculty of Social work, University of Toronto in the fall of 2005. The test consisted of reviewing the tools with front line child protection workers and supervisors. The tools were also reviewed in draft form by a focus group with Ontario Service Directors and there was consultation with representatives of the Aboriginal community (Ministry of Community and Social Services, 2007a, 2007b). From my review of both documents, it appears the Ontario tool was slightly modified from the California version to include a line at the top to ask if the family was involved in completing the risk assessment.

My Interest

My interest in researching the present actuarial risk assessment model comes from my involvement in child welfare for 12 years. I have seen many improvements from the risk assessment model to Transformation (e.g. differential response, less incident focused, increased community collaboration, kin placements), however, we are still required to complete risk assessment documents at the intake level. My discontent with the present risk assessment document is high. I will make my position and discontent explicit in the next section. I will then move into a literature review.

My Puzzle

Just as the clerk does not hesitate to use an adding machine, the child protection worker should not be reluctant to use an actuarial method to calculate the overall weight of the various risk factors....It is likely that actuarial instruments that use formal statistics to compute the answer are more accurate than clinical judgment (Munro, 2004, p. 881).

The goals of Transformation were promoted as being strength based, less intrusive, increasing emphasis on engaging families, customizing responses and strengthening workers' clinical skills (Ministry of Children and Youth Services, 2007a; Ministry of Children and Youth Services, 2005). My puzzle is that the new risk assessment document initiated is antithetical to these promised goals. Despite other positive initiatives of Transformation, I would submit that the new risk assessment document itself is deficit-focused and offers little room for clinical assessment (See Appendix One). The standards indicate that a worker should use their clinical judgment in completing the risk assessment (Ministry of Community and Social Services, 2007b), yet a review of the document reveals that there are few factors in which any subjectivity can be applied and the document leaves no room for written comments, or for any assessment of strengths or protective factors. Rather than foster worker's clinical decision making, it has removed their voice; rather than focus on strengths, it is 100% deficit-focused.

The worker is provided an option for a discretionary override of the risk rating if they disagree with it. This requires approval by their supervisor and an explanation of why they over rode the rating. Based on their clinical assessment a worker is able to rate the family *higher* than the document, but *not lower*.

Whereas the last risk assessment document contained areas which assessed family strengths and supports and allowed the worker room to discuss the interaction of risk factors and strengths, this document contains no area to rate the family strengths or protective factors. There used to be a place in the comprehensive risk assessment to discuss cultural factors, neighborhood and environmental factors. The present risk assessment has no place to document these factors. While there is a separate document intended to assess strengths and needs this does not exist at the intake level.

In my role of intake supervisor, I am required to approve every risk assessment once it is completed. When I review the document, it tells me nothing of the family, or the worker's opinion. Instead, all I see are black and white check boxes and numbers. What does the risk tell us about the uniqueness of a

family, their story and the context? What does the risk tell us about the protective factors such as: the neighbors, grandparents, extended families, the exceptions to the problem, their commitment to their children and the strides they've made? Nothing, the words are gone. And with it the context, the story, the uniqueness, ambiguity, shades of grey and complexity of decision making are reduced to black and white numbers, a check box and a category.

A further difficulty with the document is that the risk assessment often comes out with ratings which contrast with the worker clinical opinion. In my experience, there are frequent instances in which the risk assessment does not accurately measure what it is suppose to. For instance, if a foster family had one previous investigation which was not verified and they were fully assessed to be a safe foster home, using the Ontario Safe Homes Criteria, if they had a foster child placed in their care who had special developmental and behavioral needs then they would rate as high risk⁴. A foster family who has been assessed to be a safe home for special needs children would be considered high risk to maltreat the children in their care, just by virtue of the child's needs!

In my experience, whether or not present concerns have been verified, families are often coming up as high risk. I fear the present risk assessment leaves workers and supervisors liable in an era of intense scrutiny and accountability. To illustrate with a frequent occurrence, a worker conducts an investigation, makes a clinical decision that the file should close and the family is not in need of ongoing service. However, the risk assessment indicates that the family *is* high risk. Doing what is *right* by the file is not what is *defensible* (Parton, 1998).

At present, we are making a note in the closing summary documenting that although the family is rated high on the risk, for these reasons..., we feel the file can close. Yet, closing a high risk file instead of opening for ongoing service, opens room for professional liability. The statistics, the evidence base, often do not match worker assessment and I fear that the "hierarchy of credible opinion" seems to lie in the document (Philimore and Moffatt, 1994, 145). I'm left to wonder how it gained credibility. Further, has the credibility afforded the document become valued over worker opinion? In a climate of

⁴ The family would receive one point for a previous allegation, one point for the present opening, three points for child with a mental health, behavioral and developmental condition. This would put them at 5 points and a high risk rating. If they happen to have any children under the age of two they would get an even higher score.

contradiction (risk assessment that does not trust clinical opinion and Transformation which seeks to encourage it); my study was undertaken, with appreciation for workers opinion.

CHAPTER 2

Literature Review

Intent of Risk Assessments

The most obvious intent of conducting risk assessment in child welfare cases is to determine whether harm is likely to continue or reoccur, identify cases requiring intensive services, plan interventions accordingly, work toward reducing risk to children and ensuring children are safe and free from harm. (Ministry of Community and Social Services, 2007a, 2007b). Beneath these obvious and necessary goals, there are other goals embedded in the history and ideology of risk assessment. The “development of risk assessment tools in child protection work is rooted in the politics of “risk society” (Beck, 1999, 1992; Giddens, 1991, as cited in deMontigny, 2003, p. 36). In stock markets and among insurance companies and banks, the concept of risk well known (Parton, 1996). Risk assessment offers a way to reduce legal and civil liability (deMontigny, 2003; Gambriel and Shlonsky, 2001).

Method of Risk Assessment: Competing Claims and Discourses

The identification of risk and the understanding of child abuse initially came out of a positivistic ‘disease model approach’ (Parton, 1996, p. 100). This approach holds that child abuse and risk can be identified, diagnosed, predicted, treated and controlled (Houston and Griffiths, 2000; Parton, 1996; Parton, 1998). Risk assessment is a tool thought to “systematically, accurately, and reliably work to identify, assess and correct risk” (deMontigny, 2003, p. 37). The present risk assessment is an actuarial model (empirically and statistically identified) (Scott et al, 2005). With actuarial models, “empirical research procedures are employed to identify a set of risk factors with a strong statistical relationship to the behavioral outcome” (Shlonsky and Wagner, 2005, p. 410). The assessment classifies families according to the likelihood they will exhibit the behavior (Ibid, 2005).

The concept of risk “rests on an assumption we can extrapolate the scientific method to human beings and society” (Houston and Griffiths, 2000, p. 3). The focus is on deductive theory, prediction, control, causality and culpability (Ibid, 2000; Parton, 1998). It can be located in the positivist paradigm. Indeed, the aim of positivism is explanation, prediction and control of phenomenon (Guba and Lincoln,

1994; Annells, 1996). Researchers estimate the “odds of a predicted behavior”, and these odds “provide prediction of how often behavior will occur in a group” (Neuman, 1997, p. 64). This is the basis of Ontario’s present actuarial risk assessment. It is statistically computed, with check boxes and the numerical number and final risk rating is calculated by the computer.

With positivist methods, validated studies using quantitative data and statistics are seen to be of very high quality (Guba and Lincoln, 1994). Within this paradigm, what counts as evidence are “scientific evidence” and ‘expert knowledge’ and data obtained from such research (Beresford and Evans: 1999, p. 627). Positivism assumes that scientific techniques can “regularly produce ‘Truth’ whereas common sense does so only rarely and inconsistently” (Neuman, 1997, p. 65). Scientific research is thought to be “credible”, “reliable”, “objective”, “neutral” and “value free” (Neuman, 1997, p. 63; Guba and Lincoln, 1994, p. 24; Lincoln and Guba, 2003, p. 257; Hawkesworth, 2006, p. 29; Johnson, 2006). The objectivity of science is seen as “superior to other knowledge (e.g. intuition, emotional feelings)” (Neuman, 1997, p. 31). Many studies have supported actuarial and evidence models over assessments based on worker clinical opinion (Johnson, 2006; Shlonsky and Wagner, 2005; Grove and Meehl, 1996).

Objections (to using statistical models) ignore the data from well over 100 studies...The objections to using statistics also ignore the clinical mandate that, for important social purposes such as protecting children, decisions should be made in the best way possible... The evidence that actuarial estimates perform better than clinical judgment at forecasting client behavior is clear (Dawes, 1993 as cited in Shlonsky and Wagner, 2005, p. 411).

While a large body of the literature reviewed supported the use of actuarial assessments in completing risk assessments, there are competing claims in the literature review. Those in favor of actuarial risk assessment contend that it offers an objective, reliable, neutral and valid measure of future risk and harm (Johnson, 2006; Shlonsky and Wagner, 2005; Schwalbe, 2008; Grove and Meehl 1996). There is competing evidence regarding the validity and superiority of actuarial risk assessment models. To begin, actuarial models are seen to be more reliable than workers’ assessments, because two workers may rate the same family in a different way. However, it does not appear studies in support of actuarial risk assessments are any more reliable. Two different actuarial assessments may also rate the family in a different way. Indeed, “no single risk assessment tool is yet widely accepted.

Across jurisdictions, the number of items included in risk assessment instruments varies from 6 to over 40. Thus, there is no consensus about what elements are even “required to accurately assess risk” (Knoke and Trocme, 2004, p. 2). Moreover, scientifically based risk assessments can also produce faulty results. For instance, false negatives occur when a situation is judged to be safe when it is not. Also, false positives may occur, in which a family is judged high risk, when they are not (Munro, 2004). The percentage of false positives is high (Krane and Davies, 2000). Shlonsky and Wagner (2005), highlight while the California risk assessment (presently adapted for use in Ontario), distinguishes between risk levels well, there are still a high rate of misclassifications.

Moreover, there have been some challenges to claims regarding the poor validity of worker judgment. Leschild, Chiado, Whitehead and Hurley (2003) conducted a study on the consensus model and concluded that risk assessment was consistent with clinical opinion, “more than previously reported in studies of risk assessment validity” (p. 527). The overall accuracy rate for worker clinical opinion in their study ranged from 74% to 81% (Ibid, 2003).

While many academics cite evidence that actuarial models are superior to clinical judgment, there is also recognition that some clinical assessment is necessary. Shlonsky and Wagner (2005), cite numerous studies supporting validated actuarial studies over clinical opinion. Yet, they also recognize the importance of clinical assessment to address the “blind spot” of actuarial models. Meehl (1954) refers to this blind spot as the “broken leg problem” in actuarial risk assessment (as cited in Shlonsky and Wagner, 2005, 418). If an actuarial prediction was made that a runner would win a race based on past performance and the runner had a broken leg the actuarial prediction would be wrong. Likewise, the worker can observe and meet the family, thereby becoming aware of elements unknown to the actuarial assessment (Ibid, 418). While Shlonsky and Wagner (2005) contend that actuarial assessment outperforms clinical assessment, they continue to see the importance of clinical judgment. They speak to the importance of discretionary considerations and over rides to account for such situations as the broken leg. As well, they speak to the importance of a contextual assessment of strengths and needs. While an assessment of strengths and needs has been incorporated in the present Structured Decision Making Model used in Ontario, it does not inform the risk rating, they are completed in distinct

assessments and in a fragmented manner. Of importance, they are not incorporated at all for the high volume of cases serviced at the intake level. When the risk assessment is completed in intake there is no corresponding strength and needs assessment completed. This is only completed in ongoing services, if the file has been verified and transferred. As well, while workers may over ride the rating, there is no capacity for a worker to implement a discretionary consideration to lower the risk rating to address the blind spots on the document.

Moreover, a review of the literature reveals tension and debate on the value of evidence based vs. clinical judgment in decision making and risk assessment (Scott et al, 2005; Witkin and Harrison, 2001; deMontigny, 2003). Many scholars contest claims that actuarial models are superior and highlight that ambiguity and complexity of cases are not captured in actuarial models (deMontigny, 2003; Witkin and Harrison, 2001). Facts are not static; the risk factors facing families are fluid, and socially, politically and economically located. The decisions and assessments of workers are not static, but fluid, filled also with ambiguity, uncertainty and complexity (deMontigny, 2003; Parton, 1998).

Further, there is concern expressed in the literature that evidence-based risk assessments “may lead to losing social work’s traditional emphasis on understanding people in context and understanding that individual problems and social problems are inseparable” (Witkin and Harrison, 2001, p. 312). Indeed, despite evidence of structural influences associated with abuse and neglect (Todd and Burns, 2007; Harris, Russell and Gockel, 2007; Blackstock, 2008; Leschied, Chiado, Whitehead and Hurley, 2003; Campaign 2000, 2007; Krane and Davies, 2000), the risk assessment offers no structural analysis. The previous comprehensive section of the risk assessment had a portion to discuss issues of culture, environment and neighborhood. This has been removed in the present actuarial model. Families face a myriad of risks not counted, weighed or measured in the risk assessment. “These are the risks of class, poverty, oppression, and exploitation” (deMontigny, 2003, p. 37). Without the narrative, the social context in which concerns arise can not be assessed (Houston and Griffith, 2000). There is less discretion for the professional to identify what information is relevant. It is determined by the requirements of the database. Knowledge which can’t get squeezed into this format gets lost as individuals are put into categories (Parton, 2008),

The credibility afforded to evidence-based practice has resulted in a “diminished respect for professional judgment” (Plath, 2006, p. 510). The risk assessment model is an example of this diminished respect. It is numerically and statistically based and has erased space for workers to offer their clinical opinion. While clinical input is required on some of the factors, the majority are fixed categories rated solely on the presence or absence of previously occurring behaviors and workers are unable to lower the ratings.

Information and communication technologies are transforming the nature of social work, in what is referred to as, social work’s ‘electronic turn’ (Smith 2004, as cited in Parton 2008). Risk assessment is statistically based and computed on the system, with numbers, no words. Confidence in systems and technology is substituting for “trust in professionals and fails to recognize the importance of moral competence” (Smith 2004, as cited in Parton 2008, p. 260).

The low value placed on narrative in much formal writing indicates ... a prohibition against certain ways of seeing and reporting. Such restrictions often reflect a distrust of hunch, intuition, opinion, or instinct-in other words, a distrust of personal or "subjective" knowledge (Pare, 1993 as cited in deMontigny, 2003, p. 41).

This thesis will seek to explicate this subjective knowledge. I have chosen to seek worker opinion on the risk assessment. I will now turn to review the purpose and objectives of my research. I will provide an overview of the methodology I used.

CHAPTER 3

Methodology

Purpose of the Research: Objectives and Questions

The purpose of the study is to obtain workers' opinions on the present actuarial risk assessment document and risk assessment in general. In particular, I will explore, workers beliefs about what constitutes risk to children, whether they believe assessing risk is necessary, what workers think of the present risk assessment, whether it matches their clinical assessment of families, whether they feel it appropriately measures risk, whether they believe it contains all of the necessary risk factors, whether they feel it guides or constrains their interventions, whether they find it helpful or if have any concerns with the document. I will be further seeking worker opinion on how the document fits with the goals of Transformation, protection of children, child welfare and social justice goals. Further, what changes workers would make to the document if they could? I seek to gain an enriched understanding of workers' conceptualization of risks to children. As well, I seek to gain an understanding of the document's usefulness, strengths and deficits from those that interact with the document on a daily basis.

Theoretical Framework and Influences

Interpretive Social Science (ISS) looks at meaning people ascribe to their experiences and at the social context of actions (Neuman, 1997). ISS "does not dramatically depart from the experience and inner reality of the people being studied" (Ibid, 1997, p. 71). The study will not move too far beyond workers experiences and critical reflections on the risk assessment. I will explore the social context in which their concerns are expressed and situated, which is consistent with ISS (Ibid, 1997). Interpretive theorists believe "social situations contain a great deal of ambiguity" (Ibid, 1997, p. 72). ISS see facts as "fluid" and "embedded" in meaning systems (Ibid, 1999, p. 72). Facts depend on interpretations (Ibid, 1997). It is difficult to discover objective facts, as facts depend on interpretation of people in a social setting (Ibid, 1997, 72). Some critical perspectives will inform the paper. Critical perspectives influenced some of the questions asked of participants. Critical Social Science (CSS) unveils surface appearances

and asks critical questions (Ibid, 1997), which is consistent, with my question guide and literature review. As well, critical social science recognizes the power dynamics over which claims to truth and common sense are based (Ibid, 1997). Critical social science looks at what is studied, what is left out, whose opinions are forwarded, what discourses are heard and what discourses are discounted. I will link some of participants' struggles to broader issues in the field and draw upon insights from critical thinkers such as Swift, Parton, deMontigny, Aronson and Sammon. Thus, while the paper will offer an interpretive account of workers experiences with the risk assessment, critical elements will be infused throughout.

Sample and Recruitment

Ethics approval was sought and obtained by the McMaster Research Ethics Board, prior to beginning the research. I sought to recruit protection staff that have experiences with risk assessment.

Participants were obtained using a purposive, non-random sampling method (Hoepfl, 1997; Neuman, 2003). This purposive sample was obtained "less to generalize to a larger population" than "to gain a deeper understanding" (Neuman, 2003, p. 211). Hoepfl (1997) points out that purposive sampling is used when a researcher is seeking to answer specific research questions and when she/he "seeks information-rich cases which can be studied in depth" (Hoepfl, 1997, p. 43). My sampling technique flows nicely from the purpose of the research (seeking worker opinion on risk assessment).

I recruited 6 participants who work in protection departments. Participants were recruited from two protection agencies to increase chances for participant anonymity. Participants who had experiences with protection investigations and risk assessment were purposefully sought. While the sample size is small, it is sufficient to obtain rich detailed information. Qualitative studies are not designed to be representative in terms of statistical generalization and they gain little by large sample sizes and cumbersome data (Pope, Ziebland and Mays, 2000). The intent was to initiate an exploratory study and a deepened level of understanding from my participants.

A fundamental principle of ethics is that research must be voluntary and no one should feel coerced into participating (Neuman, 2003). I designed my recruitment strategy so that participants would not be approached directly. Instead, I used a passive recruitment strategy. I approached a supervisor from two

separate agencies and requested assistance in recruitment. The supervisor obtained necessary approvals from management for me to begin my study. With permission from management at both agencies, a unit assistant placed a letter of invitation and sample question guide, into each intake workers mail slot. The person delivering the invitation was not a participant in the study and did not approach workers directly about the study.

I was quickly contacted by one participant and proceeded to interview this individual. After a period of nearly two months without further response, it became apparent that my initial strategy may have been too passive. I submitted a revised ethics application requesting amendments to my recruitment strategy such as permission to send an email to recruit staff. Once necessary approval was obtained from the ethics committee, I arranged for an assistant to forward an email to participants with a brief recruitment script and an attached letter of invitation (See Appendix Two and Three).

Participants

Participants ranged in age and levels of experience. There was a significant level of experience among participants. One participant had 1.5 years experience, two participants had 10 years experience, one participant had 12 years experience, one had 13 and one had 20 years of experience. The participants all had experience in completing risk assessments on intake investigations. The participants all had university degrees. Two participants had a Master of Social Work degree, one had two undergraduate degrees and a Master of Social Work degree, one had a Bachelor of Arts and a Bachelor of Social Work Degree, one had a Bachelors Degree in Gerontology and a Bachelor of Social Work Degree and one participant had a Bachelors degree in Social Development and a Bachelors degree in Psychology. In addition to intake, many of the participants had experience in working in other functions within child welfare, including, after hours emergency work, screening, resources, children services, community based work and supervisory experience. One of the participants had experience as both a foster parent and adoptive parent. There was one male participant and five female participants. I did not ask participants to identify their ethnic or racial backgrounds or class backgrounds.

Data Collection

I used qualitative methods of inquiry in the study. According to Berg (2004), “qualitative research refers to meanings, concepts, definitions, characteristics, metaphors, symbols and description of things” (p. 3). Data for qualitative researchers are usually in the form of words, quotes or descriptions of events (Neuman, 2003). I obtained my data in the form of interview transcriptions and field notes. I employed a semi structured interview guide. My guide was quite structured, yet I left some room for flexibility. Hoepfl (1997) indicates that an interview guide “is prepared to ensure that basically the same information is obtained from each person, there are no predetermined responses, and in semi-structured interviews the researcher is free to probe and explore within these predetermined inquiry areas” (p. 47). I used open ended questions in an attempt to obtain rich data.

All of the participants chose to be interviewed in a meeting room at their local agency. The interviews were an hour in duration. All of the questions contained probes for fuller data and detailed responses. My interview guide was influenced by the purpose of the research, my own interest in the topic and review of the relevant literature. (See Appendix Four for the interview guide).

I audio taped and transcribed each interview. I took notes during the interviews, as well as field notes after each interview. I noted any striking themes, concepts, impressions, emotions and quotes which seemed to stand out. In an attempt to increase my familiarity with the data, I personally transcribed each interview. Finally, my thesis supervisor was consulted throughout.

Data Analysis

Through an inductive qualitative approach, I began with some general ideas and concepts. Following my interviews, I then moved into refining the concepts, developing generalizations, identifying relationships and expanding to broader issues (Neuman, 2003). The sheer mass of the data from the transcribed interviews needed to be reduced, interpreted, given meaning and made understandable (Neuman, 2003; Cain, 2009). The meaning given started with the point of view of my participants. I moved beyond this first order interpretation through use of some techniques from grounded theory. “Grounded theory emerges from the researcher’s continuous reflections on the data and the context” (Neuman, 2003, p. 167). “Qualitative coding is an integral part of data analysis” (Ibid, 2003, p. 436). It is

guided by the research question and leads to new questions (Ibid, 2003). In qualitative studies data analysis is a continuous process which continues through all stages of the research project (Hoepfl, 1997). As I conducted my interviews one at a time, I refined some of the questions and my understanding of the issues. As I coded and analyzed the data I could vividly hear the intonations, enthusiasm and frustrations of the participants' stories as I continued to read the transcriptions. The emphasis with which they spoke to certain themes, made the themes become alive and vivid as I attempted to analyze them.

“Open coding brings themes to the surface from deep inside the data. The themes are at the low level of abstraction and come from the researchers initial research question, concepts in the literature, terms used by members in the social setting, or new thoughts stimulated by immersion in the data” (Neuman, 2003, 438).

I made notes in the margins of major themes and striking impressions. I highlighted themes and words which were present in each interview. I made a list of the main themes present in every interview and numerically coded them. I went through the transcriptions assigning a numeric code to all of the data. I then color coded the main codes with the numeric categories as a guide. I gave headings to each of the main themes and moved the data under relevant sections. I then separated the themes into different folders in the computer. I analyzed the data for sub themes, again created a main list of all the sub themes and then again went through each sub file assigning numeric codes, color coding, moving data into the relevant subheadings. The main themes which emerged were organized under the following main headings (workers conceptualization of risk, moving from risk assessment to Transformation, what is measured and what is left out (benefits and drawbacks to Ontario's actuarial assessment), clinical versus standardization, organizational tinkering, and worker recommendations). Sub headings were also generated under each of the main headings for the sub themes which emerged under each topic. Throughout my analysis quotes will be provided “to specify the nature of key themes” (Buehler, Cox and Cuddeback, 2003, p. 65).

Limitations, Trustworthiness and Checks

There are limitations to the study. To begin, I have sought to explicate workers' voices regarding the risk assessment process. Yet, I am aware that the voices of service users remain unheard. For purposes

of my research study, I specifically sought participants most familiar with the document, both its flaws and its usefulness. Protection staff engage with the document on a regular basis and are most familiar with it. Yet, I am cognizant that service users are most impacted by the document as they are the ones being assessed. Moreover, the literature reviewed discussed competing claims or what could be referred to as dominant and subjugated discourses. Service users views on risk represent a subjugated discourse. They are absent on the present risk assessment, and appear to have been absent in the construction of the document. I would recommend further study to obtain service users views of risk assessment, as well as further studies to assess the impact of risk assessment on child welfare clients.

The small sample size poses some limitations as the data does not reach recommended levels of theoretical redundancy and saturation (Patton, 2002; Pope, Ziebland and Mays, 2000). However, as noted this small sample size is sufficient for the purposes of obtaining an enriched understanding of participants' experiences. The study can be used as a starting point to generate critical reflection and questions to stimulate further research.

My bias and interest in the area is both a strength and a limitation. It is a strength in that I was able to connect with participants, go in with intimate and rich knowledge of their culture and profession and have first hand knowledge of the historical developments related to the topic. This allowed me to ask insightful questions. On the other hand, I was cognizant that I needed to control for my bias so it did not cause me to frame questions in a biased manner or remain tuned to certain themes while overlooking others. I attempted to control for this in several ways. I attempted to frame my questions in such a way that my bias is not leading. I asked open ended questions about both the positives and negatives. Further, my training as a child protection worker assisted me in my interviews. I have extensive training on how to frame questions in non leading ways, which assisted me during the spontaneous questions which arose during the interview.

Moreover, reflexivity involves 'active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation. Reflexivity involves deconstructing who we are and the way in which our beliefs, experiences and identity intersect with that of the participants' (Lietz, Langer, and Furnman, 2006, p. 447).

“Instead of trying to hide behind a false sense of objectivity”, I have made my position explicit from the beginning (Lietz, Langer and Furnman, 2006, p. 447). Rather than emphasizing objectivity, qualitative researchers emphasize trustworthiness (Neuman, 2003). I did not share my opinions with participants during interviews as I did not want to influence them. However, explicating my own position from the beginning of the paper should increase the trustworthiness of the study, as the reader may be able to interpret any apparent bias in their reading of the study (Greenhaghl and Taylor, 1997). I intend to make a summary of my research findings available to each participant and I hope this will increase the trustworthiness of the results. This served to remind me throughout of the need to have their opinions accurately reflected. “For ISS, a theory is true if it makes sense to those being studied and if it allows others to understand deeply or enter the reality of those being studied” (Neuman, 1997, p. 71). In other words, findings shared resonate with those being studied (Neysmith, 1995). Knowing that I will be providing participants with a summary of the results, served as a constant reminder to me that I will need to accurately reflect their stories.

To further increase trustworthiness, I regularly consulted with my thesis supervisor, reviewing interview questions, final transcripts, data collection steps and emerging data. This formed a method of triangulation. Triangulation involves looking at something from several different angles and view points, rather than only one way (Neuman, 2003). With triangulation of observers, “multiple observers or researchers add alternative perspectives” (Neuman, 2003, p. 137). Constant feedback and oversight from my supervisor increased the validity and trustworthiness of the study.

CHAPTER 4

Findings

What Constitutes Risk?

Interviews began with a general discussion of workers' thoughts about risk assessment and whether they felt it was necessary to assess for risk. Every worker I interviewed responded firmly that they believed it was necessary for child protection workers to assess for risk.

There are some pretty basic things you just can't let go of. We have a risk assessment model because kids died. And I mean they died when they shouldn't have and had there been more emphasis at looking at risk factors those kids would still be alive.

Workers saw benefits to assessing risk to children and they highlighted that this was a core and essential part of their job. One referred to risk assessment as "the foundation of what we do". Workers expressed fear of what would happen if they did not assess for risk and saw benefits of engaging in risk assessments.

Everyone benefits from assessing risk. I mean in the end when the child dies I think you have to look at the parents for sure, but if we missed something, then we are responsible too and we are liable. So to prevent a child being injured or hurt or killed is only a good thing.

While no one expressed any hesitation about the need to assess risk, they did express hesitation about 'how' we are going about doing it. They questioned why certain factors were measured, how they were measured, and why certain factors were left out. They saw themselves as having an important role in navigating these tensions and complexities and in sorting through a disconnect with how the document measures risk. The following statement highlights the debate around the "how" we are going about it.

It is definitely necessary to assess for risk. The risk assessment is a measure. The conflict has been is how do we measure risk and can a tool be used to measure risk and if the risk assessment says it is this score, does it really mean the child is in need? Because you find sometimes the child gets a very high risk rating however, things are going okay with the family. So definitely our job as protection workers is to ensure we help determine what the risk is, whether the family is eligible for service and to help determine what their service needs are.

Workers began their exploration through a discussion of factors associated with risk to children. Workers identified risk factors including history of involvement with child protection, a history of abuse

in childhood experienced by the parents, a pattern of reports or verified concerns, length and extent of previous involvements, history of perpetrated abuse or neglect by the parent, severity and extent of historical and present concerns, domestic violence, mental health, substance use, intergenerational factors, caregiver capacity concerns, child behavioral difficulties, child's age and vulnerability, parent's age and vulnerability and lack of supports. Workers also identified structural factors as contributing to risk to children, including poverty, marginalization and lack of supports in the community. One worker identified that she felt "all the isms" contributed to risk to children and families. One worker also spoke of potential risks to children and families as a result of agency interventions. While workers saw common factors associated with risk they were clear that these factors could not be used across the board to indicate risk as each situation is unique.

Across the board there aren't things that I would say every time indicate risk...my understanding is that is very specific to *that* family and what has gone on, what's going in *that* family. So it is important to measure risk but I am wary of measuring it across the board.

Given this, workers felt a risk assessment tool needed to be flexible, with certain common factors to assess, yet also ability to be individualized to each family. They questioned the validity of rigid tools: "We definitely need to assess no doubt but the assessment tool that we use needs to be flexible for different cases, because every situation is different."

From the Risk Assessment Model to Transformation

Workers saw many benefits in moving from risk assessment model to Transformation. Workers described the previous risk assessment model as a punitive, deficit-focused model which was brought into place in response to child deaths. Workers recognized that there were unintended consequences of risk assessment, including: less engagement with families, more focus on paperwork, more children coming into care and a loss of trust with families and community.

When I started, if we had to apprehend they just went to foster care. We didn't look out family, we didn't think to ask can they go to their grandfather, or can we do this or that. I really do think that was harmful, not helpful always. And I remember there wasn't as much emphasis about getting the community involved. It was about assessing the immediate risk, so you were looking at the risk and if the risk was above a certain line you apprehended or if you could put a safety plan in you did, but it wasn't as much, let's connect with our community partners and work

more in an integrated fashion. There was a lot less of that. It seemed at the time we didn't get along as well with our community providers.

Workers identified with Transformation there is more ability to respond to risks in a less deficit focused and intrusive manner. Workers spoke of Transformation opening up possibilities for a differential response. There is more "permission and expectation" to look for and seek out strengths and protective factors. As well, Transformation legitimizes options not assessable under the Ontario Risk Assessment Model, such as providing community links instead of investigation on lower risk cases, a forensic or customized investigative approach, admission prevention funding, community capacity building initiatives, the use of kin for placement of children versus just foster care and focusing on solution focused models and methods to assess and address risk. The options available for workers to intervene in a less intrusive manner to address risk and build on safety have increased.

Transformation I love. Transformation is a lot more strength based and solution focused. ... It allows a more customized approach ...If I don't want to do a forensic interview I don't have to... It allows for more collaboration with the families... involving them in service planning, involving them as much as possible in the process...It continues to be very child focused. It has lowered risk in the sense of finding family strengths. Kinship opportunities are huge, there wasn't that push as there is now to find alternatives for families other than foster care. ... And that will hopefully help the community professionals we work with think differently about our care....., there is also alternative dispute resolution which I love, love, love. The main one I use is Family Group Decision making and that allows for collaboration with the family. The family makes the plan, we have our bottom lines but the family is very much involved in the plan. It is very strength based solution focused, thinking of the client as the expert in that situation and it just demonstrates all that kind of stuff and like the work with Signs of Safety, we are doing a lot of work with that now.... ADR to decrease the amount of court application and I think it does ...Community links ...that's huge too, we wouldn't have been able to close cases, before we would have had to open up, we wouldn't have provided information.

Workers spoke with tremendous enthusiasm about Transformation and also with pride in their agencies. The workers highlighted that they believed their agencies were "leaders" in the field. They spoke of increased positive relationships with clients and enhanced relationships with community collaterals, which they believed helped to increase child safety and decrease risk.

You have to get in the door first ... so they don't realize people have changed. I think Transformation has given us an opportunity to educate, rather than just assess risk period. And people could see us as the helpers that we would like to be looked at as. And I think communicating with the schools. We are all in this together. Still with the difficult cases ...we

can now look to Kin service and it is better for everyone. Children see their families. Families see their children. And um, if there is progress to be made that is fine.

Workers spoke positively about the Transformation model, but they did not feel the present risk assessment document was consistent with Transformation initiatives. Some participants pointed out that the actual document used to assess risk in Transformation is actually more deficit-focused than the one used in ORAM. The document used in ORAM had areas to assess for strengths, it had an area for them to assess for community supports, to assess for neighborhood and related factors, to assess cultural considerations and to explain the context of a situation. Provisions such as these were removed from the present document.

Oh I way preferred the old document; yes, there was a lot more writing. I get that. But you could capture things there. Even if this gave you a yes, but. Like a place where you could add something if you had to. ... Here we joke around; if you breathe you are moderate. This doesn't tell me anything, honestly, it doesn't tell me anything. Even if they had something where you could put in comments that you felt were important. Because this is something, like a cookie cutter. Like you are trying to fit a complex family into something like this and you can't. The old document, you could really tell a story. You could go in and give short answers if that was all needed or you could really tell a story. Before looking through the history, you could see where people have improved over time. I hate to sound like social workers like complain a lot and I remember all the moaning and groaning over all the writing we did, but part of it might be, if we had lower numbers, then you would be able to give the time to the writing.

Workers found it perplexing that the present risk assessment used in Transformation is itself deficit focused, with no area to assess for strengths and no area to capture the workers' thoughts in relation to risk. In the following section, I will explore what workers saw as the benefits of the present document and I will outline their concerns with the document. The benefits and concerns can best be captured under the heading what gets measured and what gets left out.

Benefits and Concerns: What gets Measured/ What gets Left out?

Benefits of a Standardized Approach

The workers said they saw benefits of research-informed risk assessment documents. Some felt that having research-guided factors may minimize possibility of middle class bias and others did not want to have assessments based solely on worker clinical opinion. The workers pointed out that there were inconsistencies in approaches from one worker to the next, from one team to the next and one manager

to the next. They identified the need for some level of standardization to the assessments and to practice. All of the workers identified that they felt having some research informed factors in the risk assessment was important. They felt that this helped to guide their assessments, as well reminded them to remain in tune to certain factors that they might otherwise not have thought about.

The other strength mentioned by all the workers is that the present actuarial risk assessment does not take long to complete. They spoke to the previous risk assessment taking hours to complete and liking that this document was quick. They appreciated that it was not time consuming so did not take away from other areas of case work and family contacts.

Workers were, however, quick to qualify any positive statements made about the present risk assessment document. For instance, while they highlighted that it was quick to complete, in general they felt the results were “unhelpful”, “useless” and “not a very good assessment of anything”.

Attempts to further probe for positives of the document were unsuccessful.

I mean this current risk is quick, it is just a click box, takes you five seconds to do it. For me, I like to look through old risk assessments, to see what was going on at that time, so you could come up with a plan, this current risk doesn't tell you anything.

One participant commented, “The factors needing to be assessed are captured in the document, yes, but they are not useful”. “Useless” was a phrase many workers used in describing the present document. The next section will more fully look at worker discontent with the present risk assessment model and standardized practices.

Concerns: What is Left out and Not Measured

Many of the workers' concerns centered on what is not measured or what is left out and not captured in the present risk assessment document. They felt that the risk assessment does not measure strengths or protective factors which mitigate the risk, does not include the principles of Transformation, does not look at context in which concerns arise, does not measure progress, change, flexibility or adaptability, does not include an area for written, does not inform their next steps, does not measure structural factors associated with child abuse and it does not capture the worker or families views. As a result, in the opinion of the participants the document comes out with inaccurate or skewed

ratings. The next section will explore each of these main concerns and will end with a discussion of how workers attempted to manage the constraints of the document.

Left out: Assessment of Strengths and Protective Factors to Mitigate Risk

If you don't assess for strengths, you just don't get a holistic view of the family because some families are just not defined by their risk. They really aren't.

When Transformation was initiated there was a strong focus across agencies in Ontario on incorporating strength based practice into worker assessments and interventions. All of the workers I interviewed referenced the Signs of Safety Model (often referred to as SOS). Many of the workers interviewed had some training or exposure to the model and all participants spoke of their agencies incorporating the Signs of Safety Model into their work. The Signs of Safety is a model based on a book by Turnell and Edwards (1999). The model emphasizes that safety can not be achieved focusing solely on risk, but also by focusing on strengths, exceptions to maltreatment and the building up of protective factors.

Workers felt the inability to explain the mitigating strengths, protective factors and progress contributed to the high risk ratings. One participant commented. "Oh I don't like that at all, that it is totally removed (strengths) because really if you were going to balance them I think it should be included and maybe everybody wouldn't be very high or high". Another participant commented, "I think to be a real true risk assessment you have to add in the strengths. You have to include strengths if you want the whole picture; otherwise it is not fair or accurate". Workers expressed if families were assessed solely on their risk you would miss out on the factors which are mitigating the risks and keeping the child safe. Hence, your risk rating would be inaccurate.

Participants explained that this does not mean "being soft" on risk or overlooking risk factors. Rather, one worker explained if you are regularly looking for strengths and protective factors and are not finding any that also speaks loudly to risk and gives you an indication of areas you need to work on. Workers highlighted that building upon strengths, protective factors and resources mitigates risk.

Left Out: Whole Picture, Social Context, Yes But...

The lack of context was identified by all of the participants as a concern with the present risk document. The assessment is based on static factors (presence or absence) and a check mark received if a factor is present. There is no room for gray. This led to confusion for workers who did not feel they could necessarily click the “no” button but didn’t want to click the “yes” button either. Workers repeatedly used the phrase “yes, but”, when describing family situations and the complexity of their assessments.

And there is nowhere, actually no where in the document, where you can put in a blurb to explain something that doesn't quite fit, because we've always got those.

They did not feel complexity could be captured in the present document. One participant summed this up by saying; “I don't know, I don't think you can capture a family’s story in a check box so I don't think it is a very good assessment of anything”. Workers provided contextual examples of where the document did not pick up on the context of the risk factors and as a result they indicated, the assessment was incomplete, inaccurate and unhelpful to them in the work.

Workers did not feel any two situations could be assumed to have the same risk level just based on the presence or absence of certain static factors. Workers highlighted that the context around the factors helped to explain whether the situation was one of high risk. The following quotes illustrate their concerns.

Because you could have the exact same scenario, this lady is completely new to the city and very isolated and this lady has lots of friends, ties to the community, really involved in the school. So it is the same scenario but higher risk in one. And it really shocks me that we were all suppose to be getting into signs of strengths and it is not really even on here (the risk assessment document). As a matter of fact it is any sign of risk and let’s double it.

Workers were unable to incorporate the nuances and complexities in people’s lives. They were unable to make many situations fit into the yes or no check box as they saw the shades of grey, the “yes buts”. The following case example offers another illustration of the complexity of context.

I don’t think there is any way to qualify yes there were a lot of problems 10 years ago and this is what they did, so dad’s no longer in the family and the concerns were about him, or maybe we’re talking about a teenager now instead of a 2 year old so there is just not enough room to be able to expand on this, whereas with the other risk assessment you could explain yes there was

substance use but, they did this, this and this, so it is not a risk now, and it was just very clear because you could explain.

Left out: Progress, Adaptation, Flexibility vs. Static Factors

Workers expressed concern that the document was so static that it did not take into account change or progress. Workers described that there is no way to capture the planning they have engaged in with the family to reduce risk. The document captures static factors without looking at progress or changes which have significantly reduced risk to children. Workers spoke to the possibility of conducting risk re-assessments in ongoing services and being able to capture some of these changes. However, if a file is open for investigation at the intake level they were unable to capture risk reduction plans in the risk assessment. Some participants wished for a more active assessment of risk, one that would speak to historical risk factors, but differentiate between active risk to the children and historical risk⁵. They highlighted if there is an active risk it should certainly be rated higher than a historical risk factor, but in the present document they are rated the same. One worker spoke to how angry she would be if she had a historical drinking problem, went to treatment when her children were toddlers, did everything the agency wanted her to do to reduce the risk, 10 years later she has remained sober, her children are teenagers and her risk rating stays the same⁶. She questioned, in such a situation, the family can never change their risk rating, there is no possibility for changing that rating, it becomes an unchanging element in the risk assessment and is viewed by the *intake* actuarial document no different than a parent who actively becomes intoxicated in the presence of their children.

Whereas if it is just a static document, they really don't have control over any the risk factors and they don't have any ability to change it ever. How do we get it down, versus if you do it based on static factors they don't have ability to change it.

The possibility for hope and ability to influence the risk rating through encouraging families' active efforts is seen as an important element of the child protection role. One worker commented that

⁵ Workers were clear they felt an assessment of historical factors and how they contributed to present risk was necessary. They felt it was important to assess for historical risk factors and identified in some circumstances historical factors could continue to contribute to risk. Yet workers believed historical risk factors should not be rated the same as active presently occurring risk factors.

⁶ The actuarial risk assessment used in intake measures static factors (presence or absence). It does not assess for progress, change or flexibility. There is a risk *reassessment* and *strengths and needs* in ongoing services which would capture this progress. However, for the multitude of families involved only at the intake stage of investigation then the strength and needs and risk re-assessment are not conducted.

families make improvements and changes; they don't stay static in their risk. Some of the participants had some concrete recommendations they would make to the document to capture this. These will be included in sections to come.

Just sometimes our families change so quickly that static objectivity can't apply to all situations, and they can adapt so quickly as well, there could be a support system, maybe an unseen support system that doesn't get captured in the risk assessment Again the risk assessment is pathology based. Based on facts, that again, don't capture everything. Does it capture what are the resilience factors, the adaptability and flexibility of certain people? The document can be rigid. But the families aren't.

Workers did not feel their practice could be fully structured. Facts used to base risk assessments on are fluid and filled with ambiguity and shades of gray, uniqueness and so many interweaving variables not captured in actuarial documents.

Left Out: The Family's View and their Story

Workers spoke to how the factors in the Risk Assessment Document were so unchanging there was little that the families could do to have input into the ratings. While workers engaged families in discussions of risk and how to reduce risk, the actual document remains static and is so heavily based on presence or absence of previously occurring factors. Moreover, some participants identified that the family and children's voice in their own perception of the risks they faced was lost in the document. One participant also explained how children may not see the same risks as the document. They may view risks of separation from their family as greater than the risks identified in the assessment. He spoke to the children being exposed to risk of emotional harm, caused by intervention itself, if they are removed from school, friends, community and their family. He questioned why this is not weighed in the present risk assessment document. He engaged in a rich conversation about why some risks to children are weighed and not others on the document. He was clear that risk assessment was necessary and children should not be left at risk of harm, but questioned if intervention itself sometimes leads to harm and why this is not measured.

So the children may not necessarily see themselves at risk themselves or might not necessarily agree that out of the home is not a riskier situation and they don't care about poverty or that they are not getting things like other kids are getting they just, want to be home.

Sometimes there are situations where teens in care continue to return to their home despite agency recommendations. At some point there are kids that say I don't care about your risk assessment. I don't care if my parents are drug addicts. Now you are forced to look at signs of safety. Now you are forced to say how we can figure out how to make this work and you got to wonder why we couldn't do this in the first place.

This participant was not suggesting leaving children in situations where they may be harmed. Rather it is necessary to consider all of the harms to the children, including the harm caused by intervention, prior to making a decision to intervene. As well, he felt it was important that children and families have a voice in defining what they believe is contributing to risk for their family. He indicated that the risk assessment does not capture the child or the parent's worries or concerns. If risk factors important to the children and family are not considered then we are missing a very significant piece of the puzzle in our assessments.

Left out: Written Assessment to Explain

Workers did not want to return to writing lengthy time consuming accounts as was necessary in their former psychosocial assessments (predating risk assessment), or as they were required to do in the risk assessment model. However, they all spoke to wanting to be able to have some areas where they could speak to the risk based on the unique set of circumstances and context that is presenting in each case. One worker stated "if I want to write a novel I should be able to". Another comment was "even if there was place for a yes, but". One participant spoke to wanting to be able to add levels. For example a risk factor can be present but there are always degrees of severity which are not presently captured. The workers saw an essential lack of fairness to the document and a lack of room in the document to insert this. They expressed empathy for families and in describing certain situations often put themselves in the families' shoes how would they want to be treated. Workers described that the human side of the assessment, the social and the relational is not captured in the present form, as well that worker intuition and assessment is not adequately captured in the check box.

Left out: Clinical Opinion

“Does it capture your clinical assessment? No it's a yes or no questionnaire”

Workers were quite clear that their opinions were an important as part of the assessment and frustrated when the document disagreed with them. None of the workers interviewed stated that the document captured their clinical assessment of risk.

Absolutely not. Absolutely not. It is check boxes. There is no where to even write your own assessment anywhere, not that I am advocating for writing reams and reams. I think typically we have always hated the tick boxes because it really doesn't capture anything well.

Workers described making decisions based on complex assessment factors that the document can not capture. They varied their assessments and adjusted them based on minute variances in circumstances: current risk, protective factors, strengths, history, systemic issues families are facing, extent and severity of the factors, age and vulnerability of the child in direct relation to the reported concerns. As well, they utilized the all the other factors identified in the assessment. Their answers appear to indicate they scaled the presence, severity and extent of each of the factors. They considered strengths, protective factors, and existing safety levels. They considered the safety level of closing and made decisions from there. In relaying case decisions workers descriptions were contextual and fluid. While the document assesses risk in a standardized fashion, the workers did not.

Left Out: Doesn't Inform Next Steps

The Ontario Child Welfare Standards indicate that the risk assessment document is not meant to replace clinical judgment, but is meant to guide workers in determining whether a file should close or open, as well as the intensity of service the family requires (Ministry of Community and Social Services, 2007a). All of the participants indicated that the document did not help them with these decisions. They indicated that the check box appearance was so standard it did not tell them anything about the family and did not contribute to greater insights for them. Aside from drawing their attention to certain factors, the workers all agreed that the document did not influence their decision making or inform their next steps at all.

Do you think that the document itself influences your decision making or helps inform your next steps? No. No. I do click, click, click, click. I don't. I look at it. I don't think it is the be all and end all. I don't think my decisions are based on the risk assessment. Glad it is a quick document then you can just send it and focus more on the other stuff.

Left Out: Accuracy

I'm not sure what the purpose is because I don't find it accurate, you can have high cases that close and low cases, that open. So I don't see what the purpose of it is... and I don't know whose interest it serves. Workers have to do it to get to the next document, but no one takes them seriously, I can tell you that.

Workers questioned the accuracy of the ratings. They indicated if there is no history of CAS involvement, but significant active concerns on the case, the file will still come up as low risk as the static factors do not capture the seriousness of the one incident. Workers indicated the more frequent occurrence was that the document would be higher than they felt it should be and they were not permitted to lower the rating. All of the workers spoke to the actuarial document often coming out with ratings they disagreed with. One participant indicated that "It is very punitive before we get together we are going to decide you are high risk. It is not accurate which irritates me". Workers commented that it was very difficult to be low risk, "Like, do you know how hard it is to come out a low risk?" Workers felt that the present actuarial assessment was flawed, as ratings so often came out moderate and high, often for factors which they did not agree with. They felt such high ratings were oppressive to families.

One participant stated "we have a joke around here, if you breathe, you are an automatic medium". "Basically, if you have lived you are a medium". Some participants commented that they have discussed rating each other and do not believe they would be low if they were to rate themselves.

Like look at this one here, it is low and I think it is the first one I've seen so low. (Surprised voice and then long pause) and of course I can't tell why. Oh wait, that's because it hasn't been filled in yet. It was just printed off and is still blank. Laughter. That was funny.

Workers described many factors as contributing to the high risk ratings, including heavy reliance on historical factors whether they were actively present or not, verified or not, no scaling or weighing of degrees of severity for the risk factors (a caregiver who is presently hospitalized with significant mental health concerns will receive the same point as a caregiver who has not had depression in years).

Workers felt the inability to explain the context of concerns, the present situation or the progress, strengths or mitigating factors contributed to the high risk ratings.

The preceding section explored workers concerns with elements not counted or measured (left out) of the present risk assessment document. A final factor workers identified was left out of the risk assessment was the absence of a structural assessment and an anti oppressive lens. This will be further explored in the next section.

Left out: Structural and Anti Oppressive Considerations

Power Inherent in the Role and in Completion of Risk Assessment

As stated, participants all agreed that completion of risk assessment was a necessary part of the job for child protection. Some workers recognized that the power inherent as a result, created a situation in which relations would always be unequal and oppressive to some extent. One participant commented,

Do you find risk assessment in general fits with AOP? It can, but a practitioner has to be very careful in addition, and the client will always see oppression. It is embedded in the whole practice in that somebody is sitting in a place of power assessing somebody else's pathology and weaknesses.

Workers were clear that part of their job was to assess risk and discuss any concern with families and wondered how this might be accomplished while at the same time minimizing power differentials and oppressive experiences. While completion of risk assessment inherently seems to create a situation of unequal power imbalance, workers felt some methods of risk assessment could exacerbate oppressive experiences for the clients.

Left out: Structural Factors

Workers were cognizant that not all risks to children were a result of parental factors. One worker responded to a question about what factors she feels contribute to risk of harm to children and she responded by saying "I'm trying to think of all the isms". Workers spoke to issues such as poverty, social isolation, insufficient community supports and resources and marginalization, as contributing to risk to children. Some participants described frustration with the document's lack of structural analysis of risks to children. After describing in length situations in which families do not have resources with which to mitigate risks, one worker commented, "Those issues frustrate me. They aren't captured very well".

Workers saw the need for a structural analysis, yet also questioned how a structural analysis could be incorporated without being oppressive. One worker spoke of her concern about what judgments would suddenly creep into the assessment. The complexity of considering structural factors, but not doing so in an oppressive manner, is demonstrated in the following comment. When asked if there were other factors she would like to see assessed in the risk assessment, one participant commented;

I'm thinking of AOP stuff there for diverse families, like are the family new immigrants? What else could be impacting? I don't know how you would do that without being oppressive too though. Maybe just another section an optional section you can create in the document, like what else may be contributing to risk to the family that may not be listed above and then maybe give them a rating to lower it, because there could be some other obstacles that the family are facing that are not captured there.

Anti Oppressive Considerations in Clinical vs. Actuarial Assessments

While workers saw concern with relying solely on actuarial documents, they also had concern with relying solely on workers clinical opinions. One worker commented that they would not want to go back to the 40s and 50s where assessments were based on middle class values. Workers spoke of the concern that assessments based solely on clinical opinion could be influenced by their social location.

I would be very wary of relying on workers clinical opinion alone, I know a lot of it is on that, but then you have take into account workers social location, where they are coming from you know we are suppose to be collaborative as well, we are suppose to see the client as expert, us prescribing it, then it would come from where we sit versus where the family sits. Although the risk assessment makes us look at risk, it is not just clinical judgment.

On the other hand, workers also commented that many workers themselves have come from marginalized backgrounds, may have experienced poverty growing up and may have lived sensitiveness to issues of oppression. They also spoke to how their educational and social work training made them cognizant of issues of oppression. Workers also pointed out how worker's assessment of structural factors and use of self could help offset the deficit focus of the present actuarial document (see section on organizational tinkering below).

Does it fit with Anti oppressive practice how or how not? I have never really thought about that but I would have to say no because we are being oppressive with these kinds of scores without taking anything into account, same with drugs and alcohol, mental health. I mean, mom is diagnosed with bipolar, she takes her medication, sees her psychiatrist, knows she needs help, her children are fine. So she has a mental health problem, but she can still parent.

Workers expressed concern about the oppressive nature of applying formulaic approaches to complex issues. One worker stated, "The document can be rigid but families aren't," One participant commented that you can't fit the same "cookie cutter" approach to all families. Some workers were quite clear that formulaic approaches were oppressive and others were conflicted whether actuarial approaches and the present document were consistent with AOP.

Workers considered whether actuarial assessments could be oppressive. One worker commented that if the assessment was based on pre determined statistical factors then she couldn't really be oppressive because her opinion was not included, and therefore, her assessment was not influenced by her social location.

But in fairness, maybe because, if it is just facts, then maybe it does fit with AOP, because I can't be oppressive then.

She continued to explore this out loud. Her internal debate over whether the document is oppressive speaks to the complexity of the issues. Earlier in the interview she expressed that the document could not oppress, as it was neutral and based on static facts. As she thought out loud she came to the conclusion that the document can be oppressive, as it measures certain factors, but not others, misses out on the whole picture and comes out with inaccurate ratings.

I don't think it is an oppressive document... (Pause). But it can be. The document itself is not, but it can be, because it misses some stuff - there I just completely contradicted myself- but maybe it is oppressive now that I am talking about it. Because it alludes to higher risk ratings when they are not existent and lower risk when it should be higher so maybe it could be depending on family situation and where there are coming from. So maybe it could be oppressive to the family. I don't think that is the intent. And I think only when it is an inaccurate level of risk that it becomes oppressive and if it is accurate then it is okay.

Participants did not feel the actuarial assessment captured their clinical assessment or the uniqueness of the family well. Participants repeatedly expressed that they felt the standardized assessment is "not fair" as it rates families on pre determined factors. It does not consider the difference between active risk and historical risk thus ignores any strides the family has made. It does not assess systemic difficulties the family may be facing and as a result does not assess the family based on their unique set of circumstances. A significant indication of the oppressive nature of the

standardized document is the loss of uniqueness for the individual family. One participant commented that you could lay the documents side by side and not know anything about the family as the documents are all check boxes.

About the Family, without the Family

One worker spoke of how she felt the document was oppressive because it was “about the family, without the family”. The standards indicate that the family are to be involved in completing the risk assessment, but the factors are so static and fixed, that there is little input they could have which would change the predetermined nature of the assessment. Workers spoke about their concern with the fixed ratings.

And I would have an issue of sharing the results with the family that's where I would say it's oppressive, not really fair to the family, like holding onto things from the past that they have dealt with, like a historic drinking issue that is not a worry at all right now, but you are there holding onto it. And I am sure there must be research and a reason it is in there but when it comes to telling the family that is why we think you are coming back, I don't think that's fair.

Workers attempted to have discussions with the families around the risk categories but did not share the actual document with the families as they did not see the document as helpful or useful. Many of the workers indicated that they would be angry if they were the client and the document was shared with them or they realized that factors which were no longer an issue continue to be rated on the assessment.

Workers spoke to discussing the risk factors with the family but none of the workers interviewed brought the actual document out to show them the risk assessment. They felt the document itself was so deficit focused that the families would not respond well. “I could just see people getting very upset with it...so I don't think bring it out, because it would upset people”. One participant stated “I won't respond well myself to having to bring it out”.

Interview findings indicate that the actual document and rating results are not shared with the family as workers often did not agree with the outcomes and did not want to share a document with the family

that they did not find helpful themselves⁷. As well, interviews indicated workers struggled to see the benefit in engaging the family with such a deficit focused, static, rigid and pre determined document. Workers all expressed concern with sharing the document with the family as they felt it was not a useful or helpful document, they did not agree with the ratings and felt that it would only anger the family. While workers saw benefits in having the family engaged in the risk assessment process, they did not feel they were able to do so fully with the present document given the deficit focused and oppressive nature of the document itself. Workers described drawing more on Signs of Safety approaches to engage families in discussions of worries about danger, harm and safety. Rather than use the actual document with families the findings indicate workers used themselves to buffer the impact of the deficit focus, preferring instead to engage families in an active discussion about the concerns and worries and plans to address them.

Wishing for Balance in the Document

Workers expressed a wish for assessments to be balanced and accurate and as non oppressive as possible. Workers expressed concern for extreme between risk assessment based on solely on statistical factors or solely on clinical. They saw the need for some research influence to prevent from assessments based solely on worker opinion; however, they clearly indicated that worker assessment was required to offer the context to the situation, to explain the ratings and to navigate the complexities of individualized factors and circumstances.

Workers saw the need to assess for structural factors and saw the necessity of balancing out the deficit and individualized focus of the risk assessment. At present, analysis is unbalanced by focusing solely on individual factors and deficits. Workers were cognizant that a more balanced assessment would look at the whole picture including strengths and structural factors which were also impacting upon the family. Many of the workers interviewed spoke to how they continued to incorporate a structural analysis, even though it was not part of the actual risk assessment. They indicated that they used their training from school and other more relevant documents. As well, they attempted to

⁷ Of note, documents that workers found helpful were shared directly with the family. Many of the workers discussed bringing the strength and needs document to share with the family. However, this document is not completed at the intake level and only after a file is transferred to ongoing services.

advocate where they could at greater systems levels. Workers recognized that the risk assessment used in Transformation is deficit focused itself, and lacks structural analysis of risk, but commented that they continued to try to include this analysis in other areas of their paperwork where the written word is permitted.

To summarize, workers did not feel that the risk assessment document used at present was consistent with anti oppressive practice. They were concerned that it lacked any assessment of structural factors, that it lacked any assessment of strength and that it was a uniform approach that did not capture the uniqueness of the situations families are experiencing. They felt inaccurately high ratings were also unjust to families. They were concerned that it did not allow the worker to discuss their impressions and as well, there was no room for the family and child's voice to have any significant impact in the assessment. Workers attempted to manage this disconnect through creative use of self. They spoke to drawing on their social work background and schooling to continue to incorporate analysis of structural factors. They also attempted to involve the families in a discussion of risk through a variety of methods. Their attempts to mitigate the deficit focus of the present risk assessment will be more fully explored in the section on organizational tinkering.

I will now move briefly to a discussion of workers' acts of resistance and organizational tinkering against the actuarial document and structured practice. I will end the themes with a discussion of what workers identified they would like to see happen.

Can't Take the Social Out of Social Work: Organizational Tinkering

How and Why Workers Resist the Box of Standardization

Workers often disagreed with the results, and consequently the results did not appear to influence their planning in any meaningful way. Moreover, because the instances of disagreement happened on a regular basis, workers began to question what the document was even measuring at all. They questioned whether it was measuring risk of future agency involvement instead of risk of actual harm to the child in the future⁸. The disconnect was so significant for one of the newer workers that she advised

⁸ Workers stated that risk of future involvement was not necessarily a 'bad thing' as many families became re involved on a voluntary basis for supportive services. As well, workers indicated future involvements often do not arise out of actual harm to the child.

me the purpose of the document was to assess whether a future report will be made to a CAS. She did not realize the intent was to assist them in identifying high risk files and to draw their attention to cases requiring potentially intensive services as a result of future risk to the child. Workers did not appear to make use of the document in any meaningful way in their work.

One of the participants commented that “even as something as static as risk assessment can be influenced”. Interviews with the workers suggested that if they did not agree with the science, they found ways to insert their own opinions and assessments anyway. They engaged in what Aronson and Sammon (2000) coined as Organizational Tinkering. Workers saw the drawbacks in accepting the science at face value and chose to disagree. Workers still used their clinical judgments (spoke to using training, SOS, social work education, clinical supervision, family input) to determine the risk rating.

I think a drawback could be just accepting that a family has a risk rating of high and if you are high you would automatically be transferred (to ongoing service). Not that we do that. But we could. Because theoretically why would you ever close a document that is high. So you could become complacent of letting this document do the work for you instead of using your clinical judgment when you are out meeting with the family.

Attempts may be made to try to lesson clinical opinion to make practice more scientific, routine and standardized, but as one of the participants commented: “you can’t take the social out of social work”. There appears to remain a human side of social work that can never be fully standardized. Workers are still managing to insert clinical opinions, they are disagreeing with the document, filling it out as they are suppose to, but using their own assessments anyway. In creating an illusion of static objectivity, workers are filling in boxes and the information within the box becomes obscured. Attempts to achieve consistency and to standardize practice to such a high degree, has resulted in worker subjectivity being hidden with a box versus explicated. As well, workers are filling in the forms as required but disagreeing with them elsewhere which as one worker noted leaves them holding a certain level of liability.

While the document is standardized families are not, workers are not. Variation comes into play. It is not possible to standardize the way workers think and as such workers continued to use clinical assessment and interventions based on their own assessments. When they disagreed that the family

was not really high risk they closed the file anyway. They explained they made the decision to close as they did not really believe the child was at high risk or they would not close the file.

Well we wouldn't be closing the file if we assessed risk that the child would be harmed, we are closing the file because we have assessed the child is safe and there is a plan to make sure that the child is safe.

All of the workers spoke to frequently disagreeing with the document. In such instances, all of the workers described that they would continue to fill the document out properly, but then doing one of two things. Workers spoke about one area on the top of the risk which asks if the family has been involved 'yes' or 'no'. There is a button to explain this 'yes or no'. The workers used this button (even though it was not intended for this), to insert their own assessment. They could not change the score as it was created via presence or absence of factors, but they included their assessment that they disagreed with the document and explained why. Workers also explained that you could over ride the rating to a higher risk level with a button to explain why you were doing this, but there was not permission to lower the rating. Some workers described clicking the over ride button and using this to explain why they were under riding the rating. The high risk rating remains in the calculation, but they have inserted their written assessment that they disagree. Another method they used was to fill in the document as it was meant to be filled in and then include in other required paperwork a statement that they disagreed with the risk assessment document.

I have often closed files that are high and I am frustrated by that because I can't explain myself well in the risk assessment document, I will explain it in the closing summary so that is where I pour everything. I will say in closing mom is in a different place, now has these supports whatever, risk high, based on factors not presently presenting as a concern.

One participant explained that she had some concerns with doing this as the document still reads as though the family is high risk. Workers did express some level of discomfort in having a document say the child is at high risk and their own assessment saying they are not. One worker described that she did not like having to be put in this position as she worried if anything happened on the file she would be left to explain why she closed a high risk file.

There is, one of the things that's hard is and I just had one, when you want to close a file and the risk is high or very high ...so it's really, really skewed, like we've had to close with it very high and there's no way to change that so that's just a conversation I have with my manager, um, but

whether it comes out, like if the case has got to close it's got to close and I have no control over whether it is high and I mean I go back and I'm like you know I don't want to see tweaking or lowering something because it shouldn't be lowered. But then you're left closing a case with a risk that is high or really high and there is really no place to say you know why you are closing this. You know, why you are closing this? So you can say in other places but you can't say on here.

The liability. If you ended up in an inquest or an inquiry and I mean someone is going to look at it and say you closed it and it was high risk and it is there in black and white. And you are going to have to explain yourself and hopefully you have a good explanation for why you did it and four or five years later and there is an inquest and you can remember. But there is no place really for you to explain why you made the decision you did. I guess maybe in a supervisory case note, but realistically that doesn't happen. I'd rather be able to explain it in the documentation so the document is left as an accurate reflection of what you believe the risk is.

Workers indicated that the risk assessments were sent to their supervisors for approval. Some of the participants spoke to how difficult it would be for the supervisor to know anything at all about the file based on what was in the risk assessment. One participant commented, "it would be easy to approve a check mark". Workers expressed concern that the complexity of the family and the situation became lost in the check box "you could line them up side by side and not know anything about them". Some workers advised in situations where the file came up *very high* that they would consult with their supervisor and or an internal review committee to close the file. Workers indicated there were so many high risk files that closed they could not possibly bring them all to an internal review committee. Workers looked to their supervisors to provide "checks and balances" to make sure the file could be closed although it is coming up high risk. Interviews with workers suggested that supervisors and agencies were also aware of the frequent disconnect between the document and workers clinical opinion.

In another act of organizational tinkering and injecting the social into the work they described a complex variety of ways that they came to an assessment of risk. They spoke to using factors in the document to guide their assessments, previous training, case experience, training related to solution focused models, risk assessment training, signs of safety training, ecological and systems theories, anti oppressive training, education, mentoring from other staff and factors specific to the individual family they are working with.

I do this because it is a ministry requirement. But how I assess risk is based on my training, my experience, manager input. Those bigger structural issues, societal issues that's where School, University comes in.

Incorporating strengths and needs, SOS stuff. I like using them at the point of intake so what is working well, what are you're worried about and what needs to happen. I find it's a great way to gather info about a new family that you haven't worked with before.

Their responses suggest that the idea that a document can standardize their assessments is a fallacy. Workers still engage in use of self to come to an assessment of risk. The complexity of their risk assessments is not captured within the check marks and goes unseen and held within the file is a document which remains a stand alone contradiction of their opinion.

Navigating the Contradictions between Transformation Initiatives and the Document

As stated, interviews with the workers indicated that workers did not rely just on the document to assess risk. Their interviews suggested that they all strongly felt the need to assess for risk remained and they found active ways to do this outside of the constraints of the document and along side the principles of Transformation (actively searching for strengths, protective factors, pulling in family members or community collaterals to reduce risk etc.).

Ironically, the findings suggest that the drive for consistency and standardization may have led to inconsistencies in approaches to assessing risk. If the intent of the document is to be used to assess risk to children it would seem that the document needs to be viewed as helpful by those who engage with it. If not, my findings suggest workers may continue to tinker with it and come up with individualized ways to make it work for them in their individual practice, in their various units and across different agencies. Further, if the goals of risk assessment are also to minimize liability it would seem in this instance it may have inadvertently and unfairly increased it.

CHAPTER 5

Discussion and Conclusion

The critique of “actuarial risk assessment” in this paper is impelled by an appreciation of the art of performing face-to-face relationships. This art is always and everywhere replete with the dynamics of power, will, contestation, and conflict. Human relations are inherently political, and as such are not reducible to neutral and objective measurement (deMontigny, 2003, p. 34).

Research supporting the risk assessment is seen by many academics to be credible, objective, valid and reliable. The research consensus and positivist positions are challenged by assertions that social values and dominant ideologies find their ways into research, by what is studied, what is counted and what is left out (Neuman, 1997; Aronson, 2008; deMontigny, 2003; Third, 2000). This thesis illustrated competing claims regarding the risk assessment, as well as the neutrality and objectivity of the present risk assessment. The risk assessment measures some risks and not others, takes a moral stance on assessing risk to children by parents, while not assessing some of the structural and even agency risks to children.

How could a document said to be so reliable and accurate often feel unreliable and inaccurate in practical application? My professional experience of this disconnect led to my interest in exploring how other workers view the document. I began by exploring workers’ conceptualization of risk. Their answers were consistent with some of the original studies which found that workers agreed upon many of the factors in the present assessment (Shlonsky and Wager, 2005; Ministry of Community and Social Services, 2007a). Workers agreed that the factors on the present risk assessment contributed to risk, yet they found the analysis of these factors alone was insufficient in assisting them at arriving at an applicable assessment of risk.

Workers spoke to shifts in paradigms from focus on the least intrusive and family preservation, to a focus on risk assessment and increased intrusion, and then Transformation. The changes in approach have been referred to by Dumbrill (2006) as a swinging pendulum. These changes in approaches and subsequent shifts in ideology and research claims seem to undermine positivist claims and add credence to theorists who submit that research is never neutral but guided by ideology, values and political opinion. The risk assessment is an example. Influenced by an outlier

based approach and moral panic the whole system shifted in the direction of an intrusive and reactive approach (Dumbrill, 2006). The risk assessment under ORAM, once promoted as “State of the Art”, resulted in significant unintended consequences (e.g. loss of clinical engagement and financial and human costs in apprehensions). What was once promoted as “State of the Art” is now highly criticized in the field. In place of the risk assessment is “the next generation” risk assessment, an actuarial model promoted by researchers to be “the gold standard”. Shifts in approach, while guided by research, curiously highlight some of the limitations of positivist claims of research.

I then shifted to look at workers’ transitions from risk assessment to Transformation. A disconnect between the scientific claims and practical experience became more evident in this section. Workers experiences seemed to mirror the professional disconnect that I experienced with the document. Workers spoke with tremendous enthusiasm about Transformation initiatives. They did appreciate some of the actuarial documents (strength and needs which is only completed in ongoing services). They were perplexed to find the new document appeared inconsistent with Transformation initiatives. They appreciated the brevity, as well as having some research factors which they saw as relevant to guide their analysis. Yet, in practical application all of their firsthand accounts challenge the claims of the documents accuracy, reliability, validity and usefulness. Workers identified concerns that the document lacks: assessment of the unique, individualized and contextual factors influencing risk for each family; assessment of structural factors contributing to risk; space for the workers to voice their own assessments; ability for the family to contribute their own assessment of risks or to change the static nature of the predetermined factors; consistency and credibility of accuracy claims; guidance for workers to determine their next steps; space to explicate subjective assessments; appreciation for change or progress. As a result the document was seen to be inconsistent with Transformation and anti oppressive initiatives. The document was described as a “uniform approach: which “does not tell you anything about the family.” Some workers came to the conclusion that the document may be measuring risk of future child welfare involvement versus risk of actual future maltreatment.

Workers struggled to determine whether the document was oppressive and how better to respond. They were aware of the power differential inherent in risk assessment. They saw the need for research related factors and guidance from research. Yet workers were also concerned that risk assessment that was over standardized was also oppressive as it did not capture the individual and unique characteristics of families. They identified a need to measure for structural factors yet worried how to do this without being oppressive (they were unsure how to measure for structural factors in the risk assessment without perpetuating stereotypes). They identified a risk assessment that measures some factors while missing out on other risks could be oppressive. As well, a risk that discounts family experiences and input was also viewed as oppressive.

Workers did not believe fully standardized practice was possible given the human and social nature of the work. One worker summed this up by stating “I see them striving for consistency and good luck with human beings. I don’t think we’re ever going to get there”. Workers indicated that subjectivity and difference of opinion from one worker to the next continued to exist and did not believe that standardizing documentation would remove this entirely. Rather, workers expressed concern that subjectivity became hidden within the check box instead of explicated through explanation. They actively resisted the constraints of standardization and the technological turn of social work (see section on organizational tinkering). They demonstrated that practice can not be fully constrained as the social continues to be inserted. Their responses highlighted the fallacy of assumptions behind standardization. While standardization may obscure workers clinical thoughts and actions (in a check box), independent thought and action continues to exist. Workers resisted their clinical judgments being standardized. Moreover, attempts to decrease liability through rigid standardization may not be possible when the gray and ambiguous situations still require flexible thought and action and as a result workers and supervisors are left in a tenuous situation of navigating situations which do not fit within a check box, without full institutional sanctioning and support. Their necessary creative solutions appear to arise out of a sense of rightness. They would not open a file to ongoing if they did believe this should occur just because the document said they should.

In the litigious and liable climate of child protection workers need to have space opened up to work with the ambiguous and unique. It is this unknown and ambiguous element that can cause stress for protection workers. Given that child protection workers need to respond to varied, unique, complex and ambiguous situations, there needs to be some recognition of the limitations to standardization. Indeed, interviews with protection workers in this study suggested they were unable to standardize all their responses. Yet, the document continues to guide them in a standardized manner. Their fear lies in the “what if” the contradiction between the reality of their job and the expectation for them to standardize their assessments has left them in an untenable position of making risk decisions outside of the required text. As I stated in the beginning, I fear in a worst case scenario credibility would lie with the box and the worker/supervisor/agency would be left to account for this inconsistency. The routine acts of tinkering were unofficially sanctioned and lacked full institutional supports. In some respects a drive to standardize what inherently can-not be standardized, may actually increase liability. In other words, workers are asked to standardize situations that are not standard and when the situations do not fit in a box, there is no legitimized space for workers to speak to this in the document. As result they are left with an inconsistency between a ‘credible document’ and their contradictory assessment.

Workers suggested many ideas as to how to assess for risk in a manner more consistent with AOP, service users’ theory, social justice, social work values and principles and Transformation initiatives. They suggested a document that gathered forensic information in situations where this was called for, that still contained research based risk factors, but also opened up space to assess for the contextual and unique strengths, needs, protective factors and worries in each family⁹. They provided suggestion for an active vs. static document that incorporates the understanding that risk fluctuates, that incorporates child and family identified concerns and worries, active and historical risks, as well as structural and systems factors impacting upon the family. One worker suggested that statistics related to structural factors associated with risk could be incorporated. One worker

⁹ As noted, the Strengths and Needs assessment used in ongoing is not completed in intake investigations. It is only completed if the concerns are verified and after the file has been transferred to ongoing services. It is not completed at all for the high volume of files serviced only at the intake level. Additionally, workers did not view an assessment of strengths, protective factors, and needs as separate and distinct from an assessment of risk. Rather, they felt that an assessment of these factors was crucial to arriving at an accurate assessment of risk.

suggested including a question on other factors that could be contributing to risk not mentioned on the form. They spoke of the importance of scaling factors as just by virtue of a risk factor being present; it did not mean it was presently serious or concerning in nature. They felt they should be given an option to both raise and lower the rating. One worker spoke of creating an area on the document where one could conduct an assessment into the risk of intervention itself. This worker identified that workers assess the risk of intervention against risk of harm on a regular basis and saw benefits to including this on the document itself. Workers identified need for a document that was applicable and helpful in guiding practice. Indeed, the findings indicate for research to be applied it needs to be viewed as relevant, practical, helpful, and consistent with professional values and beliefs.

Methodological Discussion

The concerns outlined by workers in this study are interpretive. I suspect their accounts are indicative of present experiences in the field with the document. However, given the limitations of this study, I am unable to extrapolate these results to make such wide ranging claims. On a micro and interpretive level their responses provide an illustrative account of some concerns with the present document and the inconsistency with Transformation initiatives. However, when analyzed from a critical perspective their accounts certainly draw attention to macro level concerns. Their responses highlight concerns with the debate between knowledge paradigms (positivism which believes there is one truth and post structuralism which highlights many truths and competing claims). Their responses highlight concerns with standardization being reductionist (missing the grey, the complexity, the social influence which cannot be removed). Their responses draw attention to the social and political construction of risk (namely that some risks are counted while others not).

Indeed, the risk assessment provides “only a very narrow window, that yields a politically directed view of the complex neighborhood of child abuse and neglect” (deMontigny, 2003, p. 43). Statistics show the way in which “child protection work is entangled in and reproduces inequalities that shape Canadian Society” (Todd and Burns, 2007, 24). “In particular, they suggest that racism, colonization, sexism and classism are directly related to the degree in which an individual must endure state surveillance and is perceived to be in need of intervention” (Ibid, p. 24). Many scholars have

identified concerns with child protection assessing risk of individual parental factors, without assessing risks of the system, wider context and structural factors. These researchers stress there has been a significant amount of research showing links between structural factors and child welfare involvement (Callaghan, 2001; deMontigny, 2003; Witkin and Harrison, 2001; Swift, 1995a; Swift, 1995b; McSherry, 2004; Todd and Burns, 2007; Harris, Russell and Gockel, 2007, Blackstock, 2008; Leschied, Chiado, Whitehead and Hurley, 2003; Campaign 2000, 2007; Krane and Davies, 2000).

Consider the difference for families who occupy “prime social space” vs. “families from socially marginalized groups”. White, two parent, home owner families, not on social assistance, with less than 4 children and less than one person per room, have a *1 in 7000* chance of their children coming into care. Mixed ethnic origin, single parent families, on social assistance, living in rented accommodation, with more than 4 children, and more than one person per room, have a *1 in 10* chance of their children coming into care (Dumbrill, 2008, p.13). Moreover, “Aboriginal children are drastically over-represented in the child welfare system with more Aboriginal children in the care of the child welfare authorities than at any other time in our history” (Campaign 2000, 2007, 4). With almost one in two First Nations children in poverty, neglect is the most common reason for child welfare involvement and the apprehension of first nations children (Blackstock, 2008).

While Statistics clearly point to structural risks to children, the social and political construction of risk guides child welfare to assess and intervene on an individual and case by case basis (Swift, 1998). This account would be called ideological because it is socially organized and constructed (Campbell and Gregor, 2002). Societal values regarding the responsibilities of parents for their children influence a fragmented view of risk to children by focusing solely on the risk posed by parents (Gambrell and Shlonsky, 2001). This construction is reflective of a dominant neoliberal discourse. In the objectified and ideological way of knowing created in risk assessment document, “there is no way back to the client’s or the professional’s own experience” (Campbell and Gregor, 2002, 40). “The official objectified version dominates” and the “text replaces and trumps competing versions” (Campbell and Gregor, 2002, p. 40). This “prevailing view appears as formal knowledge, and is revalidated and fed constantly by new research” (Swift, 1995a, p. 176).

While workers may continue to see beyond the constructed reality of the document, the possibilities with which workers have to respond are constrained by an ideological construction of risk. Workers and agencies most often do not have the legal mandate, supports or resources with which to intervene and

respond on a more structural level, as the system remains largely organized around individual interventions (Swift, 1998). Under this ideology risks to children and families are “recast from a societal and structural problem to a personal and biological one” (Brodie, 1999, 45). As a result, the options available for workers to intervene are limited. While there have been some improvements with transformation increasing emphasis on community capacity building initiatives and workers spoke with pride in their individual agency efforts (internal anti oppressive committees, community kitchens, community outreach, letter writing and advocacy for housing for individual families). Child welfare legislation, standards, resources and funding remain largely focused on individual family assessments and interventions.

Participant responses draw attention to the complexity of engaging in risk assessments with a structural and anti oppressive lens, as well, their responses draw attention to the present lack of a structural lens in the document. When interjected with the literature and a competing truth that risks are not all individual, they should offer the reader pause for thought about the present structure of Child Welfare services and risks assessments.

Implications for Practice

Major implications for practice are to reconsider any approach that is so standardized that uniqueness is lost. Moreover, knowledge that even seemingly objective and neutral studies can be influenced by bias and changes in ideological and political perspectives would assist workers in maintaining a critical mind and approach. This knowledge opens room for possibilities. If facts were as static, objective and unchanging, as positivism would lend us to believe then there would never be any room for critical thinking, changes or improvements. Using a critical approach highlights that change and shifts in practice are possible. Indeed, the shifts in practice (family preservation, risk focused, Transformation) indicate that change and improvement are always possible. Change in ideology and critical thinking must lead the way.

The literature review and questions posed (how we are assessing risk, why this why, for what purpose, what is measured, what is left out), highlight possibilities for assessing in other ways. As noted, critical thinkers challenge the individualized focus of Child Welfare (Swift 1995a; Swift 1995b; Dumbrill, 2006; Dumbrill; 2008; Callaghan, 2001; Gambrill and Shlonsky, 2001, 79; Lindsey, 2004; Bronson and Bouchard, 2003; Coady, Cameron and Adams, 2007). Such critical considerations raise a

challenge for an ideological shift in the field from a focus on child protection to a focus on child welfare and well being (Lindsay, 2004; Knoke and Trocme, 2004). Some critical thinkers speculate that if all risks to children were counted and weighed child welfare agencies would have more opportunity to assess and intervene in wider systems, thereby improving welfare of children and increasing protection for children (Lindsay, 2004; Bronson and Bouchard, 2003; Coady, Cameron and Adams, 2007). Indeed, some academics question the focus on collection of evidence and investigative approaches for all cases, when statistically; the majority of cases in child welfare agencies are not cases of serious harm to children (Knoke and Trocme, 2004). Enhancing child welfare agencies capacity to respond to families' needs in more concrete and practical ways and enhancing community collaboration and interventions could also reduce risk to children. Such an approach would require restructuring and an ideological change in approach.

Such a shift in approach is not necessarily at odds with Transformation initiatives. Indeed, one of the improvements which came from Transformation was a shift in applying a forensic approach to all investigations. The ability to modify between a forensic approach and a customized approach in assessment of risk would be consistent with Transformation goals. Participants were clear that they still assessed for risk no matter what model they worked under, however, Transformation opened up possibilities for them to respond in a less intrusive and more collaborative way. The participants described their agencies as "progressive" and felt they had "leaders at the top", who were engaging in unique efforts to respond at a community level to address systemic factors. Workers were conscious that this approach was not replicated across all child welfare agencies. Drawing regular attention to the structural and systemic causes of risk would draw more attention to the need for creation of different ways of intervening. There may be many circumstances in which the risks are individually posed by parents and intervention at the individual level is required. Yet, providing enhanced opportunities, space and legitimacy for child protection workers to assess and gear interventions to structural and systemic risks as well would move the work from a *child protection* focus, to a *child welfare and wellbeing* focus. The study has demonstrated the enthusiasm that less intrusive and more collaborative approaches have brought to the field. I would speculate an approach that allowed for a forensic where

necessary, and an enhanced customized supportive and advocacy approach would be welcomed by workers, families and community alike. The first step may be to open up the discourse and shift the ideological focus away from static and standardized, deficit and individual focused risk assessment. In the interim, workers and families continue to be impacted by regular pendulum swings, discourse and ideology shifts. My hope is that one day it will swing in the direction more toward assessment of all risks, strengths and needs, inclusion of research, worker input and real family input, as well as possibilities to intervene in larger systems that contribute to both risk and well being for children and families.

Implications and Suggestions for Future Research

To begin, any research completed into the reliability and effectiveness of a risk assessment document would need to recognize limitations to their studies. In particular, any study which compares risk assessment ratings from different workers based upon reading case studies, suffer from a significant methodological flaw. The face to face of meeting with the family and listening to the child is not present and can not be measured in a written case study. Having two workers read a case and rate the risk can not compare to having two workers meet the family and rate the risks.

As well, when studies measure the effectiveness of a risk assessment, it is not sufficient to measure the effectiveness by seeing if high risk files results in a future protection openings. Some families have repeated involvements but never engage in actual harm to their children. Future involvement does not lend itself as confirming evidence that a high risk rating was accurate (not unless the intent of the document was to assess whether the client was at risk for returning for service). Moreover, another important consideration from studies looking into risk assessment is that future verifications can not be used solely as a measure to determine the effectiveness of a risk assessment. In Ontario, verification may not mean that the investigation verified *harm was caused* to the child; it may have verified *a risk of harm was there* (emotional or physical). Any studies which state they use future verification decisions as evidence of accuracy should specify if the verification was a verification of *actual harm or risk of harm*.

I would suggest future studies assess factors which led workers to close a high risk file under the present risk assessment document. As well, I would recommend future research into how

structural factors may be incorporated into assessment of risk in a manner most promoting AOP principles. Further research on the ideological construction of risk and impact on practice would be beneficial. Moreover, further research into the impact (on practice and on families) of a lack of structural approach is recommended. Future research exploring a lack of worker confidence in the tools used and resulting impact of the effectiveness of the tools would be warranted. It would seem to me effectiveness would be enhanced if workers themselves found the documents trustworthy. Further research into how to involve parents and children in an active assessment of risk and creation of documents would be beneficial. As well, a theme began to emerge in my later interviews. I would have liked to further explore how workers navigate the complexities of dual risk factors (i.e. how they balance risks posed to the child in the home and the risks caused by intervention itself). Expanding on this idea, I would be interested in reading further studies on how workers weigh risk (risk of intervention, risks identified by the child, risks posed by the parents, risks posed by the system, and risks posed by structural factors) and how they plan their interventions accordingly.

An interesting second part of this study would be to interview workers and supervisors about how they make intervention and safety planning decisions, how they consider when to intervene and what factors they use to decide what creates enough risk to apprehend and what factors they consider in weighing risk of harm against risk of intrusive intervention. This study was limited and did not further delve into these research questions, yet these factors would be interesting future research topics. Further research into the impact of misclassifications of risk is warranted. As well, further research looking at how assessment of strengths and protective factors would impact the final ratings would be of interest. Finally, I would recommend further research into the purpose and necessity of risk assessment on all cases and whether collaborative, supportive and advocacy approaches can be implemented for some files.

Final Thought

My conclusions have drawn me full circle to my puzzle, how did the document gain credibility? The participants, and myself, steeped in a tradition of forensic investigative approaches all continue to see the need to assess for risk and to plan interventions accordingly. However, this paper concludes with

the same question it began with. I continue to question how we are going about it. Is this the best way and what other possibilities could be explored, if only the dominant discourses and prevailing ideologies could shift?

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72.

Appendix One

Case Name: _____	Case Status: Intake and Investigation
Case Number: _____	Current Case Worker: _____

Family Risk Assessment

Worker Name _____ Date of Assessment: _____

Active Case Members

Name	Age	Relationship	Child Caregiver	
_____	_____	Birth Father	<input type="checkbox"/>	<input checked="" type="checkbox"/>
_____	_____	Birth Mother	<input type="checkbox"/>	<input checked="" type="checkbox"/>
_____	_____	Birth Child	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Has the family participated in the completion of the Risk Assessment? Yes No
 Explain: _____

Neglect / Abuse Calculations

NEGLECT		Score	ABUSE		Score
N1.	Current Complaint is for Neglect <input type="radio"/> No (0) <input type="radio"/> Yes (1)		A1.	Current Complaint is for Abuse <input type="radio"/> No (0) <input type="radio"/> Yes (1)	
N2.	Number of Prior Child Protection Investigations (assign highest score that applies) <input type="radio"/> None (0) <input type="radio"/> One or more, <u>abuse</u> only (1) <input type="radio"/> One or two for <u>neglect</u> (2) <input type="radio"/> Three or more for neglect (3)		A2.	Number of Prior Child Abuse Investigations (Number:) <input type="radio"/> None (0) <input type="radio"/> One (1) <input type="radio"/> Two or more (2) (Actual number:)	
N3.	Family Has Previously Received CAS Ongoing Services (<input type="radio"/> voluntary / <input type="radio"/> court-ordered) <input type="radio"/> No (0) <input type="radio"/> Yes (1)		A3.	Family Has Previously Received CAS Ongoing Child Protection Services (<input type="radio"/> voluntary / <input type="radio"/> court-ordered) <input type="radio"/> No (0) <input type="radio"/> Yes (1)	
N4.	Number of Children Involved in the Child Abuse/Neglect Incident <input type="radio"/> One, two or three (0) <input type="radio"/> Four or more (1)		A4.	Prior Injury to a Child Resulting from Child Abuse/Neglect <input type="radio"/> No (0) <input type="radio"/> Yes (1)	

N5.	Age of Youngest Child in the Family		A5.	Primary Parent/Caregiver's Assessment of Incident (check applicable items) Maximum score 3.	0
	<input type="radio"/> Two or older (0) <input type="radio"/> Under two (1)			<input type="checkbox"/> Not applicable (0) <input type="checkbox"/> Blames child (1) <input type="checkbox"/> Justifies maltreatment of a child (2)	
N6.	Primary Parent/Caregiver Provides Physical Care Inconsistent with Child Needs		A6.	Partner/Adult Conflict in the Family in the Past Year	
	<input type="radio"/> No (0) <input type="radio"/> Yes (1)			<input type="radio"/> No (0) <input type="radio"/> Yes (2)	
N7.	Primary Parent/Caregiver has a Past or Current Mental Health Problem		A7.	Primary Parent/Caregiver Characteristics (check applicable items) Maximum score 3.	0
	<input type="radio"/> No (0) <input type="radio"/> Yes (1)			<input type="checkbox"/> Not applicable (0) <input type="checkbox"/> Provides insufficient emotional/psychological support (1) <input type="checkbox"/> Employs excessive/inappropriate discipline (1) <input type="checkbox"/> Employs overly controlling / abusive or overly restrictive behaviour (1)	
N8.	Primary Parent/Caregiver Has Historic or Current Alcohol, Drug or Substance Problem. (Check applicable items) Maximum score 2.	0	A8.	Primary Parent/Caregiver has a History of Abuse or Neglect as a Child	
	<input type="checkbox"/> Not applicable (0) <input type="checkbox"/> Alcohol (current or historic) (1) <input type="checkbox"/> Drug (current or historic) (1)			<input type="radio"/> No (0) <input type="radio"/> Yes (1)	
N9.	Characteristics of Children in Family (check applicable items) Maximum score 3.	0	A9.	Secondary Parent/Caregiver Has a Historic or Current Alcohol, Drug or Substance Problem	
	<input type="checkbox"/> Not applicable (0) <input type="checkbox"/> Medically fragile/failure to thrive (1) <input type="checkbox"/> Developmental or physical disability (1) <input type="checkbox"/> Positive toxicology screen at birth (1)			<input type="radio"/> No (0) <input type="radio"/> Yes, alcohol and/or drug (1): <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug	
N10.	Housing		A10.	Characteristics of Children in the Family (check applicable items) Maximum score 3.	0
	<input type="radio"/> Not applicable (0) <input type="radio"/> Current housing is physically unsafe (1) <input type="radio"/> Homeless at time of investigation (2)			<input type="checkbox"/> Not applicable (0) <input type="checkbox"/> Criminal or acting out behaviour (1) <input type="checkbox"/> Developmental disability (1) <input type="checkbox"/> Mental health/behavioural	

			problem (1)	
TOTAL NEGLECT SCORE (Maximum 16)	0	TOTAL ABUSE SCORE (Maximum 18)	0	

Risk Levels

SCORED RISK LEVEL: Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

- Neglect Score: 0 - 1 Low Scored Risk Level: **Low**
 2 - 4 Moderate
 5 - 8 High
 9 + Very High
- Abuse Score: 0 - 1 Low
 2 - 4 Moderate
 5 - 7 High
 8 + Very High

OVERRIDING CONDITIONS: Select 'Yes' if a condition shown below is applicable in this case. If *any* condition is applicable, override final risk level to **Very High**.

- | | | |
|-----------------------|-----------------------|--|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim. |
| <input type="radio"/> | <input type="radio"/> | 2. Non-accidental injury to a child under age two. |
| <input type="radio"/> | <input type="radio"/> | 3. Severe non-accidental injury. |
| <input type="radio"/> | <input type="radio"/> | 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current). |

DISCRETIONARY CONSIDERATIONS: If a discretionary consideration is determined, select 'Yes'. Select the discretionary risk level, and indicate reason. Risk level may only be overridden one level higher.

- | | | |
|-----------------------|-----------------------|-------------------------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | 5. Select override risk level |

FINAL RISK LEVEL: **Calculate**

Appendix Two

Email Recruitment Script

Mary McVeigh Palmer, B.A / B.S.W.

Masters Candidate in Social Work

Actuarial Risk Assessment and Child Welfare: A Paradox of Purpose

E-mail Subject line: Actuarial Risk Assessment and Child Welfare: A Paradox of Purpose

I am a Master of Social work student who works in the field of child welfare. I am seeking to recruit child protection workers to interview for my Masters thesis. The subject is on the present Risk Assessment used in Child Welfare. I am interested in learning about workers opinions on the present risk assessment. Do workers find the document useful? Is it consistent with transformation initiatives? What are the strengths of the document? What are the deficits? If workers could change or reformulate the document in any way what would they do? The interview would take approximately one hour, at a location of your choice. Your participation in the research is voluntary and will be kept confidential. In appreciation of your time you will receive a ten dollar Tim Hortons card. I have requested this recruitment email be forwarded to any protection workers have experience in completing the present risk assessment.

I have attached a copy of a letter of information about the study that provides full details. This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Office of Research Services

E-mail: ethicsoffice@mcmaster.ca

I hope to hear from you and would like to thank you in advance for your time and consideration. If you are interested in participating please contact me at 905-977-7292 or by email at bpalcben@yahoo.ca

Mary McVeigh Palmer, B.A / B.S.W.

Masters Candidate in Social Work

Department of Social Work

McMaster University,

Hamilton Ontario

Cell: [REDACTED]

Email: [REDACTED]

Appendix Three

March 28, 2011

Letter of Information

Actuarial Risk Assessment and Child Welfare Transformation: A Paradox of Purpose

Student Researcher: Mary McVeigh Palmer

Faculty Supervisor: Dr. Roy Cain
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 27960

About the researcher:

I am an MSW student at McMaster University and I have worked in Child Protection for the past 11 years. I am doing this research as part of a requirement for my Master of Social Work degree. I would like to interview child protection workers about their experiences working with the risk assessment document used in protection investigations. If you are interested in participating, please contact me at [REDACTED]. Your participation is voluntary and all inquiries are confidential.

Purpose of the Study

The purpose of the thesis is to examine workers' opinions on the present actuarial risk assessment model used in Ontario. Is it consistent with the goals of transformation? Does it allow workers to consider strengths and protective factors? Do workers believe it accurately measures what it is suppose to? How do they feel it is received by families? Does it assist in decision making and clinical assessment? Do workers agree with the final ratings? Does it capture all the areas workers feel are important to assess to arrive at a risk rating?

What will happen during the study?

If you agree to participate in this study, you will take part in a confidential interview with the researcher.

Please note that your employer is not sponsoring this research and a copy of the final thesis will not be circulated to your employer. Interviews will be conducted during your own time.

Interviews should take around one hour and will take place at a location of your choice. You will be asked questions about what you think about the present risk assessment document. For instance, do you like the present document? Why or Why not? If you could change or reformulate the document what recommendations would you have? Do the final ratings match your clinical assessment of families? Have there ever been times you have disagreed with the final rating? Does the document capture all the factors you feel are important to assess? Is it consistent with the goals of transformation? All interviews will be taped and transcribed for research purposes only. Your interviews will be kept confidential.

Potential Harms, Risks or Discomforts:

There is always a possibility that you may experience some feelings of discomfort during the interview. You do not need to answer any questions with which you are uncomfortable. You can stop at any point in time during the interview. You can also contact me after the interview if you change your mind and want to have any part of your interview removed from the record or to withdraw from the study.

Potential Benefits

The research may not benefit you directly, although I hope that it will allow workers opportunity to share their insights related to working with the present risk assessment. It is my hope that this will facilitate critical discussion of the benefits and drawbacks of the present document. As a graduate student, I will benefit from the experience of conducting research.

Reimbursement:

To thank you for your time, all participants will receive a 10 dollar Tim Horton's Gift Certificate

Confidentiality: Who will know what I said or did in the study?)

Your interviews will be kept confidential. I will not be asking you to provide your name or any personal information. As it is sometimes possible to identify people by the details of the stories they tell, you may chose not to share any information which could potentially identify who you are. If you become concerned after the interview about any details you have shared, you may contact me and I will remove any portions that you are concerned with. To maintain your confidentiality, I will be approaching two agencies to request interviews, interviews will take

place at a location of your choice and the name of your agency will not be mentioned in the report. I will not reveal whether you participated in the study. Your privacy will be respected.

The information obtained from interviews will be kept in a locked cabinet and only available to me and my faculty supervisor. The report will be created on my password protected home computer. The interview transcripts will be destroyed after publication.

Limits to confidentiality, exist in all research projects. Information that a child may be at risk of harm can never be kept confidential.

Participation: What if I change my mind about participating in the study?

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. In cases of withdrawal, any data you have provided to that point will be destroyed, unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information About the Study Results:

I expect that the study will be completed by July 2011. With your permission, I will contact you at the conclusion of the study and provide you with a summary of the research results. The thesis will be kept at Mills Library and in the Social Work Department at McMaster University.

Rights of Research Participants:

If you have questions or require more information about the study itself, please contact Mary McVeigh Palmer at [REDACTED].

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Office of Research Services

E-mail: ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Mary McVeigh Palmer, an MSW candidate, of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

I agree that the interview can be audio recorded.

Yes ___

No ___

Signature _____

Name of Participant (Printed) _____

Date: _____

Appendix Four

Sample Interview Questions

Some information about you

What is your level of education?

How many years have you worked in child protection?

In which departments have you worked?

Thoughts about Assessing Risk:

Over the years there have been many different models of delivering child protection. In general, do you think it is necessary for protection workers to assess risk? Why, or why not? What factors do you think contribute to risk of child abuse or maltreatment?

From the Risk assessment model to Transformation

Did you work under the risk assessment model? If so, what changes have you noticed in practice since transformation?

How would you compare the present risk assessment document to the document used under the Ontario Risk Assessment Model?

The previous document had an area to document strengths, what do you think of this being removed from the present document? How does this impact the results?

Do you think it necessary to assess for strengths and protective factors when determining if there is a risk of child abuse or maltreatment?

The former risk assessment included areas for written, what do you think about this being taken out? Would you prefer to have a written part? Are there ever things you would like to add to the risk assessment but can't because there is no written? What kinds of things?

The Present Risk Assessment Document

Do you think the present risk assessment appropriately captures all the areas you would like assessed? Are there further areas or factors you would like to see assessed in the document?

Some researchers express concern that risk assessment misses out on the social context of concerns what do you think? Is there room for workers to take social context into account? In what ways?

Do you feel the document captures your clinical assessment of families? Does it influence your decision making or inform your next steps? If so, in what ways?

Does the final risk rating match your clinical assessment of families? Have you ever disagreed with the risk rating? Can you tell me about that? What do you think may have caused this discrepancy? What have you done in these instances?

What have your experiences been in involving the family in completing the risk assessment?

What are the strengths of the document? What are the deficits?

Overall, what do you think of the present of the present Actuarial Risk Assessment Model? Do you like it? Why or Why Not?

If you could change or reformulate the document in any way what would you do?

Purpose, Benefits and Concerns

Is the document consistent with transformation initiatives? Anti Oppressive Practice? If so, how and in what ways? If not, can you explain, how not?

What do you see as the purpose of risk assessment? Who benefits from risk assessment? Are their benefits to the agency? To workers? To parents? To children? What are these benefits?

Are there any drawbacks (or risks) to using risk assessment? To workers? Parents? Children? The agency?

In Closing

Do you have any other thoughts or comments you would like to share with me?

Is there anything I haven't asked you about, that you think is important for me to ask other participants about, or to include in my paper?