

The Need for Clinical Observation in Decision-Making

Thomas D. Morton
President & C.E.O.

Barry Salovitz
Vice-President

For more than a decade, some authors (e.g., Baird and Wagoner, 2000) have argued the superiority of actuarial decision-making over clinical judgment and what they have described as “consensus models” for child maltreatment risk assessment. More recently, other authors (Baumann, Law, Sheets, Reid and Graham, 2005) reported on randomized field trials of an actuarial model versus an alternative model and did not find the actuarial model superior. In some instances, it was actually inferior. A recent evaluation of an actuarial model used in Minnesota concluded in regard to the model’s accuracy, “This error rate is high for an instrument that is to be used as the *sole or central criterion for decision-making* (emphasis in original) regarding post-assessment services. However, it is not necessarily high for an instrument that is to be used with other assessment and decision-making tools.” (Loman, A. L. and Siegal, G. L., 2004, p. 69)

In a forthcoming article to be published in *Children and Youth Service Review*, the authors cite the observations of Meehl, one of the fathers of actuarial decision-making:

The logic of the transition from actuarial scoring to clinical judgment was originally described by Meehl (1954). He noted that actuarial assessments had a limited purpose and relied on limited client information. Only the clinician could interview the client directly and make certain qualitative judgments. Meehl referred to this blind spot in the actuarial method as the “broken leg” problem. An example is a situation where an actuarial formula derived from an analysis of past race performance predicts that a runner will finish a ten kilometer race in approximately 45 minutes. If the runner has a broken leg, the actuarial prediction will be wrong. This kind of contingency can not be accounted for in an actuarial assessment, but a clinician, given access to the subject, can often observe such information. Actuarial assessment in child welfare should not be used to dictate type or scope of service. Rather, it should be used to improve clinical decisions (particularly those made at the close of the investigation) - thereby improving the agency’s ability to manage risk to children. (Shlonsky and Wagner, in press, pp. 12 & 13 of original manuscript)

Using data from a validation study of an actuarial model used in California, Shlonsky and Wagner report a predictive accuracy of .35 for cases rated as high or very high risk. This means that for cases classified as high or very high risk, approximately one in three will actually experience recurrence. Relying on the same data reported by Shlonsky and Wagner, only about 12% of cases rated as moderate or low risk by this instrument will experience recurrence. This raises a concern about the category of moderate risk and leads one to believe it is an ambiguous classification in regard to what it actually means.

Child Welfare Institute

3950 Shackleford Road
Suite 175
Duluth, GA 30096
770-935-8484
fax: 770-935-0344
web site: www.gocwi.org

If actuarial models are not necessarily superior to all other models, and if existing actuarial models are not sufficiently powerful to use as the sole criterion for decision-making about case opening, how should agencies integrate actuarial decision-making with clinical judgment? Alternatively, "can clinical judgment improve actuarial classifications?" If Meehl's advice is sound, there is reason to believe this is the case. Although some actuarial models permit overrides, implementation procedures in some cases appear to discourage application of overrides. In a New Jersey newspaper article reporting on implementation of an actuarial model in the Division of Youth and Family Services, the trainer was quoted in an article in the Newark Star Ledger as cautioning trainees who wanted to consider an observed safety concern as a reason to elevate the risk classification. The trainer (McCarthy) was quoted as saying, "Trust the tool, it will take you where you want to go." The article went on to report, "We ask you not to imagine what could happen. Initially as you use these tools, you may be uncomfortable. ... When you trust the tool, it will take you where you need to go." McCarthy added that workers and their supervisors will be encouraged to discuss scenarios that seem to demand "an override" of the protocol, and in certain cases, that will happen.

In the past few months, Ohio has moved to integrate an actuarial instrument with a clinical risk assessment for making decisions about ongoing services. In Georgia's application of its actuarial model, cases classified as moderate risk were recommended for case opening. However, after observing a large number of cases classified as moderate risk and recognizing the comparatively low rate of recurrence for cases in this classification, Georgia has abandoned an actuarial model in favor of a concept guided model developed in Texas. Georgia's adoption of the Texas model has been guided by the model's perceived additional value in explaining the *nature* of the risk, in contrast with simply describing the *level* of risk.

In addition to its explanatory capacity, clinical observation can reveal trends. This is valuable additional information. A caregiver may have a history of mental illness, substance abuse or criminal involvement. But, what is the recent history and pattern? Are mental health symptoms intensifying or in remission? Is an alcoholic currently using or in recovery? Are tensions within the family escalating or subsiding?

Whether using actuarial risk assessment or not, child protection agencies must continue to refine the validity of clinical risk variables used in decision-making, and the staff training that supports the use of these variables. Agencies also must consider the relevance of the clinical risk elements they choose. There are a number of family dynamics that

may affect child and family well-being and represent family service needs that do not have strongly established relationships to a child's maltreatment. Several theoretical models suggest an interaction of individual, family, community and cultural factors when explaining child maltreatment. As child welfare agencies have moved increasingly to a case management model, clinical risk assessment has evolved toward a pattern of problem or service need identification, with the implication that the caseworker refers to the family to external services and does not devote much effort in an in-depth assessment toward understanding the actual pattern of maltreatment within a family. This case management trend may run contrary to improved decision-making throughout the life of the case as caseworkers may never truly understand the dynamic they are trying to influence

Evidence exists that suggests current actuarial models lack sufficient power to be used alone in case decision-making. If Meehl is correct, actuarial assessment should be used to improve clinical decisions, not replace them. This suggests a need to improve clinical decision-making through the choice of theory guided and research based variables believed to influence child maltreatment. It also suggests that caseworkers must be trained to reliably and validly use these variables in decision-making. The latter is one of the greatest weaknesses of current practice. Caseworkers are often given protocols containing assessment items, but not adequately trained to apply them in their work with families. This is like knowing what to look for without knowing what it looks like or what it means when you find it.

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