

The ethics of predictive risk modelling in the Aotearoa/New Zealand child welfare context: child abuse prevention or neo-liberal tool?

Abstract:

The current White Paper on Vulnerable Children before the Aotearoa/New Zealand (A/NZ) parliament proposes changes that will significantly reconstruct the child welfare systems in this country, including the use of a predictive risk model (PRM). This article explores the ethics of this strategy in a child welfare context. Tensions exist, including significant ethical problems such as the use of information without consent, breaches of privacy and stigmatisation, without clear evidence of the benefits outweighing these costs. Broader implicit assumptions about the causes of child abuse and risk and their intersections with the wider discursive, political and systems design contexts are also discussed. Drawing on Houston et. al. (2010) this paper highlights the potential for a PRM to contribute to a neo-liberal agenda that individualises social problems, reifies risk and abuse, and narrowly prescribes service provision. However, with reference to child welfare and child protection orientations, the paper suggests ways the model could be used in a more ethical manner.

Keywords: Early intervention, child protection, ethics, orientations, New Zealand.

Introduction: systems design, vulnerability and ethics

The prevention of child abuse remains an elusive goal of social research, with governments everywhere engaged in attempts to prevent the complex and ‘wicked problem’ of child abuse (Devaney & Spratt, 2009). In the context of high demand for services, rapidly increasing referrals to child protection services in most Western democracies (see Spratt, 2008), and high rates of child death by maltreatment (especially here in Aotearoa/New Zealand¹) it is clear that prevention requires more attention (UNICEF, 2003). However, when considering the provision of preventive services, ethical issues abound across the ecological spectrum, ranging from macro issues concerned with political ideology, to meso level factors such as systems design

¹ Aotearoa is the Maori (indigenous) name for New Zealand. Noted as A/NZ.

and the mix of universal and targeted services, to micro level individual ethical concerns around privacy, rights, protection of children, consent, and types of intervention. For example, one prominent conflict in the provision of preventive services is achieving a balance between targeting prevention services to those most 'at risk', while recognising the value of broad-based universal services (Kriz & Skivenes, 2013). There is a broad consensus that a combination of services is needed to effectively deal with child abuse prevention, however, how that combination is structured is contested, often due to political ideologies as much as efficacy considerations.

Where a society places itself on the spectrum of universal, targeted and specialist services is intimately connected to the political persuasions of the time. Those to the left, generally committed to various forms of social democracy, prefer an increased emphasis on universal services based on an assumption that: the role of government is to promote general wellbeing; that all citizens have a right to state support; and that universal services contribute to social cohesion and a concomitant reduction of a range of social ills. Those to the right, reflecting libertarian justice ideals, pursue a more residual approach aimed at providing a safety net for those most at risk, rejecting an assumption of state responsibility for social problems (Berescroft, 2012). While I have presented these differences somewhat simplistically, nevertheless these political genres broadly affect the framing of systems, the provision of services, and beliefs about what is good and proper, in short, what is considered ethical. Reisch & Jani (2012) emphasise this interconnection between politics and ethics, stating that the term 'politics' includes "...those relationships and activities that reflect power and value differences and which influence critical decisions..." (Reisch and Jani, 2012: 1133). Thus, political ideologies, systems designs and ethics are inextricable.

One lens used to deepen a discussion of the intersections between ethics, systems and politics in national contexts is the concept of orientations, described as broad 'flavour differences' in overall policy directions (Gilbert et. al, 2011, Kriz & Skivenes, 2013). These are oft described in the child and family social work arena as reflecting 'child protection' (individual child) or family-oriented 'child welfare' priorities. Within a child welfare orientation, the best interests of the child are closely linked to the interests of the family as a whole, and assessments include strengths as well as

difficulties. It views its purpose as preventive, and the focus within this approach is to “...create those material and social conditions within which all children are given sufficient opportunities to reach their full potential” (Fargion, 2012: 2, drawing on Craddock, 2004). Thus, a child welfare orientation offers a broad based prevention policy framework, based on a long-term understanding of epidemiology, rather than focussing on a single risky event (Spratt, 2008). Gilbert et al., (2012) conversely characterise a ‘child protection’ orientation as one that: frames problems in individualistic and moralistic ways; directs legalistic and investigatory intervention types; promotes adversarial state-parent relationships; and results in the use of mostly involuntary out of home placement. Fargion (2012) adds to this, stating that child protection orientations define children’s best interests narrowly in terms of children’s protection, reifies ‘abuse’ as something objectively apprehendable, and utilises standardised assessment tools. Significantly, she claims this approach “treats difficulties as signals of risks” (2012: 2). Whilst these two orientations shape the construction of risk, the application of these orientations is not straightforward, with some countries having a ‘mixed’ orientation, including A/NZ (Keddell, forthcoming; Spratt, 2001, Gilbert et al., 2011). Overall, a child protection orientation, combined with a residualist approach to social policy, is likely to contribute to a highly risk-averse practice environment where problems are individualised, and the identification of risks dominate the aims of intervention (Križ and Skivenes, 2013).

Orientations, in turn, clearly have links with political ideologies. Child welfare orientations contain an assumption of state responsibility for broad-ranging social well-being, linked to a universalist social democratic ideal, while child protection orientations can be related to the individually targeted, investigation and punishment—driven models of residualist, neo-liberal approaches. Adding further complexity to meso level systems design and macro level political ideology, are more traditional ethical concerns. These include the duty-based and consequentialist frameworks by which ethical tensions concerning the targeting, monitoring, and interventions on people may be considered.

The issues of systems design, ethics and ideology are currently writ large in A/NZ. Here, a discussion about the provision of universal and targeted preventive services is playing out against a backdrop of simultaneous benefit and child welfare system

restructures. The benefit system changes have decreased the range of benefits available, increased work-testing for both single parents and those with disabilities, introduced ‘social obligations’ for parents in the benefit system, (for example requiring them to have their 3 or 4 year old children enrolled for 20 hours or more early childhood education per week) and introduced financial sanctions for non-compliance or failed drug tests (NZ Government, 2012). The concurrent child welfare systems changes include the creation of a new national information-sharing database for identifying and tracking ‘vulnerable’ children, changes to the privacy legislation to enable this, changing the pathways for referral, assessment and responses to child abuse referrals, (with the creation of ‘Children’s Teams’ – professionals in each area who meet to make plans for at-risk children), heightened accountability for professionals working with families to prevent abuse, and increased sanctions for people found to either have not reported abuse, or been the perpetrators of abuse (Ministry of Social Development, 2012b).

A major aspect of the latter reform is stated as early intervention on ‘vulnerable children’ (NZ Government, 2012c). The term ‘vulnerability’ can “...shape the ways in which we manage and classify people, justify state intervention in citizens’ lives, allocate resources in society and define our social obligations” (Brown, 2011: 313). Here, ‘vulnerable’ in the initial Green Paper on Vulnerable Children meant those vulnerable to a broad range of longterm poor outcomes including poverty, poor school achievement, hospital admissions, domestic violence, and the impact of multiple adversities, (:4) however by the next iteration, the White paper, the focus had narrowed almost exclusively to children who have been – or are likely to be – abused or neglected, with little mention of other negative influences, most notably, poverty (MSD, 2011, 2012b). In this context, the use of a predictive risk model (PRM) was suggested as a technology that might assist with identifying those who will go on to abuse their children, with a view to early intervention on high-risk families.

Introducing the predictive risk model

The authors of the PRM report themselves indicate that there are significant ethical and moral questions to be addressed in the use of the PRM, and recommend a full ethical evaluation before its implementation (Vaithianathan, 2013). The PRM was created from a large linked data set of Benefit (public welfare) and Child, Youth and

Family (child protection services) information, supplied to a University Economics Dept. to establish if it was possible to predict substantiated child abuse. The sample consisted of babies born between 2003 and 2006, who had a 'spell' (period of time) in the benefit system between the start of mother's pregnancy and age 2 years (Vaithianathan, 2012, Vaithianathan et al., 2013). 57, 986 children were captured in the sample. The modeling was based on 132 variables, selected initially on availability in the data and known risk factors, then narrowed based on which were significant after the model had been run (never published in full but see Vaithianathan, 2013 for the fullest indication). Of the variables, 45% of them relate to the demographic information, socioeconomic status and history of the primary caregiver (including history of own abuse), 37% relate to the partner, (present in 29% of spells), 18% relate to children (mostly prior substantiations of abuse). The model approached a percentage of 75% under the ROC curve, but can also be understood when stratified into deciles of risk. In the top decile, the PRM was 48% accurate in terms of prediction of substantiated abuse within the child's first five years of life, and in the top two deciles, 37% accurate. Only 2% of those in the lowest risk decile went on to have a substantiated abuse finding. In the top two deciles, 44% of all children with a maltreatment finding were captured. In relation to all children with substantiated findings, this cohort captured 83% of them over this time period, despite its limited sample, that is, the benefit drawing population². Based on these findings, it is proposed that targeted, voluntary services to those in the highest two deciles could be offered, with a cost-benefit analysis done using the Olds Nurse-family partnership as an example (Vaithianathan et al., 2012; 2013). The authors note that despite extensive literature searches, no other use of a PRM in this way has been found throughout the world (Vaithianathan, 2012).

Within paradigm ethical issue one: duty

The first ethical lens to apply to the proposed use of this model is that of duty. A traditional universalist approach, ethical concepts relating to duties are strongly connected to Kant's idea that people are rational, agentic beings intrinsically worthy

² The authors propose that any national implementation of the PRM should be completed using a more extensive linked data set that included health data that would capture the whole population.

of respect. This nature creates a duty to respect individual autonomy. It is from this approach that many 'rights' are constructed as universal, and from which those in the helping professions deduce commitments to privacy, consent and self-determination, as well as 'respect for persons' (Banks, 2006). However, the operationalisation of duties is never straightforward in a social policy context, as many rights compete (Banks and Williams, 2005). How can we appraise the PRM from a duty-based perspective?

Firstly, the retaining of individual identifiers required for the PRM to direct services to specific families is a major threat to the duty-based imperatives to respect people's right to privacy and to give consent for their information to be used for certain purposes. In the PRM, information provided for one purpose, for example, to apply for a benefit, is being used for another – to generate an individually identifiable risk score that would be passed to a contractor. That contractor would require individual details regarding the family to offer an intervention. It could be argued that the context is of potentially competing duties: to protect children as well as the autonomy of parents, however, the ability to override the rights of parents to protect the rights of their own children usually only occurs if they have actually harmed their children – this is not the case in this instance, as harm has not yet occurred, and importantly, nor can there be surety that it will. Overriding duties towards parents is therefore difficult to justify from a rights/duties perspective, especially given the probability that only 37% of families will go on to abuse their children (top two deciles). A suggested solution is to seek consent from parents for their information to be used in the PRM at the point of supplying information to the benefit agency or health service (Dare, 2013). However, consent to this cannot be considered free from coercion, as the vulnerable status of families in the process of applying for an essential service makes genuine consent impossible to ensure. Another duty-based ethical issue is that the PRM may set practitioners at odds with their own professional codes of ethics, as they will be expected to both give and receive private information regarding a family's risk score and personal details.

A further duty-based ethical consideration of the PRM is a pragmatic consideration of how the PRM might affect relationships with service users. Munro (2007b) points out that in systems where privacy issues are brushed over in the name of information

sharing, collaborative practice with families is sorely challenged. Such blatant breaches reinforce power differentials and reduce trust. Thorpe reminds us "...family inclusion in child protection practice is a key strategy both for ... providing clear benefits for children, their families and communities" (2008: 4). In the context of PRM, establishing rapport and functional working relationships, fundamental to changing family dynamics or intervening on personal issues with service users, is likely to be difficult (Howe, 2010). Munro (2007b), for example, notes that too much information sharing too quickly can lead to excessively intrusive and conservative reactions, oppressive interventions that are extremely stressful for families, close down more supportive and engaging options for struggling families, and more importantly, do not improve the lives of children involved. Research in the US shows that the brunt of such an investigatory 'over-reach' is primarily borne by those who are poor, brown, single women (Roberts, 2002), and despite its empirical base (or perhaps because of it) a PRM is likely to reproduce this pattern here (see below). Thus, the generation of a high risk score may be used to justify the overriding of important rights, create conflict between practitioner's ethical commitments and the tasks demanded of them, affect the relationships possible with service users that effective intervention relies on, and reproduce existing structural inequalities embedded in the data (from child protection and welfare systems) that the PRM uses.

Within paradigm ethical issue two: consequences

Consequentialist ethics evaluates the ethics of policy based on its overall future consequences for society and to some extent, the individual – arguing that ethical action cannot always be achieved via duties towards individuals without recourse to a consideration of consequences (Banks, 2006). One way of applying a consequentialist approach to policy evaluation is by using a typology of prediction, treatability, and the level of damaging effects (Munro, 2007a). If prediction is accurate, treatment has a high success rate, and there are few damaging effects, for example, from a consequentialist position you might argue the policy is a sound one. In terms of prediction, Munro comments that "In predicting risk of child abuse and neglect, existing risk instruments lead to an unacceptably high level of false positives (families inaccurately deemed to be high risk) and a high level of false negatives (dangerous families wrongly judged safe)" (Munro, 2007a: 50). She goes on however, to note that what is felt to be 'acceptable' is a moral judgement, rather than an absolute:

“ultimately judgments about “acceptable” levels of accuracy come down to a moral judgement: how many innocent children is it acceptable to wrongly label...in order to catch a high number of accurate predictions?” (2007a: 50). Many writers agree that an unacceptably high number of false positives are generated by risk scoring – but this PRM model can guarantee ½ for the top decile (Spratt, 2011). Is this enough?

One issue in answering this relies on the second criteria: treatability. In order to ascertain this, more information is needed on which types of interventions will be offered, who will deliver them, and what their theoretical, research, and cultural bases are. While the Olds Nurse-Family partnership model has been suggested, and this has a rigorous research base, this will not be appropriate for all the families identified via the PRM, though it may be highly effective for others (Olds, 2006). One reason for this is because the risk score is based on demographic and historic information relating to previous child protection and welfare services involvement, but cannot tell a practitioner what the actual issues facing the family in the present are, what were the causes of the previous referrals to child protection, or indeed, if there are any current issues at all (in the case of false positives or life change). In this sense, the variables used by the model itself would be more useful if they were based on fundamental risk factors, rather than sightings in other systems. The PRM captures some of these (such as parental age at first birth), but not others. In general, it is extremely difficult to ascertain ‘effectiveness’ for interventions on complex social problems – child abuse has numerous causes, various types, and shifting definitions that make establishing the real issues for a particular family, and the offer of an appropriate intervention, extremely difficult when a standardised service is used. Not all abuse can be addressed by a standardised family intervention, especially when aimed at family functioning only (Devaney & Spratt, 2008; Munro, 2002).

A major issue in establishing the effectiveness of intervention (or ‘treatability’) is engagement. If the method of identification seriously damages the opportunities for successful engagement and take up of the service, is the method of identification therefore useful? Can effectiveness be estimated accurately? As noted above, when the efficacy of all social interventions relies on the relationship between social worker and service user to contain qualities such as trustworthiness, genuineness, warmth, rapport, and non-judgmentalism, this cost is not just one of offending families or breaching their legal rights to privacy (though these are important) but may also

impede the effectiveness of interventions (Bundy-Fazioli, 2009, Howe, 2010). Finally, family level interventions will not address macro issues contributing to abuse. All these issues make realistic appraisals of treatability difficult to evaluate.

With regards to damaging effects, having a high risk score may result in stigma for already stigmatised populations, and thus reinforce existing structural inequalities. As the variables used rely more heavily on data about mothers (as is more available in the data), and uses socioeconomic status as a variable, female caregivers will overwhelmingly be identified as ‘risky’. Likewise, although ethnicity is not used as a variable, the inclusion of SES, age at first birth and previous contact with the child protection system as variables will result in identifying a disproportionate number of Maori. This is because they are disproportionately represented as a percentage of children in the benefit system and in those reported to the child protection system (Welfare Working Group, 2011, Ministry of Social Development, 2012a, 2012b). Thus, the generation of risk scores using these data is likely to reinforce existing structural inequalities by contributing to the ongoing stigmatisation of this population. While stigma could be lessened if the score (and thus identification) was only supplied to the NGO contracted for the service provision, in the context of other changes that heighten methods of information sharing, surveillance and intrusive intervention, it is unclear if this caveat will be followed (NZ Government, 2012d). Risk scores may be entered in the new national information sharing platform, assigning the label ‘risky’ permanently to people who have not and may never harm their children based solely on statistical association.

Critical engagement with ethical issues in policy development

Beyond these more obvious ‘within paradigm’ ethical concerns, there are a number of broader philosophical issues raised by the PRM proposal. Houston et al. (2010) argue that the use of ethical axioms help inquirers examine ethical dilemmas in policy. Rather than produce a set of neat answers, these axioms can produce a “...creative tension from which moral decision-making may evolve” (:288). These are especially useful in domains where there is an “...attempt to balance the rights and interests of children with those of their parents, the discordance created by the contrasting care

and control themes in procedurally governed, professional environments (and the)...dissonance between family support practices and risk averse, child rescue initiatives” (Houston, et al., 2010: 288). In other words, ideal in this instance. The first axiom suggested by Houston et al (2010) is: “An inquirer should critically appraise the relevant knowledge informing an ethical dilemma in social policy” (:289). Critical appraisal of knowledge must ask what the functionality of knowledge, is, that is, how certain types of knowledge operate as discursive phenomena, and how they contribute to the knowledge context that frames and regulates policy and practice. Critically appraising the knowledge underpinning the PRM in this context would lead one to ask:

1. What are the assumptions concerning children, families and the causes of child abuse implied by this proposal?
2. What does privileging prediction models using risk factor science and economic modelling suggest about the construction of the issue in public and political discourse?
3. What discourses of risk does this proposal promote, and what are the effects on policy and practice?

These questions will be addressed in turn. Firstly, what are the assumptions concerning children, families and the causes of child abuse promoted by this proposal? The first assumption embedded in the PRM concerning children, families and causality is that families are the sole genesis of child abuse, as families, and more specifically mothers, are defined as the site of risk generation and suggested as the target of intervention. Thus the risk factors used hold individuals accountable as they ascribes complex social problems to those of individual, gendered failing. Where risk is conceived of in this manner, it is decoupled from its wider context, one that includes significant inequalities (OECD, 2011). Risk factors constructed in this way have been critiqued “...for isolating the individual from the social world and for separating a particular risk or risk behaviour from the context of associated risks and behaviour” (Stalker, 2003: 214). The development of programmes and services in response to an individual conceptualisation of risk tends to rationalise scarce resources “...in the absence of appropriate political lobbying for adequate resourcing” (Morley, 2003: 33). Thus the responsibility of the state is narrowed to intervene on a small number of problematic families rather than promote general well-being or

recognise the context-dependent or at least context-influenced nature of child abuse. Considered against the backdrop of benefit reform described earlier, the individualisation and gendering of social problems, masked by the appearance of a neutral ‘scientific’ method of identifying risky individuals, can be understood as part of a wider move towards a neo-liberal agenda that may emphasise individual failing at the expense of structural considerations (Wilson, 2011).

The assumptions underpinning this method of knowledge production is that child abuse is predictable, and by using it professionals are able to identify and ‘treat’ families. This construction has a number of consequences. Firstly, Gillingham (2006) drawing on Beck, (1992) points out that where risk identification is equated with predictive power, individuals can be held accountable for resultant harm as an indication of both the personal failing of the person who behaved harmfully, and the person charged with predicting that harm. Gillingham (2006) notes that in this manner, social problems become reconstructed as individual choices and responsibilities and, consequently, “...governments are able to avoid risk to themselves by displacing responsibility onto the individual or, as a last resort, on the mediating professionals within the agencies of social welfare provision (Kemshall, 2002: 87)”. This is a likely outcome in this instance as other changes within the child protection system emphasise the responsibilities of professionals and ‘the community’ to identify abuse and be held accountable for its resolution (NZ Government, 2012). However, there are some positive aspects of constructing abuse as predictable. Firstly, it provides a focus on prevention, rather than the usual emphasis on secondary and tertiary service responses that function simply as an ‘ambulance at the bottom of the cliff’. However the nature of the data informing the model must be carefully considered in order to maximise the opportunities for prevention. Epidemiological studies, for example, the MACE study (a long-term study of multiple adverse experiences faced by children and their consequences over time) provides sophisticated ways of attempting predictive models, and complex research such as this alerts practitioners and policy makers more accurately to the myriad of factors that *may* lead to a range of poor outcomes, focussing on the cumulative nature of adversity (Spratt, 2011, Devaney and Spratt, 2009). However, this research is much more nuanced than the data informing the current PRM. As the data informing the PRM (currently) can only draw on benefit and child protection services data, other

important adverse experiences cannot be incorporated into the risk model (though this is planned for the future). Establishing risk of a range of future poor outcomes may address some of the issues with stigma as it is likely to result in services framed around needs and risks of a range of poor outcomes, rather than risk of abuse exclusively.

Suggesting child abuse is ‘treatable’ in the same way as a disease implies abuse operates in the same way as a physical illness, and this has a number of consequences. The use of medical metaphor is widespread in the PRM and White Paper on Vulnerable Children. For example: “The accuracy of this model is similar to mammography as a method for predicting breast cancer among women Yet, although it is government policy to universally screen ... to increase early identification, no attempt is made to apply the same logic by screening children for maltreatment risk” (Vaithianathan et al., 2013:355). It can be argued that this construction provides rhetorical potency to the argument for preventive, population-based services. By comparing the predictive ability of the PRM to other screened-for diseases, it garners moral power for justifying preventive services. It also, arguably, attempts to de-stigmatise the nature of abuse by comparing it directly to other public health problems which are, by and large, constructed as sicknesses that befall individuals, rather than are caused by them. Reconstructed as a health issue, rather than a moral failing or welfare problem, it may be more readily accepted as within the realm of state responsibility. However, it may also imply that child abuse similarly operates as an intrinsic and inherent pseudo-biological trait that may lie dormant for a number of years, but inevitably will progress to actual harm without ‘treatment’ (Jack, 1999). Jack (1999) notes that the discourse of child abuse as a disease means that if a child is abused, parents or the ‘system,’ are to blame. This focus “virtually excluded consideration of the effects of such factors as poverty, social deprivation and discrimination” (: 660). Thus, in relation to our first question, the PRM may individualise and ‘gender’ assumptions about abuse causality and overemphasise prediction and treatability, however, it may also lead to a more hopeful discourse of abuse as something with antecedents that may draw the focus to prevention.

This leads to the next question: What does privileging prediction models using risk factor science suggest about the construction of the issue in public and political

discourse? This way of conceptualising risk, and privileging it in policy, is embedded in a wider context of increasing requests from government for evidence of both the existence of problems, and effectiveness of interventions. In and of itself, this is not a negative thing, however, when statistical risk factor analysis is used as the primary mechanism for risk identification, this reflects faith in a particular type of evidence, in the 'hard science' that will in turn produce rational efficiency. A narrow focus on risk factors derived from statistical association only has been critiqued as too narrowly focussed, with many arguing that risk factors should be viewed as just one aspect of developing a holistic approach to prevention policy and practice (France et al., 2010). McDonald & McDonald (2010) point out that very different systems are created if the aim is to prevent 'extreme bads' that is, extremely rare, high cost events (such as child deaths) as opposed to a system that aims to increase the range of factors that promote child and family well-being.

Furthermore, using risk factor science to construct risk reifies risk itself in practice contexts, even though developers and policy makers alike may understand that risk factor analysis yields a broad-brush picture, rather than absolute determinants. Risk factor analysis models, while not claiming to be deterministic, nevertheless are often used as if they can give surety about future behaviour (Shlonsky, 2010, Munro, 2010). This notion that risks are real, deterministic and individually meaningful can scarcely be avoided if the PRM was to be implemented, as individual identifiers are retained and used to direct services. Munro et al. (2014) further discuss the use of risk factors to imply causality, pointing out that while generally speaking it is accepted that where risk factors are multiple "the risk gradient increases sharply", (:65) many questions about causality remain. These include how to weight different risk factors, limits on the specificity and sensitivity of risk measurement instruments which make them difficult to apply to individual situations, the lack of representativeness likely in data derived from known or reported cases, and the fact that risk factors in and of themselves are neither "necessary nor sufficient" for abuse to occur (:66). When applying these critiques to the PRM, it is clear that all of these issues are relevant to its development and use.

Furthermore, as the PRM relies (out of necessity) on abuse substantiations as a measure, this can also inadvertently constitute abuse as something unproblematically

defined by some objective criteria, that is, it reifies abuse. This suggests abuse itself is easy to define, when a multitude of culturally relative factors influence the social construction of child abuse across time and place in all but the most extreme cases (Munro, 2002, Parton, 2011, Darlington et al., 2010). For example, difficulties in definition include: "...lack of social consensus over what forms of parenting are dangerous or unacceptable; uncertainty about whether to define maltreatment based on adult characteristics, adult behaviour, child outcome, environmental context or some combination; conflict over whether standards of endangerment or harm should be used in constructing definitions; and confusion as to whether similar definitions should be used for scientific, legal and clinical purposes" (National Research Council Report 1993: 30). These definitional factors point to the interpretive and uncertain world of actual practice, where constructions of abuse are often contested and contestable. Such interpretive difficulties are particularly challenging in cases of neglect and emotional abuse, as opposed to physical and sexual abuse, due to the latter categories being much less open to differing value and belief systems. Emotional abuse and neglect made up 80% of substantiated cases in 2012/13 (Office of the Chief Social Worker, 2014).

Studies of abuse substantiations³ further challenge the claim of objectivity of abuse definitions inherent in substantiation numbers, and risk models that rely on them. For example, some studies highlight the manner in which confirmation biases affect decisions regarding thresholds and judgements about the consequences of parental behaviour (Arruabarrena and De Paúl, 2012, Everson and Sandoval, 2011) while others highlight the moral content of decisions to substantiate abuse that reflect judgements about lifestyle, culture and client reaction to intervention (Thorpe 1994). Wynd, (2013) in a New Zealand study, notes the variability in the proportion of substantiated cases of abuse against notifications to child protection services (suspected cases) between different Child, Youth and Family offices, ranging from 5.9% (Wellington) to 48.2 % (Whakatane). While the reasons for this range cannot be established, it suggests that the criteria for substantiation of abuse rests less on a consistent definition or threshold, than the proportion of referrals to resources present in each location, or site specific institutional cultural practices that influence

³ Where abuse is confirmed following an investigation by a child protection agency.

substantiation criteria. This suggests judgements about abuse substantiation are mediated by a range of other factors including social worker's values and organisational context (Kemshall and Maguire, 2001, Gillingham, 2010). Thus, the use of risk factor science can narrow policy and service responses, create a disconnect between risk factors and their wider social environment, reify 'risk', and reify abuse in such a manner that the interpretive aspects of abuse substantiation are obscured.

Finally, if the use of the PRM signals a wider move to embracing a 'risk paradigm', (a discursive policy field that embraces risk as a central organising principle) (Houston and Griffiths, 2000) what discourses of risk will this promote, and what are the effects on practice and policy? While the concept of risk management dominates many child protection systems worldwide, its use as a central organising feature of child protection systems has long been criticised (Keddell 2014). Where 'risk thinking' is allowed to dominate social work practice, this can contribute to conservative, risk-averse interventionism (Turnell & Edwards, 1999). Children are removed early in reaction to what 'might happen' instead of an evenhanded assessment of the range of strengths, weaknesses, needs and risks in the family's immediate and wider ecological context. A 'risk paradigm' creates professionals as experts, with lay people considered biased, and untrustworthy processors of knowledge (Stalker, 2003). This decreases space for family-led, creative responses to difficulties, and can contribute to a deficit/problem orientation instead of the strengths/resilience/safety orientations currently considered best practice (Saleebey, 2006; Graybeal, 2001).

Secondly, in terms of policy, the implication that risk assessments are impartial and take place in a disembodied, objective fashion belies the interconnected nature of the social construction of knowledge in a given microcontext, and within a given socio-political context. Where risks are individualised, for example, this clearly reflects a neo-liberal concern with personal responsibility and a limited role of the nation state. Within this conceptualisation, individuals are viewed as 'prudential citizens', if they are able to react rationally and responsibly to the demands of modern life (Rose, 1996). "Through this 'responsibilisation', the self is made responsible for his or her risk choices, and only 'good' choices are rewarded by inclusion in society; those who make 'bad' or risky choices are excluded" (Kemshall, 2010: 1250). To apply these concepts to the A/NZ context, a worrying picture emerges, as 'responsibilisation'

concepts are deeply embedded in the current welfare and child protection reforms of A/NZ. This is evidenced by the use of sanctions and obligations, heightened work testing, and in other child welfare changes, an increase in surveillance and monitoring mechanisms, with no further resource made available for the actual provision of direct services to families (Vance, 2012, Ministry of Social Development, 2012b). In this wider context, it is difficult to avoid worst-case views of the PRM. Overall, the justification of social exclusion based on the identification of some people as making risky or irresponsible choices may contribute to a divisive discourse, or ‘us and them’, particularly when tied to beneficiaries or other marginalised people groups. This possible development seems likely where other rights of poor people are increasingly threatened. Increased work-testing, drug tests and benefit cut sanctions for non-compliance have been justified with the implication that the poor are ‘feckless and feral’ (Beddoe, 2013). The creation of a new centralised information sharing platform about ‘risky’ families, able to be accessed by professionals from a range of services, is further evidence of a strong belief that more surveillance of some ‘types’ of people is justifiable, even at the expense of people’s right to privacy and given the possibility of stigma (Keddell, 2012, NZGovernment, 2012, Stanford and Taylor, 2013). Considered from this angle, the PRM may contribute to risk averse practice and a policy environment where risk anxieties are used to justify the social control of certain groups of people.

Avoiding worst case scenarios – risk within a child protection or child welfare orientation?

In order to avoid this rather grim and perhaps overly apocalyptic view of the role of the PRM in contributing to a wider risk paradigm, the question must be asked, how could the PRM be used in ways that could contribute to lowered harm to children while avoiding seduction into a neo-liberal agenda? One way is to give closer examination to the wider policy arena it operates within. Avoiding the potential negative outcomes of the PRM model while recognising its utility in contributing to a prevention agenda is difficult but not impossible. It could avoid the worst consequences as described above if the wider system it is embedded in returned to the child welfare orientation reflected in our child abuse legislation (NZ GOVT 1989). What would this look like? Firstly, a recognition of poverty as an important contributor to a range of poor outcomes. Continuing high rates of poverty and

inequality threaten the wellbeing of many kinds for children, including child abuse (Gilbert et al., 2012, Wynd, 2013, Slack et al., 2004). Secondly, follow the best practice pattern of using strong universal services, (including poverty reduction) as a bridge to moderately targeted family support services within the same organisation if possible (UNICEF, 2003). This type of service lessens stigma and enhances service take up due to the client's existing relationship with service providers. The PRM could be used at the juncture between universal services to more targeted ones as a complement to professional discretion – but only at the population level, or individually with consent. The PRM could contribute to decisions to refer on to tertiary services for those families for whom targeted services are unsuccessful. In addition to identifying priorities for who services should be provided to, an PRM can also (especially when other data sources such as health information are added to the model) be used to develop specific types of services. For example, if the model can be used to identify which combination of risk factors are most harmful, this can be used to develop specialist tertiary services to address the cumulative effects of specific clusters of risk factors (Spratt, 2011). However, the fundamental development of universal services as the primary mechanism by which families are targeted for preventive services remains the best place for ensuring families access the range of services that can contribute to child abuse prevention.

Conclusion

The use of predictive modelling as a tool is just that – a tool – and in and of itself is not inherently connected to a particular politics or ethical position. However, if it is used to lead the identification of people within a child protection orientation, rather than one aspect of a system predicated on the assumptions of the child welfare orientation, the likelihood of some of the more pernicious outcomes described here remains high. Where it is used as a method of first identification in place of the development of universal services, its issues of consent, privacy and the potentials for risk-averse, highly individualised practice responses are heightened. Primary prevention should not be conceptualised as finding a few problematic needles in a haystack so as they can be fixed. Effective prevention should instead be thought of as stopping hay from turning into needles, that is, recognising that families who become abusive are usually ordinary families who require a non-stigmatising service to avoid

the decline into abuse. The ethics of the PRM thus prompt a much wider conversation regarding the overall direction of systems development, as many of the ‘within paradigm’ ethical issues around duties and consequences are difficult to settle without acknowledging the ‘outside paradigm’ ethical issues of knowledge production, national orientation, and the politically contestable views of what the aim of social policy should be – to prevent acts of abuse or build a supportive society that ensures well-being. This leads, in turn, to an exploration of core values, particularly what kind of orientation is most desirable, and who is in control of deciding.

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