Managing 'Risk' in Ontario Social Services: Cases, Causes and Consequences

by

Laura Rudy, H.B.A.

A Thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Master of Social Work

School of Social Work
Carleton University
Ottawa, Ontario

December, 2007

Your file Votre référence
ISBN: 978-0-494-36855-8
Our file Notre référence
ISBN: 978-0-494-36855-8

The undersigned recommend to the Faculty of Graduate Studies

and Research acceptance of the thesis

Managing 'Risk' in Ontario Social Services:

Cases, Causes and Consequences

Submitted by Laura Rudy, H.B.A.

in partial fulfillment of the requirements for

the degree of Master of Social Work

Patricia M. Evans

Thesis Supervisor

Diana Majury

Acting Director, School of Social Work

Carleton University

December, 2007

Abstract

Risk has been a longstanding concept in contemporary society and more recently has emerged as a popular discourse in the social welfare arena. While it has been advanced with relative ease and claimed to be a necessary framework in the regulation and management of social services, opponents have raised concerns around the problematic implications risk has on the organization, delivery and impact of service. Given that social policy reflects and advances broader societal norms and values which shape and guide how social problems are defined and responded to, risk management has sparked debate on how services are organized and delivered as well as who is identified as eligible for receiving care. Of equal importance, are questions surrounding how and why risk has emerged as a central notion in social services.

The purpose of this research is to broaden the understanding of how and why risk has become a popular discourse in social service provision by tracing, and offering a critical analysis of, the policy-making process of risk management in three areas of social service in Ontario.

Acknowledgments

I extend a special thank you to Pat Evans for all of your ongoing support, encouragement and understanding throughout this process. Your direction, feedback and patience guided me through this work and I am forever grateful for how you inspired and challenged me along the way. Working with you has been an absolute pleasure and I would not have been able to get through the more difficult aspects of this thesis without your guidance and insight. Also, to Rashmi Luther, Adje van de Sande and Dawn Moore for all your feedback and contributions.

I also compassionately thank all my family and friends. You always believed in me and offered endless support throughout the year. I thank you for everything.

Table of Contents

Chapter 1: Introducing the Thesis

Social policy is an important area of study in social service provision and social work practice. It provides an overarching structure that reflects and advances broader societal norms and values which come to the surface when social problems are defined and responded to. While policies do not operate through a simple cause-and-effect, linear manner, and the advancement of values and beliefs is part of a complex process that is dialectical and dynamic, policies do *shape* and *guide* how social problems are defined and constructed and consequently, frame how services are delivered, practice is organized and how users of services become conceptualized.

Since the 1990s, a discourse of risk has emerged in social policy in Ontario and across many Western nations. While not a new idea in contemporary society, risk has appeared on the social welfare agenda within the last twenty years with a particular prominence. Terms, such as 'at-risk', 'risk factors', 'risk assessment' and 'risk management' have become commonplace in a range of social services, embed practices that are currently in operation across a number of organizations and agencies, and are currently a popular discourse in provincial policy. For example, the McGuinty Government's recent release of the *Action Plan for Healthy Eating and Active Living*, a province-wide effort to combat obesity, identifies health risks associated with obesity and advocates for healthy eating habits and increased physical activity (Ministry of Health Promotion, 2006a). The *Smoke-Free Ontario Strategy*, also implemented by the provincial government, advocates for a complete provincial smoking ban by May 31st, 2008, as an effort to prevent and manage ill-health for people in Ontario (Ministry of Health Promotion, 2006b). Other prevention initiatives advanced through a lens of risk

across the province include preventing bullying in schools by identifying who is at risk; preventing violence/harassment in the workplace by managing risks; preventing gambling behaviors by assessing for individual risk; and preventing the operation of 'gangs' through identification of 'at-risk' youth.

Critical of this trend, opponents have pointed out that the use of 'risk' has short-term and long-term problematic implications for social services. Concerns have been raised with regard to an increase of targeting cultural and racial minorities, maintenance of a paternalistic and 'expert'-based system, an increase in defensive and dehumanizing practices, as well as the emergence of an overall shift to a philosophy of social control versus social rehabilitation. What is less clear and infrequently studied, yet of equal importance, is how and why risk has become such a dominant discourse in social policy.

This thesis contributes to the understanding of the notion of risk in Ontario social services through an exploration of social policy within the areas of child welfare, mental health and violence against women. Specific to the parameters of this thesis, risk is identified as central to service delivery and service users in these areas of social service (see. Leslie & O'Connor, 2002; O'Brien & Farrell, 2005; Hilton & Harris, 2005). It has been documented as a dominant theme in the decision-making of who gets care, when and how (Parton & Mathews, 2001; Waterson, 1999) and has been argued to be a central organizing principle in the delivery of social services and social welfare more broadly (Kemshall, 2002).

The aim of this thesis is not to determine whether risks exist or whether risk management strategies are needed but rather, to offer insight into how and why risk has surfaced as a key concept in social policy by situating risk in the interplay of broader

social, political and economic trends. In this thesis, risk is recognized as a reflection of the interaction between complex social phenomenon, dominant political ideologies and global economic activities which, despite at times being at odds with each other, merge together to support and advance a discourse of risk. It is assumed throughout this thesis that risk, in itself, is indeterminate and boundless, and it is through the adoption of a belief system, as reflected in dominant ideologies and philosophies of social problems, that it is given meaning and understood to be relative and subjective. This is commonly referred to as a social-constructionist perspective which maintains that an understanding and knowledge of 'reality' is subject to interpretation and is fundamentally subjective (Foucault, 1977). This perspective is in contrast to a realist perspective which, assumes that risk is objective, measurable, absolute, stable and value-neutral. Examples that support a social-constructionist perspective of risk are the fact that smoking historically was perceived as a health remedy although it is currently understood to be a health 'risk'. Mental illness, once understood to be a reflection of being possessed by the devil is now recognized as a bio-chemical imbalance in the brain. As well, historically, drinking in Euro-Western countries was viewed as culturally acceptable in celebrations while today, parameters have been constructed to indicate when drinking too much becomes a health risk.

I unpack the relationship between risk, social policy and social service provision by exploring three separate, but overlapping areas of social policy in Ontario - child welfare, mental health and violence against women. These areas are particularly appealing because each has recently experienced a policy decision to introduce a risk assessment or risk management strategy. The Ontario Risk Assessment Model (ORAM) -

to guide child protection practice – was introduced in the late 1990s and achieved full implementation after being legislated in 2000. Community Treatment Orders (CTOs), a form of risk management in mental health, was legislated in Ontario in 2001 and the Ontario Domestic Assault Risk Assessment (ODARA) tool, an actuarial risk assessment instrument was introduced in the province in 2004 and is currently in the process of implementation. This thesis investigates the policy decision and traces the processes involved in implementing these provincial risk assessment and risk management strategies for the purpose of revealing: (a) the ways that risk is becoming increasingly important to the domain of social policy; (b) why it is emerging within social services and across social work practice in Ontario; and (c) the implications this has for social service delivery, professionals and service users. This will be illustrated in each area through an exploration of individual case studies of each tool. The presentation of each case study will highlight the unique and overlapping processes related to the emergence of risk in each policy domain.

The first case study presented is the ORAM in the area of child welfare. This is the most in-depth, complex and documented area which made it possible to provide a thorough analysis of the claims and concerns regarding the delivery of services through a risk-based model. The next chapter presented focuses on CTOs in the area of mental health and analyses the operations of risk management as a central administration principle in mental health services. The last case study presents the ODARA and critiques the functions of assessing and identifying risk through an actuarial risk assessment instrument. While each of these areas of social policy are unique, they share similarities

in that they are all subject to the same provincial and national political landscape as well as are an extension of the global economy at large.

While the processes behind a policy coming into fruition and being enacted is complex and often difficult to pinpoint, I trace the emergence of risk in these three case studies through a broader social, political and economic framework to add to the understanding of how and why a risk discourse has become such a central focus in social policy in this province. I draw on the work of Hazel Kemshall (2002), who highlights how risk is intricately related to the broader restructuring of the welfare state in Western nations and incorporate literature from Ulrich Beck (1992), Anthony Giddens (1990) and Mary Douglas (1992) to expand on how risk manifests as a broader social phenomenon. I extensively review a broad range of documents to identify and analyze the driving forces behind the policy decisions; the developmental processes involved in constructing each procedure; the underlying assumptions and consequences of advancing these frameworks; and the implications this has for social service delivery, social work practice (or service providers) and service users. With equal attention, I am mindful of what is documented as well as what is not in order to reflect the extent to which risk has received attention and has been critically appraised.

The presentation of these three case studies raises a number of questions to be considered regarding the process of policy-making and how risk is operational in society. With respect to policy-making, it is inevitable that some ideas, beliefs and values will advance at the expense of other perspectives; however, what is of critical importance is how this is occurring and whether government officials and policy-makers are being critically reflective of this process. In the last chapter I highlight common themes that

emerge from the initiation and development process of the three risk-based policy decisions to demonstrate how risk is a construction deriving from these processes. I provide a subsequent discussion on how constructions of 'who' is 'risky' and 'who' is 'protected' are given meaning in these areas of social policy through the application of underlying norms, assumptions and values in the policy-making process.

In closing, I provide a framework of questions that derive from the findings in this thesis which aim to enhance a process of reflection during the evolution of initiating, developing and operationalizing policies. This thesis marks a preliminary exploration of risk in social policy in Ontario to contribute to a better understanding of how and why risk has emerged on the social welfare agenda and can be considered as a starting point to future understudy and investigation in this area.

In the next chapter, I provide a literature review of the theories and perspectives that I have drawn upon to inform my analysis in this thesis and subsequently highlight problematic implications that have been raised in the literature with respect to the use of risk assessment tools, social service delivery and social work practice. I will present my methodology and introduce the analytical framework used throughout each case study. The following three chapters – chapter three to five - will present each case study in order of the ORAM, CTOs and the ODARA and chapter six will present my conclusion.

Chapter 2: Laying the Groundwork

Literature Review

The 'risk society' thesis

The 'risk society' thesis has been widely cited as expanding our understanding of the development and implementation of risk assessment and risk management in social services (see. De Montigny, 2003; Kemshall, 2002; Taylor-Gooby, Dean, Munro & Parker, 1999; Kemshall Parton, Walsh & Waterson, 1997). The 'risk society' thesis argues that the notion of risk is intimately tied to a broader paradigm shift in Western society. Beck (1992) suggests that contemporary Western society is undergoing a transformation from the modern era, depicted by a high level of trust and confidence in science's ability to solve problems, to a postmodern period where beliefs in an 'expert' system and trust in authority is now questioned. Globalization and the emergence of postmodern schools of thought have challenged traditional ideas of 'scientific fact' and positions of authority and expertise. What results are citizens who are immersed in a society of imprecise global risks, indeterminate probability of risks, uncertainty in outcomes and anxiety in dealing with risks in general (Beck, 1992; Giddens, 1990). Thus, it is not necessarily that risks overall have increased, but rather that contradictions in the traditional processes of regulating and controlling risks are beginning to surface. This has led to an emergence of a new collection of risks, an adjusted perception of risk and indeterminacy in the location of risks.

It is argued that the process of modernization has brought about a number of risks which have been arising from the very systems of science and technology that originally evolved to control and regulate risk. In an interesting example, Christie & Mittler (1999)

point to the 'new risks' that emerge through the creation of residential homes for children in Merseyside, UK. While the intention was to provide temporary care for children, these homes became a host for other risks, namely risks of violence and child abuse by professionals (often men) (p. 232). Thus, as new risks emerge, more effort is undertaken to regulate and control these risks, and as these methods of regulation and control expand, they become sites of manifesting new risks. Beck refers to this process as 'reflexivity' where society becomes a problem for itself (Fox, 1999). What develops is a perpetuating cycle of uncertain and unmanageable risks alongside processes falsely believed to provide certainty.

It is important to note that the framework of the 'risk society' is not without criticism. Elliot (2002) points out that the discussion of this paradigm shift implies a discontinuous shift and assumes that one line of thinking has directly replaced another, which is not necessarily the case. Rather, the transition from a modern paradigm to a postmodern paradigm is better understood as dialectical, fused and traversed. Moreover, critics have pointed out that Beck's construction of risk is fairly unidirectional and that claims about the relationship of risk and globalization are over-generalized (Elliot, 2002; Lash, 1993). Nonetheless, the most significant aspect of the 'risk society' thesis is that it draws on the wider influences of globalization, modernization and technological development to illustrate how the notion of risk is becoming ingrained in the broader paradigms of society and exposes the paradoxes in attempts to handle risks.

Post Welfare State: Neoliberalism and New Managerialism

Alongside the 'risk society' thesis, scholars have pointed to how risk in social policy is strongly related to the restructuring of the welfare state. The 1980s brought about widespread criticism of the inadequacies of the welfare state (Rice & Prince, 2000). Right-wing critics argued that a 'needs-based' welfare system gave the government too much power in intervening in the private lives of citizens and in addition, was becoming too costly on the economy as a whole. The welfare state was also being criticized by the left as insufficiently responding to the 'needs' of citizens by being too bureaucratic, labeling and blaming the poor as 'needy' and essentially using social assistance as a mechanism to regulate and control the population. These critiques paved the way for restructuring the welfare system through the adoption of 'New Managerialism' or the operation of business models within social services. These models applied the notion of risk as a resource distribution principle and arguably removed the tendency to label and blame social welfare recipients (Kemshall, 2002; Newman & Clarke, 1994). Thus, it is important to not see a needs-based welfare system through rose-colored glasses, however at the same time, adopting a risk-based model as a 'solution' to what was identified as problematic in the operations of the welfare state should not be glossed over either.

Implicated in welfare state restructuring, managerialism and the shift from need (however problematically defined) to risk is the continued dominance of a neoliberal political ideology. From a neoliberal perspective, a functional welfare society is defined in terms of the degree to which citizens can self-actualize and overcome their economic and social disadvantages (Powell, 2003; Rose, 1996). It encompasses existential concepts of self-governance and individual responsibility, which are distinguished as providing

citizens' 'choice' rather than encouraging strong government intervention (see. Leonard, 1997). Alongside this perspective, is the belief that social citizenship, and the morals and values that underlie it, are intimately related to, and partly defined by, one's participation in the labor market (Edwards & Glover, 2001). Emerging then, are policies that support government intervention on the condition that a person demonstrates self-sufficiency and self-reliance by contributing to the labour-force. This is illustrated in the re-workings of welfare benefits and social assistance in Ontario through the introduction of Ontario Works (OW) and the Ontario Disability Support Program (ODSP).

In addition to policy-outcomes being affected by broader welfare restructuring, the policy-making process has undergone an overall transition as well. The concerted effort to include and engage citizens in the policy-making process was highly valued during late 1960s and early 1970s when overall civil and social advocacy was at its peak. Consumers and participants of services did not only hold decision-making power in implementing practices at the program and policy level, but also withheld the right and entitlement to independently develop and contribute their own voice and perspective (Cornwall & Gaventa, 2001). Curry-Stevens (2006) points out that in Ontario, the value of participatory democracy and citizen engagement has been greatly reduced since market ideology and corporate influence has emerged in the welfare state. Not only have the number of organized consumer-based advocacy groups been reduced (mainly due to funding cut backs by the Harris government) but involvement of communities and advocacy groups in policy-making has been eroded. Governments claim to operate within an inclusive policy-making framework and justify this by publicly announcing the use of public consultations in the policy-making process; however the number of consultations

have decreased significantly over the years and the processes behind these consultations have been widely criticized as being selective and unreliable (Curry-Stevens, 2006).

As neoliberalism continues to dominate the political arena, policies are also increasingly designed to shift responsibility from the welfare state to individuals, families and communities (Green, 2004; O'Malley, 1992). With respect to risk, this agenda reinforces the assumption that risk is located at an individual level rather than in broader social, economic or political processes. For instance, the recent release of the McGuinty Action Plan highlights that a person's risk for obesity lies in their poor eating habits and lack of physical activity and not in wider socio-economic conditions such as poverty or government cutbacks in recreational programming. In addition, Powell (2003) emphasizes the ways that social policies and the delivery of welfare within a neoliberal market economy are increasingly organized around processes of 'assessment' and 'monitoring'. Thus, risk manifests as something to be assessed, monitored and managed and sheds light on the emergence of risk assessment and risk management strategies, procedures and policies.

Applying a neoliberal framework to account for risk has received some criticism. O'Malley (2002) points out that the application of 'neoliberalism' as a blanket term overlooks the 'hybridity' of neoliberalism across Western nations and simplifies its variation across regional social, political and economic platforms. Nevertheless, this perspective is particularly relevant as it links risk to political ideology and broader socio-economic influences and expands the breadth of current theoretical approaches to risk.

Unpacking the construction of 'risk'

The concept of risk, and/or what is considered to be 'risky', traditionally has been conceptualized as a neutral value – one that involves weighing the probability of an event through the consideration of neutral factors. From this standpoint, risks are objective, stable, measurable and value-free and are determined though the calculation of probabilities. Lupton (1999) refers to this as the 'techno-scientific' perspective, which is widespread in the areas of science, engineering, economics and psychology. It assumes that risks can be identified, and mapped on individuals or aggregated populations, and thus appropriately managed by experts who have accumulated the knowledge to do so. From this standpoint, risk is approached through a realist or rationalistic lens which embraces fact and the belief that a reality exists independent of perception, and subsequently, supports statistical relations and scientific theory as the basis of constructing risk (Lupton, 1999).

In contrast, other theorists have provided frameworks that attempt to understand the construction of risk from a socio-cultural and political perspective. A realist position of risk is openly challenged as being too simplistic and under developed because it fails to recognize that the very construction of risk as objective, measurable and value-free, is actually part of a broader belief system in itself (Cradock, 2004). Some scholars illustrate this point by suggesting that the conceptualization of risks and determining what is 'risky' has not remained stable over time. Giddens (1999) points out that, historically, smoking was not always a 'risk' or 'harm' to one's health. Rather, at one time the medical profession, physicians and the health field generally, endorsed smoking tobacco as it was recognized as a remedy for alleviating stress and anxiety. Today, smoking is

condemned due to the widespread 'scientific evidence' that highlights a number of health hazards associated with smoking, such as heart disease, strokes and cancer. This raises questions as to what degree risk is actually impartial and unbiased.

Moreover, Kemshall (2002) provides a discussion of risk in contemporary society that highlights the value-laden nature of the concept. Specifically, she illustrates that the notion of risk today insinuates perceptions of 'danger', 'harm' or 'threat'. Society no longer perceives risk as a neutral concept, but rather as a concept that is increasingly associated with negative consequences and/or leads to the likelihood of an adverse event. This is particularly obvious through the increased framing of 'risk factors' in the area of health, the environment and sexuality. For example, poor eating habits and little physical activity increases ones risk for obesity; increased pollution and material consumption leads to a higher risk for global warming; and self-identification of being gay, lesbian, bisexual or transgendered increases ones risk for suicide[1]. In all of these examples, the neutral connotation of risk is displaced with an undertone of adversity and thus the underlying message is to predict and prevent these risks. Alongside this line of thinking, 'risk-taking' is not widely viewed to be admirable. In fact, it is largely discouraged in the social policy arena, unless the risk-taking itself is 'safe' and 'predictable', or occurring in the economic market where it is perceived to be smart and desirable.

Consideration of the subjective features of risk also contests the notion that risk is objective and stable. With respect to social services, Kemshall et al. (1997) points out that the construction of what is 'risky' is not only reflective of the values in wider society, but also involves a subjective estimation of what is considered to be a risk and

[1] It is useful to note that these examples also highlight the influence of a neoliberal political ideology as all 'risks' are situated at an individual level.

what is not. Research surrounding the disparity between risks identified in an 'expert system' and risks identified by a lay person reveals that the construction of the notion of risk evolves from a complex process that reflects a negotiation of objective and subjective risk amongst and within the self (Lupton, 1999; Giddens, 1990). For example, a woman could be told by 'experts' that her risk of being sexually assaulted are higher with someone whom she knows than by a stranger; yet she may still choose to walk with a male friend at night through a secluded area because she perceives this as safer than walking alone.

In addition, perceptions of risk are shaped by socio-cultural processes rooted in how people understand themselves and their surroundings (Douglas,1986). For example, a person's individual attribution of risk to a negative event is partly shaped by a number of potential rational cognitive processes (e.g. smoking – my peers are doing it; I will never get cancer). However these processes are also bound to the social context through which a person constructs their understanding, and how this unfolds will depend on the point of reference. For example, someone who understands smoking to be hazardous to their health, and thus identifies with the health promotion campaign, may perceive smoking as risky but a person who understands the risks associated with smoking as historically and socially bound, may perceive these risks as minimal. Thus, risk can be understood to be multi-dimensional, relative and dependent upon how one positions oneself in relation to a risk and to what degree an individual identifies with high-risk groups and empirically-produced risk factors.

Areas of Concern

The Usefulness of Risk Assessment Tools

Since the 1970s, risk assessment tools have been adopted in the area of criminology and forensic investigations. Within approximately the last ten years, these tools have been put into operation across a range of social services. In comparison to clinical intuition, formalized risk assessments are argued to provide a more accurate approach to assessing for risk. They are seen by many to be free of cognitive perceptions and biases, to be empirically valid because they are based on statistical calculations and to improve the accuracy of assessing risk by providing a more consistent and standard approach (Munro, 2004). In fact, some have pointed out that to not use them would be an injustice to professionals and service users as they are considered to reflect 'best practices' in social service delivery (Grove & Meehl, 1996). It is clear that risk assessment tools are reflective of a broader movement towards increasing evidence-based practices in the human service field and promoted as a way to improve accuracy, predictive validity and efficiency in assessments.

Generally, there are two types of risk assessment instruments – actuarial risk assessment tools, which identify risk characteristics by assessing the probabilities of future harm through statistical analysis; and consensus-based risk assessment, which identify risk characteristics to be assessed based on expert clinical judgment. The usefulness and validity of assessing risk with structured risk assessment tools has raised a number of concerns. Some have widely criticized risk assessment tools as being empirically flawed (Dutton, 2006; Hilton & Harris, 2005; Leschied, Chiodo, Whitehead & Hurley, 2003). Specifically, consensus-based risk assessments have been said to have

loose predictive validity since they are not developed from statistical analysis. Risk assessments generally are also criticized as being too individualistic because they situate risks within individual characteristics and overlook that risks can be situated in the interaction of that individual and their environment as well as from the broader societal context. In contrast, some have argued that risk assessment instruments cannot be applied in a vacuum and that clinical judgment inevitably plays a role (Taylor, 2006; Lupton & Tulloch, 2002; Lash, 1993). Advocates for the use of risk assessment instruments, however, point out that the validity of the tool lies in how practitioners work with statistical analysis and interpret results so that clinical judgment does not interfere (Munro, 2004).

Risk assessment instruments reveal the tensions around the presumed ability to assess for objective risk factors while at the same time, understanding that factors are inevitably part of the individual's environment and the broader context.

Framing Social Service Delivery

The shift towards the dominance of the notion of risk in social services frames service delivery by advancing particular philosophical perspectives on who should receive services, how services should be organized and delivered, and what approaches should be embraced in service delivery. Scourfield & Welsh (2003) argue that the notion of risk maintains a philosophy of social control in contrast to an approach of social rehabilitation. For example, regardless of whether risks are situated within the individual or within the external environment, there is a perception that risks should be avoided because they will lead to damaging consequences. What arises from this understanding is

the support of a system that attempts to control and manage social action. In contrast, rehabilitative principles embrace concepts of self-growth and empowerment which often require, to some degree, an element of risk-taking. Stalker (2003) suggests that risk management exists on a continuum, where at one end lies punitive approaches that attempt to control and avoid risk and at the other end are more empowering approaches that facilitate risk-taking. Thus the concern around risk assessment instruments or the adoption of risk in social service provision is not necessarily the focus on risk itself, but rather the concept that risks are framed to be avoided, controlled and managed.

With respect to how services are organized, it has been argued that the adoption of risk assessment and risk management strategies, and the overall shift towards a risk discourse in social welfare, has led to a displacement of need as a central organizing principle of service delivery. Specifically, service provision has shifted from a needs-led framework to a system that investigates risk, shifting social service delivery from a more collective approach that addresses need, to one that is more residually offered to those at risk (Kemshall, 2002). This approach has overshadowed the importance of assessing and providing resources for the 'needs' of service users and families, such as housing, employment and ongoing/long-term social support (Parton, 1998). While principles of need, universality and entitlement have not been displaced completely, the emergence of risk has brought into question how these principles play out when attention is given to the organization of service delivery.

Risk has also been linked to the broader restructuring of the welfare state and plays a role in rationing services. Prioritizing and distributing services through a lens of risk offers a manageable delivery system when resources are scarce and funding is cut.

Kemshall (2002) exemplifies this point through her discussion on rationing in the health care system in the UK. Increased attention towards cost-benefit calculations, alongside the invasion of economic values in the health care system and the dominance of neoliberal governance, shifted the focus towards providing efficient services and resources by allocating through a discourse of risk. This trend is also observable across other areas of social service provision, particularly with the emergence of early intervention strategies, targeting at-risk youth and increasing measures that emphasize public safety and security. Thus, while services have always been prioritized to some degree, they appear to be increasingly organized through a risk management framework.

Not only does risk ration services but the notion of risk influences who is defined as a deserving service user. Risk creates divisions and has been linked to the social process of dividing groups according to whom and what is 'risky' and 'non-risky' (Carter, 1995). The processes of moral panics and politicizing risk to invoke fear[2] form a basis for the boundaries of social inclusion and exclusion. This occurs because risk is associated with a set of social indicators that repeatedly get associated with 'risky', 'dangerous' or 'harmful' behaviour. In particular, risk has been argued to be a concept that defends moral and political boundaries between the self and others as well as normative definitions of who is 'normal' and who is 'deviant' (Carter, 1995).

This perspective is demonstrated in literature that documents the gendered, classed, and raced nature of risk (Hudson, 2006; Hudson & Bramhall, 2005; Hannah-Moffat, 1999) and its ability to mobilize particular cultural and/or racial constructs (Hudson & Bramhall, 2005; Mackey, 1999). For example, Hudson & Bramhall (2005)

---

[2] See Kasperson, Renn, Slovic, Brown, Emel, Goble, Kasperson & Ratik (1988) for an in-depth discussion on a dialectical conceptual framework on the social amplification of risk.

provide a detailed analysis of how risk assessment procedures in probation services have played a central role in the construction of Asians as 'other'. It is argued that these group constructs then serve as mobilizing agents in social governance and the maintenance of social order. With respect to the application of risk in women's prisons, Hannah-Moffat (1999) explains that risk as a moral concept mobilizes cultural and gender-specific constructions in contrast to being an objective factor that solely leads to efficient assessment and service delivery. In drawing on Foucault's work on governance, Carter (1995) explains how the construction of 'at risk' populations is a renewed attempt to identify and manage certain populations. The language of risk and definitions of who is 'risky' has replaced previous notions of the 'deviant' or the 'dangerous' and sustains polarized groupings of 'us' and 'them' or 'the norm' and 'the deviant/other' (Mackey, 1999; Carter, 1995). From this perspective, risk is an intense political activity that draws boundaries between what or who is 'safe' or 'normal' and what is 'risky' or 'threatening'. Thus, a risk framework allows for the rationing and prioritization of resources and services, but also influences how these categorizations are constructed and as result, affects who is defined as socially included and excluded.

The Organization of Social Work Practice

Another area of concern identified in the literature is the impact of risk-based practices and policies on social work practice. Some scholars have pointed out that risk plays a role in the institutionalization of professional knowledge and the 'expert' system. Christie & Mittler (1995), for example, demonstrate how the discourse of risk in social services provides a common language for professionals to universalize a response and

assert their 'expertise' and consequently, propagate unequal relations of power and authority between workers and service users. This type of power imbalance is also illustrated in how risks become defined, in that the identification of risks occurs from a position of expertise with little input and feedback from the person deemed to be 'at-risk' (Culpitt, 1999). Regardless of whether risk assessments are actuarial-based or consensus-based, they are constructed and designed from a perspective of authority and expertise, not from the subjective perspective of the service user.

Questions have also been raised concerning whether these tools objectify social work practice and dehumanize the client-worker relationship that is inherent in direct social work practice (Houston & Griffiths, 2000). The practice of assessment generally has evolved from a modern empiricist paradigm which advances assumptions of objectivity, measurability and scientific expertise (Iversen, Gergen & Fairbanks, 2005). Not only then does the use of risk assessment simplify a social problem, but it also brings into question how an assessment tool impacts and shapes social work practice. An increased emphasis on these assessments results in an increase of paperwork and completion of forms and checklists, less holistic assessments and approaches and an overall depersonalization of worker intervention. As a result, more importance is placed on administrative aspects of interventions and less significance is given to clinical skills of workers.

The application of the notion of risk in social services has also been discussed within the context of liability and criminal responsibility of social workers. Regehr, Bernstein and Kanani (2002) suggest that risk is heavily interconnected with accountability and therefore, "workers must ensure that they practice in a manner that

reduces further the risks of liability and prosecution" (p. 36). What emerges alongside a governance of risk is a society of 'blame' and accountability. As a result, practitioners become more defensive in their practices (see Kanani, Regehr & Bernstein, 2002) and education around legal responsibility for practitioners has become an imperative aspect of training and practice (Filippelli & Goodman, 2001). Social workers have become 'auditable' in their work (see. Parton, 1998) and despite the lack of attention to whether civil suits against practitioners have actually increased, it is reported that this shift has led to a culture of practice where the focus is not necessarily on making the 'right' decision, but rather making a defensible one (Scourfield & Welsh, 2003). In contrast, others point out that risk assessment measurements actually displace accountability and responsibility from the worker to the tool itself (Cradock, 2004). So, on the one hand, the implementation of risk assessment is holding practitioners more accountable through the documentation of their decision-making, while at the same time, it revokes their responsibility and their ability to practice by dismissing clinical judgment.

Analytical Framework

This thesis provides a critical analysis of risk in social policy that draws upon the theoretical approaches outlined in the above discussion. The specific analytic framework consists of a series of questions that are designed to address aspects of policy-making that are commonly overlooked in policy analysis (Wharf & McKenzie, 2004). Rather than be outcome-driven and discuss whether risk assessment and risk management is or is not effective, this analysis will be process-driven, in that it traces how the policy was initiated and developed and how this affects implementation. The analytic framework was flexible

and open to change in order to reflect the themes that emerged from the document review. In addition, as the evaluation unfolded the framework was re-worked and the following key questions became the basis of this analytical framework:

1. What are the driving forces of this policy-making process?
   - What activities and events led to the initiation of this policy decision?
2. How did these policies develop and what did the process look like?
   - Who supports them and who opposes them?
   - How was the process organized and facilitated?
3. What underlying assumptions are advanced in these tools and what consequences does this have on framing social problems and guiding responses?
   - What philosophical approaches are embedded and advanced in these tools?
   - How does this shape the structure of how to respond?
4. What are the documented problematic implications of this framework on service delivery, social work practice and service users?

Methodology

Research Design

The methodological lens for this thesis is a multiple case study approach that looks at three different, yet overlapping, areas of social policy. A case study approach is a structured and focused exploration of a selected aspect of an historical or contemporary phenomenon for the purpose of developing or evaluating explanations, which may be generalized to other events or theoretical perspectives (George & Bennett, 2005). The design itself is highly informed by, and dependent on, the set of questions that are used to guide information-gathering which derive from the research objective. Rather than seek out the frequency to which particular outcomes occur, case study analysis is designed to uncover the processes and mechanisms of how and why an outcome occurs (George & Bennett, 2005). As a result, the research design is structured and focused while at the same time, involves a high level of adaptability and flexibility by the researcher.

With respect to social policy, case studies have been used in a wide array of research studies (e.g. Ainley, Barnes & Momen, 2002; Ghosh, 2002; Maton & Salem, 1995; Kasperson et al., 1988) and have been particularly useful in exploring contemporary social phenomenon to offer valuable insights into complex processes (Yin, 1989). The case study approach applied in my thesis follows an analytical process that situates this case study within a process of negotiation and recognizes that any type of evaluation is a construction rather than an absolute truth (Guba and Lincoln, 1989). It assumes that an evaluation is a product of how information is constructed by the evaluator and recognizes that a different evaluator would potentially create a different evaluation. It assumes that the course of this research is inextricably bound to broader social, political and value-laden context as well as an evaluator's perception of the phenomenon. Thus, rather than attempt to provide a 'solution' to how and why risk has emerged, or bring resolution to the conflicts arising between various claims and concerns, this thesis will follow the approach outlined in Guba & Lincoln (1989), which unravels the process of how claims and concerns have been unresolved to better understand why this phenomenon exists.

My research will be based on accessible documents related to the ORAM, CTOs and ODARA. This research assumes that the content of documents is interlinked with the broader context of their development and production (Prior, 2003). It assumes that documentation is not an objective or neutral account of a situation or phenomenon; it is, like this thesis, a constructed version that necessarily reflects a selective perspective. Documents are a product of the interaction between a number of social processes involving the author, the audience, the interpretation of the information, the intended

purpose, the course of production, the publisher and other influential processes. It also recognizes that the production and accessibility of documents represents a narrow selection of voices, often those who are of the dominant race, mainstream and privileged. Thus, the process of searching documents in this thesis consists of a combination of key word searches and actively seeking out documents that reflect voices and perspectives that may be excluded from general searches.

Furthermore, this thesis assumes that an exploration of social policy should attend to both the content and text expressed in documentation as well as the political context surrounding the production of documents (Wharf and McKenzie, 2004). My analysis considers where documents emerge from and which perspective it reflects, but also attends to the political culture of when and how these document were produced. Thus, this case study focuses on the relevant risk assessment and risk management tools while at the same time, remains broad enough to capture wider trends and the broader context across social services.

Methodological Limitations

As with all research, there are a number of limitations that are ingrained in this research design and data gathering process. First, as indicated above, documents reflect a very selective and privileged voice and the exclusion of interviews and personal communication may leave out perspectives of non-mainstream and marginalized groups. While brief contacts were made particularly with more intimate, grass roots organizations for the purpose of seeking documents, in-depth interviewing was not conducted as it fell outside the scope and feasibility of this thesis research.

Second, the process of data collection is unavoidably shaped by a research bias. While I have limited experience adopting risk assessment tools in practice, I observed how policies and procedures shape and impact social work practice, service delivery and consequently service users. Therefore, this thesis incorporates both an insider and outsider perspective to these issues. In practice, I observed how the development and implementation of policies and procedures was not overly transparent and I perceived how service users are frequently excluded from these processes. The education that I received at a structural school of social work, coupled with my observations about the ways that power relationships play out in the organization and delivery of social services, shaped my approach to this thesis and influenced my research questions. As I have more direct experience in the mental health field, I have an advantage conducting the case study in this area. However, I am also familiar with child welfare and violence against women because all three areas overlap greatly. In addition, I am a white, middle-class Canadian woman and my experiences through this social lens inevitably surface in this work.

Third, the findings from this research provides insight into how and why risk assessment and risk management procedures emerged in the areas of child welfare, mental health and violence against women in Ontario. It is acknowledged that the findings from this thesis cannot be generalized across other areas of social service or risk assessment and risk management in other regions. It makes no sweeping claims about the emergence and implications of risk in social policy, but rather presents these findings as an interpretation of the processes operating in the relationship between risk and these three areas of social policy in Ontario.

Case selection and data collection

The areas of child welfare, mental health and violence against women were chosen for case study for several reasons. First, some type of risk assessment or risk management strategy is central to the provision of services in each area (e.g. ORAM, CTO and ODARA). Second, each area reflects different types of risk assessment and risk management. The ORAM is a consensus-based risk assessment model that involves the assessment of future risks and also guides the practitioner response. CTOs are care-contracts or plans tailored to the individual but highly influenced by the adoption of a risk management framework in mental health. The ODARA is an actuarial risk assessment instrument that identifies the risk of future abuse through a statistical analysis of risk factors. Third, each area reflects different levels of development and implementation of risk assessment and risk strategies. Both the ORAM and CTOs are well implemented in Ontario while the ODARA is still undergoing a process of development and revision. Finally, each of these tools are designed to serve different populations while at the same time represent overlapping areas of policy and service delivery (e.g. a mother subject to interpersonal violence, with children and dealing with a mental illness).

The data gathering process consists of an extensive document search and retrieval of available academic articles, research and government reports, agency fact sheets and publications, newspaper articles and editorials, community newsletter pieces, press releases, speeches, policy briefs, advocacy/opinion pieces, standing committee reports, website coverage and legislative debates, specific to the ORAM, CTOs and ODARA. Additional relevant documentation was also retrieved if it pertained to risk assessment and risk management strategies and any of the areas of child welfare, mental health and

violence against women more generally. This included documentation within Ontario and across other provinces as well as other Western nations, such as the UK, Australia and New Zealand. Materials were retrieved by searching through the social science databases Ingenta, Alternative Press Index and Social Science Full Text. Newspaper databases such as Canadian Newsstand and Canadian Business and Current Affairs (CBCA) were searched for both mainstream as well as alternative and community newspaper coverage of the development, implementation and implications of the ORAM, CTO, ODARA and general risk in social policy. Internet searches were also conducted through search engines such as www.google.com and www.scholar.google.com4. Various stakeholder websites were also searched to retrieve applicable documentation. Examples include, but are not limited to, the Ontario Association for Children's Aid Societies (OACAS), Canadian Mental Health Association (CMHA), the Woman Abuse Council of Toronto (WACT), National Clearinghouse on Family Violence (NCFV), Ontario Association of Interval and Transition House (OAITH) and the Ontario Council of Agencies Serving Immigrants (OCASI) (See. Appendix for list of agencies reviewed). The Parliament of Canada website database and provincial ministerial websites were also searched for materials pertaining to legislation, debates, inquiries, reports, speeches and press releases.

The document analysis is the major method of exploration in my case study. For the ORAM and CTOs, the documents analyzed range from the early/mid 1990s to the present day. For documents regarding the ODARA, the time period ranges from the late

---

[3] Searches revolved around the ORAM, CTOs and ODARA specifically, as well as involved combinations of key words such as, "risk assessment", "risk management", "actuarial risk", "community treatment orders", "risk prevention", "social service delivery", "social work practice", and "social policy" alongside the areas of child welfare, mental health and violence against women

[4] Google Scholar is an internet-based search engine that allows for broad searches of scholarly literature. It also searches across many disciplines and sources (e.g. peer-reviewed papers, theses, books, abstracts and articles, from academic publishers, professional societies, preprint repositories, universities and other scholarly organizations).

1990s to today. Documents retrieved in all three areas can be generally categorized into two overlapping areas: documents that address the policy decision to introduce the ORAM, CTOs and ODARA specifically; and documents that situate these tools within the broader context of provincial system reform in the areas of child welfare, mental health and violence against women. For example, reports released from the OACAS and research derived from the Centre of Excellence for Child Welfare (CECW) tend to focus specifically on the ORAM and its integration into Children's Aid Societies (CAS) as an organizational policy; whereas most academic literature discusses the integration of a risk management framework into child welfare more generally. Government reports and Parliamentary debates tend to address both of these issues and frequently highlight public inquiries into the deaths of children as a justification for the ORAM and system reform. Similarly, newspaper coverage tends to raise public awareness into the deaths of children and the need for systemic reform. There is little documentation on the resistance to the ORAM until after it was implemented; whereas resistance to implementing CTOs was extensively represented at the point of initiation, particularly in documents deriving from consumer advocacy groups and in mental health literature. CTOs were rarely discussed as a risk management strategy in the majority of documents, with the exception of a few academic articles that make a direct link between risk, CTOs and policy. For the ODARA, most organizations providing services to women who have been victims of abuse welcome the risk assessment tool. There has been little documented resistance to the ODARA specifically which, is partly a reflection of it still being in its infancy; however, some grassroots organizations, such as OCASI and OAITH, have raised the issue of risk in the field of domestic violence more generally.

In general, there has been an over-representation of academic literature, government reports and organizational documents that account for the ORAM, CTOs and ODARA as a 'needed' strategy in service reform. Critical perspectives of these tools are evident in some reports, letters, opinion pieces, briefs and editorials released by advocacy organizations, such as the Association of Native Child and Family Services of Ontario (ANCFSO), OCASI, OAITH and CMHA, and from the general public and service users. However, these perspectives are under-represented in the documents as a whole. Moreover, the processes involved in the initiation, development and implementation of all three tools is also under-reported in the documents, particularly in government reports. Most documentation across all three areas provide a written account of "what" led to the emergence and implementation of these tools, but fall short in providing specific details on "how" they developed and neglect to include a critical reflection of this policy-making process.

Data Analysis

During the analysis, attention was given to what was documented and what was not, as well as which organizations/agencies were providing the documentation and who was providing the information. The retrieval of documents initially occurred across all three sites simultaneously so that the analysis of one area could also be informed by the other areas. For example, when particular claims, concerns or issues were identified in one area, I pursued these themes and was mindful of them while exploring the other areas. The process of going back and forth in sifting through each area, not only contributed to the development of the analytical framework, but also ensured that the

framework was relevant to each area. Eventually, once the framework became established, each area was given concentrated attention in turn to further develop the analysis. In addition, an ongoing journal was kept to record my observations and impressions throughout the research process and was continually revisited throughout the research process.

Throughout the analysis of this research, I reflected on a number of questions which were developed and adapted from Wharf & McKenzie (2004, p.66). These questions were designed to enhance a process of self-reflection and critical awareness while I embarked on this thesis. These questions are presented below in no particular order.

- Am I engaged in a process of self reflection as this research evolves?
- Have I considered my values and experiences that I will bring to this analysis?
- Am I exploring the power relations that are explicitly reflected in these materials, as well as the power relations that are inherent and perhaps, less visible?
- Have I been conscious of including a diverse representation of available materials?
- Am I ensuring a flexible information gathering process?
- Have I explored available documentation that has been generated by a wide range of voices and perspectives?
- Can I identify any materials that could be included that I may have overlooked?
- Who can I consult for feedback and input as this project progresses?

Summary

The use of risk assessment and risk management strategies in social policy has been widely cited as having implications for social service delivery, social work practice and service users. Broader social, economic and political trends have been argued to play an important role in the emergence of risk as a central principle to social service provision. In this chapter, I discussed how I will explore the emergence of risk in social

policy in Ontario by conducting a case study of the ORAM, CTOs and the ODARA. I will draw on the theories outlined in this chapter to offer a critical analysis of how and why risk has surfaced as a central notion to the areas of child welfare, mental health and domestic violence by analyzing documentation available in these areas. The next chapter presents the first case study of the ORAM in the area of child welfare.

Chapter 3: Risk as a Principle for Allocating Resources

Background of the Ontario Risk Assessment Model (ORAM)

There has been a longstanding preoccupation with risk in child welfare so it is perhaps not surprising that it is the most widely documented area in the literature in terms of how risk has been conceptualized and operationalized within social services. Service delivery has increasingly been organized around the notion of risk and workers are progressively more engrossed with the risks associated with their practice. In Ontario, child welfare has experienced the development and implementation of the Ontario Risk Assessment Model (ORAM) (OACAS, 2000). The tool is designed with the intention of guiding decision-making in order to improve consistency of decisions, and as a result, increase the safety and protection of children in the province (Leslie & O'Connor, 2002). Moreover, the ORAM was thought to be an effective means of predicting and preventing future events of child maltreatment. The ORAM is an organizational policy used by front-line workers at the Children's Aid Societies (CAS) to coordinate and systematize the process of investigations into cases of child abuse and neglect. It was fully implemented in all 53 agencies across the province by 1998 and in 2000 it became a legislated procedure under the Child and Family Services Act (CFSA).

Risk assessment in Ontario child welfare comprises a three-channel approach to assessing risk - the Ontario Eligibility Spectrum (OES), the Ontario Safety Assessment tool (OSA) and the Risk Assessment tool (RA). The OES was designed to provide consistent decision-making with regard to eligibility for services based on risk and safety. It guides the CAS referral process by coding the reason for referral to CAS and assigning a level of risk severity to determine the type and rate of a child worker response. The

OSA tool provides a focused, structured assessment of a child's immediate safety and the RA tool comprises 11 critical decisions which guide the process of collecting information on the 'influence' of risk within a case. Examples of these decisions are: the response rate to a case, how to document, how to verify whether a child is 'protected' and how to assess the likelihood of future neglect and abuse in the home. The RA tool is completed once it is determined whether a child is or is not in need of protection and if there is a need for subsequent case reviews (OACAS, 2000). Taken together, these three instruments are referred to as the ORAM.

Understanding the Driving Forces of the ORAM

It is widely documented that the ORAM emerged from, or paralleled, a broader child welfare reform agenda put forth by the provincial government during the late 1990s. The Ministry made a policy decision to place the need for a structured risk assessment model on the child welfare policy agenda in Ontario in 1996, but activities around adopting a risk assessment model can be traced back as early as 1994. In *Developing a common risk assessment tool in child welfare*, the Ontario Association of Chidren's Aid Societies (OACAS) explicitly states that a risk assessment model derived directly from an accreditation process in 1994 (OACAS, 1997). Moreover, the Child Welfare Training System, which is funded through the Ministry and delivered by the OACAS, included risk assessment as a priority for 1996. This illustrates that the beginning discussions of adopting a risk management framework were occurring between the Ministry and the OACAS and suggests that the original idea to implement a risk assessment model in the

province did not occur in isolation, but was expert-driven and introduced by professional bodies operating within a realm of high authority and power in child protection.

Other broader social, political and economic activities occurring within the province, and abroad, served to support this decision and accelerate the full implementation of a risk assessment model in 2000. One trend identified in the documents was that the problem of child mortality was becoming 'out of control' due to failings of the current CAS system. In one article in *The Hamilton Spectator,* the headline reads: "Top priority to protecting children: Eight Hamilton children have died in the last 18 months. A recent Toronto inquest into a child's death called for a major overhaul of the child protection system in Ontario" (1997, p. A11). This article illustrates that it was not individual CAS agencies failing children, but the provincial system at large.

While it is not specifically stated that the deaths of children under the supervision of the CAS have been increasing or are 'out of control', this is often implied in the 'spin' of the story in the newspaper coverage. For example, Crane's (1998) analysis of the journalism conducted by the reporters who ran the Toronto Star series suggests that the reporters framed the story in a way that presented the CAS and workers unfavorably. One CAS worker interviewed openly admitted that she saw this story as an opportunity to present the efforts of the CAS in a positive light, but instead, the story focuses on the 'flaws' or 'failings' of the agency. It explains child mortality as a result of poor decision-making amongst workers and a reflection of the inadequacies of the CAS. It offers little attention to how the death of a child under the supervision of the CAS is, although tragic and devastating, incidentally low compared to the number of children who benefit from the CAS services and have their cases closed. As a result, this article not only frames the

response of CAS workers as negative, but overall simplifies and possibly over-exaggerates the problem of child mortality as a direct result of workers' oversights. Moreover, it is unclear whether the incident rates of child mortality at CAS or in the child welfare system generally are actually 'increasing'. Nonetheless, the construction that gets advanced is that child mortality in the child welfare system is problematic because something is going wrong with the system. This gets advanced, not just because the deaths of children are present in the media, but because of how the media constructs these stories - through an 'inquest' that seeks to expose the 'faults' of the CAS and child welfare system.

The operation of inquests and inquiries also serve to advance the construction that the deaths of children are a result of the 'flaws' of the system. In 1997, the Ontario Child Mortality Task Force (OCMTF), led by the Office of Chief Coroner and the OACAS and supported by the Ministry, released a report on an inquiry into the deaths of ten children receiving services from the child welfare system. It cites two out-of-province child deaths as motivating factors for the need of inquiry and child welfare reform – John Ryan Turner who died of starvation in New Brunswick in 1994 and Matthew Vaudreuil, a 5-year old boy who was killed by his mother in British Columbia in 1992. It also indicates that Ontario professionals were becoming increasingly concerned about the state of the provincial child welfare system because the systems in other jurisdictions, such as England, Australia and Europe, were undergoing heavy scrutiny due to the deaths of children. The OCMTF report claims that these deaths could have been prevented and makes sixteen recommendations for preventing the risk of child mortality in service delivery, including the need for a structured risk assessment model to be included in the

child welfare reform agenda (Trocmé, Mertins-Kirkwood, MacFadden, Alaggia, Goodman, 1999). In 1998, the Ministry itself conducted a number of reviews, such as the Accountability Review, the CAS case file review and the Experts Panel review, to also investigate how the system 'failed' to protect these children.

The operation of inquests and inquiries not only frame the death of children as 'evidence' for child welfare reform, similar to newspaper coverage, but also symbolize that the government was going to, and has the 'expertise' to, respond to this problem and prevent it. From a broader ideological perspective, this reflects a dominant assumption that human knowledge and authority can serve to regain public trust. Risk is situated in a linear relationship between the operations of the system and the problem of child mortality, and the identification of risk in this location and the identified response of inquests and inquiries, leads to a pursuit of risk as a phenomenon that can be managed and controlled. Little attention is given to how risk, in reality, is indeterminate and relative, and in fact, achieves meaning from the processes involved in how it is constructed and advanced as a concept. Thus, the construction that child mortality is a result of a 'failing system' and the subsequent operation of inquiries and inquests, coupled with the embracement of the belief that a system of experts can regain control of this problem, serves to validate the initial discussions between the Ministry and OACAS on risk assessment and demonstrates how a risk-based model of service delivery was advanced on the child welfare reform platform.

The philosophical approach of 'investing in children' and keeping children 'safe' which, became prominent in the late 1990s (see. Bala, 1998) also functions to accelerate the adoption of a risk assessment model in child welfare. This philosophical outlook is

observable in the legislative changes of the CFSA 2000 and has been documented as part of a broader paradigm shift which refers to the transition of the ideology of preservation of family[5] (e.g. child welfare) to the protection of children (e.g. child protection) (King, Leschied, Whitehead, Chiodo, & Hurley, 2003). Under the family preservation approach, there was a commitment to removing children from families if remaining in the home posed a risk for abuse or maltreatment. There was, however, no structured measurement of these risks and the primary focus and starting point in investigations was to keep families together if at all possible. By the 1990s, the adequacy of a family preservation model began to be questioned, as concerns grew that leaving a child in a home environment could potentially lead to abuse or neglect and would be harmful to the long-term development of the child. As a result, prioritizing the safety and protection of children emerged as a primary focus because it was believed that keeping a child's safety, well-being and development at the forefront of decision-making would decrease the chances that a child would be exposed to a harmful home environment.

The movement towards prioritizing child safety is intertwined with an overall 'investing in children' ideology, and the continued acceptance of a 'child-centered' approach in policy, as well as the increased popularity of 'evidence-based' practices. At a province-wide level, this is demonstrated in the development of a child focused Ministry – the Ministry of Children and Family Services – which was introduced in 2003 to commit and direct attention to child and youth welfare issues. More specifically, this ideology is strongly reflected in the increased willingness to focus resources on early

[5] During the late 1970s and early 1980s, with the support of the parents' rights movement, removing children from their home and their families and placed in long term state care was challenged because it led to long term negative effects on children and perpetuated a racial and class bias. This led to legislation changes in the CFSA 1984 to espouse policies that support family preservation.

intervention and prevention in the areas of child health, mental health as well as behavioural and developmental issues. The recent initiation of the *Best Start* programs across the Early Years Centres within the province by the Ministry of Children and Youth Services (MCYS), the recent addition of the Provincial Centre of Excellence for Child and Youth Mental Health to services at the Children's Hospital of Eastern Ontario (CHEO) and the increased campaigning around early intervention of mental illness promoted by the Canadian Mental Health Association (CMHA), and the mental health community at large, are all examples of how this ideology is operating and how child-centered approaches are embraced.

In addition, the increased popularity of evidence-based practices and research directed to prevention, coupled with the 'investing in children' philosophy, made a risk assessment tool aimed at preventing future child maltreatment appealing. Structured risk assessment models were gaining momentum as 'best practices' in child welfare generally, particularly in the US. Scientific concepts, such as standardization and consistency, alongside business-type principles of efficiency and effectiveness, were increasingly being adopted into the provision of child welfare services. For example, it was reported that the 'expertise' of Arnold Love, a project consultant who reviewed 'best practices' in risk assessment tools in Aboriginal and Non-Aboriginal agencies, informed the Risk Assessment Steering Committee on 'evidence-based' risk assessment tools (Trocmé, et al., 1999). In addition, the Ontario Incidence Studies of Reported Child Abuse and Neglect (OIS), conducted in 1998, was a major empirical study that was undertaken to provide hard facts about the scope of the problem of child maltreatment.

Broadly speaking, assumptions that are rooted in scientific-thinking started to be endorsed in the child welfare reform agenda, which is illustrated in the adoption of risk assessment and consequently, a prioritization of 'evidence-based' practices. This, alongside the construction of the problem of child mortality as a result of the 'flaws' of the system, the philosophical shift to 'investing in children' and allocating resources to prevention, as well as the advancement of the belief that risks can be managed and controlled, led to an acceptance of risk assessment techniques without much resistance or critical appraisal. Beyond these activities and events, the political and economic backdrop of the province is also documented as an influential trend in supporting the identified need for risk assessment in child welfare.

In 1995, the federal government introduced 'block funding' under the Canadian Health and Social Transfer (CHST) which limited the involvement of the federal government and shifted the responsibility of funding social programs to provincial dollars (Evans, 2002). In addition, in 1995, the provincial Progressive Conservative government under the leadership of Mike Harris won a majority and began to implement their proposed political platform, the 'Common Sense Revolution'. In *Open for business: Closed to people*, Clarke (1997) argues that the political agenda of the Harris government was highly shaped by the interest of transnational companies and more broadly, the global economy. The provincial government curtailed their manifesto to serve the interests of investors and businesses by proposing policies that supported trade and investments so that the province could be competitive in the global market (Clarke, 1997). This agenda was not only being embraced within the province of Ontario, but at the Federal level through the introduction of the CHST and broader prioritization of

transnational corporate needs. Market-based principles were taking precedence over citizenship rights and universal welfare. As a result, widespread cutbacks in funding social services and an overall rollback of the welfare state began to occur within Ontario and across Western nations generally.

In the OACAS presentation to the Standing Committee on Social Development in December 1995, a discussion of the 'funding crisis' in child welfare, and its impact on service delivery, is prominent. The Committee was told that child welfare workers are expected to "do more with less" and children and families are feeling the impact of the cutbacks in service. As a result, the provincial government was pressured to offer some type of solution to address these shortcomings and its negative impact on professionals and families. However, due to the dominant conservative rhetoric of the province, tied with extensive cutbacks in funding, resources were limited and the need for reinvesting in child welfare services became conceptualized as a need for allocating and prioritizing resources through a lens of risk. As a reflection of broader restructuring of the welfare state from universal to residual approaches to social benefits, what resulted was an agreement across the Ministry and the OACAS to increase the regulation of resources and keep a tight reign on how child welfare workers allocated their time. So, while risk is inherently unclassifiable, in this case, it was given the meaning of being an organizing principle to ration resources, and accordingly, symbolizes the invasion of managerial knowledge in the delivery of services.

In sum, my analysis of the driving forces of the ORAM shows that it emerged as a result of the intersection of a number of social, political and economic processes. It is a product of the interplay between the construction of the problem of child mortality as a

'fault' of the system and the belief that, through the nature of human ability and expertise, this problem, although overly simplified, can be managed and controlled. In parallel, philosophical ideologies on child-centered approaches and policies and the desire to invest resources into children, alongside preferences for evidence-based practices, served to make risk assessment, in this case, attractive. Understanding these activities as situated within the political context of neo-conservative practices, the global economy at large and a broader shift to more residual approaches in social welfare, shows how the notion of risk became easily accepted and received little opposition on the child welfare policy agenda.

Development Process of the ORAM

Documents that account for the development of the ORAM report that the development of this risk assessment model involved a lengthy and thorough process of consultation and collaborations. The Ministry formed a Risk Assessment Steering Committee consisting of a total of eight members that represent the OACAS (2), Association of Native Child and Family Services Agencies of Ontario (ANCFSO) (2), and specific CAS agencies (4) to start a discussion focused on the process needed to develop a risk assessment model in Ontario and the identification and selection of existing tools and instruments to inform this model. Alongside this committee was the Working Group to Develop New Standards for Child Protection Cases, which consisted of 18 members from the Ministry of Community and Social Services (MCSS) (8), OACAS (2), CAS agencies (7; 2 from the CAS in Toronto) and a Risk Assessment Training Coordinator (1). Subsequently, a Technical Advisory Group consisting of 10

representatives from the OACAS (1), ANCFSO (1) and CAS agencies (8) was also formed to design the risk assessment tool itself by adapting the New York risk assessment model. This process occurred over a span of two years and CAS agencies played a key role in the development of this approach which is critical since the model would be implemented and operating across these agencies.

Attention to who was invited and who was excluded from this process reveals that there was a fairly diverse geographical representation of rural and urban CAS on the committees. The committees were largely represented by the OACAS, the Ministry and CAS agencies, but the particular positions and/or roles of committee members were not reported (OACAS, 2000). While it is clear that CAS agencies were involved in the development of the ORAM, it is less clear to what extent advocacy groups, professionals and agencies outside of CAS, and families and services users were involved in this development. Documentation reveals that roundtables, consultations and discussions were conducted as part of the developmental process of the ORAM (see Trocmé et al., 1999); however, there is no information that indicates who attended and/or how these consultations were managed. Similar concerns have been raised with respect to the debate over Bill 6 which proposed the legislative changes to the CFSA that encompassed the ORAM. It is claimed that the process was rushed through the provincial senate and there was little effort to consult with groups outside the legislature. Liberal Member of Parliament (MP), Sandra Pupatello, exemplifies this point in her presentation to the Ontario Legislature:

> We were very disappointed to see that once the bill had been introduced it was gone, never to be seen again until the 11th hour before Christmas, when suddenly it was revitalized and discussions ensued about how on earth we were going to finish discussion, debate and approving of this bill, and would we then start

> consideration of no hearings, no travelling in Ontario, no meetings with other groups. It occurred to us then that the government probably never did have any intention of allowing appropriate debate with this bill (Legislative Assembly of Ontario, 1999).

Moreover, the introductory pages of the ORAM make no indication of any effort to include advocacy groups, families and service users or other agencies or professional groups outside CAS in the various committees or other consultation activities. Two members of the ANCFSO were involved in the development of the model but concerns have been raised as to the extent that perspectives of First Nations communities were represented in the development of the ORAM. A 1999 study that evaluated the ORAM reveals that workers interviewed from First Nation communities were dissatisfied with the level of inclusion in the developmental process of the ORAM. Concerns around the language used in the ORAM and the short timelines for investigation and documentation for remote communities were also highlighted as problematic by the ANCFSO members (Trocmé, et al., 1999). In addition, reports that represent First Nations communities have highlighted a number of problematic implications of risk assessment in First Nations child welfare generally, but documentation did not trace whether these issues were considered during the development of the ORAM.

Also not captured in the documentation that addresses the development of the ORAM, are the perspectives of racial and cultural minorities or recent immigrants and refugees. It is not stated whether there were efforts made to include representatives from visible minority groups or agencies that advocate on behalf of recent immigrants. Documents reviewed from the Joint Centre of Excellence for Research on Immigration and Settlement (CERIS) and the Ontario Council of Agencies Serving Immigrants

(OCASI) address immigrant issues related to child welfare (e.g. unaccompanied children under refugee status), but do not specifically raise concerns about the use and impact of risk assessment on immigrants or the impact of the ORAM on immigrant communities. The only document that addresses 'risk' and children/families locates the issue of child safety within the context of domestic violence and suggests that a broader risk model designed to support and enable immigrant women, will inevitably lead to the protection and safety of children (OCASI, 2006).

Overall, it is difficult to comment on the extent that groups outside the OACAS and the Ministry were included because the documentation is silent about such efforts. The neglect to state this in the majority of documents however, may suggest that most of the decision-making was occurring behind 'closed doors' with little input from First Nations communities, non-aboriginal racial and cultural minorities and recent immigrants. Moreover, it was not possible to trace how families and front-line workers were consulted in the development of this tool. Documents that address the ORAM did not include the perspectives of families, and the only document that captures the experiences of front-line workers is The Final Report of the ORAM which accounts for the implementation process of the tool. Specifically, in assessing perspectives on the implementation of the ORAM, this report states that senior administrators had a good understanding of the implementation process, while front-line workers reported that they were confused and not always clear about the implementation process (Trocmé et al., 1999). This suggests that even front-line CAS staff may not have been included in this process. In addition, it has been suggested that OACAS, a body that represents CASs in policy development and government relations, embraced the development of a risk

assessment model by the Ministry without much opposition, and in fact, 'praised' the government for reinforcing the ideology of 'investing in children' (Kumove, 1997). Thus, it appears that the ORAM was mainly government and management driven without much involvement of front-line workers.

Consideration of the activities outlined as driving forces of the ORAM, alongside attention to the lack of documentation on the involvement of groups outside the OACAS and Ministry in the development of the tool (and the fact that the documented development process derives from a handful of reports deriving from institutions), suggests that the ORAM was mainly driven by the institutions implementing the tool, rather than the communities who would be impacted by its delivery. The exclusion of children and family advocacy groups in this process as well as the lack of documentation on this issue by OCASI and CERIS further highlight this point. Overall, it appears that the ORAM developed in a fairly unidirectional manner under the direction of the government and OACAS. While collaboration has been noted, closer attention to who is involved suggests that it was mainly limited to the Ministry, OACAS and perhaps the management tier of selected CAS agencies.

Underlying Assumptions and Consequences

In the October 1996 volume of the OACAS journal, the then Executive Director of the association, Mary McConville, made the following remarks about developing a risk assessment model in child welfare:

> This project is a first step towards understanding and addressing the unexplained and violent ways in which children die. The death of any one child is a failure. With a better understanding of some of the issues involved in the deaths of

> children, attention can be focused on the prevention, where possible, of future deaths (OACAS, 1996).

This claim is reinforced by the introductory paragraph in a publication from the Centre of Excellence for Child Welfare (CECW) which states that "in child welfare, risk assessment is used to determine the likelihood of future abuse or neglect, so that action can be taken to prevent it" (Knoke & Trocmé, 2004). Moreover, within the first couple of pages of the OCMTF Final Report, it states that the deaths of children have been perceived as a result of the 'failings' of their current child welfare system, suggesting that the Ontario child welfare system needs to undergo reforms to 'prevent' similar occurrences within the province.

It is clear that the adoption of a risk-based model for service delivery further advances the assumption that risk for child abuse and maltreatment is identifiable, predictable and preventable. The Eligibility Spectrum which, is used to determine whether cases fit the criteria of CAS services, is based on 5 risk factors set out in Section 37(2) of the Ontario Child and Family Services Act (CFSA): Physical/Sexual harm by commission; Neglect or harm by omission; Emotional harm; Abandonment or Separation; and Caregiver Capacity. Each area is assessed and assigned a category of risk that ranges from minimal to severe. If the case is classified as moderately or extremely severe, the case is investigated. If the case is classified as minimally or not severe, the case is not investigated (OACAS, 2000). The introduction of the RA tool states that it is designed to guide the worker in developing strategies to reduce risk and to protect children. This is achieved through the application of each critical decision, which represents 'what' is identified as needing attention and management in order to reduce the risk that a child may be abused or neglected. For example, decision #2 provides

direction on how quickly a worker needs to respond to an investigation based on the associated 'risk' level of the case (e.g. severe, moderate).

In the case of the ORAM, the message is clear: accurately managing and allocating a worker's response time (identification) based on the 'severity' of the risk will lead to (prediction) the reduction of risks (prevention) associated with a case. Underlying this assumption is an individualistic approach to risk. For example, the above criteria in the Eligibility Spectrum locate risks factors in parenting and care giving practices. Examples include, but are not limited to: (a) the child has suffered physical harm inflicted by the person having charge of the child or because of that person's failure to care for, provide for, supervise or protect the child adequately; (b) the child is suffering serious emotional harm and the caregiver is not responding to the condition or the emotional harm is caused by the actions or inaction of the parent; (c) there is a risk that the child is likely to suffer serious emotional harm and the child is in imminent danger of suffering irreversible emotional damage; and (d) the child is under 12 and has committed a serious act, and the caregiver does not respond with treatment or better supervision - the lack of response could be extremely detrimental to the child (OACAS, 2000).

The emphasis on parenting practices shifts attention away from environmental, structural and systemic issues contributing to child abuse and neglect and individualizes the problem to the characteristics of a person. As a result, a consequence of adopting risk assessment is that it advances a limited understanding of the problem of child abuse – the act of harm itself becomes the central focus and is viewed as a failing of parenting while an understanding of broader factors, such as socio-cultural indicators and economic means of the family, are swept aside and largely ignored. In the case of the ORAM, the

model is developed specifically to identify and isolate caregiver behaviours that are deemed as 'risky'. This results in an increased scrutiny of parenting deficits and incompetence's as defined by the tool and subject to the worker's interpretation. Parenting practices get targeted while little attention is paid to the adequacy of such influences as family support, housing and living arrangements, income and social support network.

Of equal importance, the argument that risk is an objective and measurable concept that can be isolated falls short in accounting for how this very belief is constructed through the influences of broader paradigms and ideologies present in Western society. Risk factors in child welfare are shaped by Euro-Christian values which inform the development of ideas about families, children and care/support for social inclusion (Callahan & Swift 2006). Also, the idea that risk factors are objective and neutral is actually an extension of the values inherent in the broader assumptions of scientific knowledge. Thus, what results is an advancement of the understanding that risk is a neutral concept, without recognition that it is actually politically and contextually bound to values and beliefs advanced in scientific assumptions of objectivity as well as framed by Euro-Christian attitudes and beliefs about families.

Another consequence of advancing the assumption that the response to child abuse lies in the identification and prevention of risk factors is the reinforcement of the belief that we, or human nature, possess the ability to control and manage these problem. The OACAS acknowledges that a risk assessment model was developed to not only prevent the likelihood of the recurrence of harm to a child but also to improve the consistency of decision-making amongst child welfare workers and the system as a whole

(OACAS, 1997). This assumption is a product of the scientific belief that increased standardization of complex phenomenon leads to absolute 'truths' about understanding an experience. This belief becomes problematic because, as highlighted previously, it is accepted and advanced without critical reflection. For example, most documentation surrounding the ORAM praise the tool as an effective way to 'fix' the systems problems because it supports more consistent and standardized decision-making across workers. Little attention is given to how this 'solution' is part of a larger philosophy that believes in the ability to control and manage responses, and that this belief is perceived as the 'right' or 'best' way to handle the concerns of the child welfare system.

Adopting 'at risk' terminology has also been argued as a way to proceduralize and formalize the protection of children through the application of managerial practices (Parton Thorpe & Wattam, 1997). The Ministry and the OACAS claim that there was no way to systematically assess decision-making at the investigation phase and across front-line workers in the child welfare system in Ontario and have located the failings of the system in inconsistent (and therefore perceived as inadequate) decision-making across front line workers (OACAS, 1997). Moreover, The Children in Limbo Task Force Report (1996) which was prepared by professionals and workers from community and institutional settings in Toronto, state that risk assessment makes child welfare more accountable because decisions are documented and therefore, traceable and visible. This example illustrates two assumptions that are advanced in the ORAM (and risk assessment in child welfare more broadly) – managerial and administrative processes are favored as a 'solution' and individuals, or in this case individual workers, can be blamed and

perceived to be at fault for the death of a child who is involved in the child welfare system.

Providing procedural direction around timelines to respond, what to do when a certain degree of risk is identified within a case and how to document decisions and actions around this are all illustrations of how the ORAM reflects managerial and administrative aspects of child welfare investigations. The intention was that the ORAM makes the work process detectable and operational in stages so that when attention is given to 'what went wrong', it can be pinpointed and someone can be held accountable. Adopting managerial procedures to tighten control on workers' decision-making so that 'errors' can be identified to increase accountability in workers, which was favored by the Ministry and the OACAS, raises a number of concerns.

Despite that research available indicates that the rate of child mortality in confirmed cases of abuse is less than one in 2000 (e.g. Trocmé & Lindsey, 1996), workers are blamed for these deaths and become the scapegoat for understanding the deaths of children involved in the system. Little attention is given to other alternatives and instead, a system of 'blaming the individual' becomes endorsed. The following example illustrates that blame is directed at the individual case worker, and that the belief that the ORAM can prevent the deaths of children appears to be an illusion. In the case of Jordan Heikamp, a child who died at the age of 9 months due to mal-nutrition, Angie Martin, a CAS worker responsible for the case, was charged with criminal negligence for the first time in Ontario[6]. A Canadian Broadcasting Company (CBC) article reports that

[6] In this case, Jordan's mother Reneé Heikamp was also charged with criminal negligence and an article in the *Canadian Review of Sociology and Anthropology* finds that newspaper coverage constructed Reneé as 'Canada's most notorious bad mother'. Charges for both Angie Martin and Reneé Heikamp were later dropped due to lack of evidence.

Martin received training in how to assess 'high risk cases' just a few months prior to the incident, which suggests that the ORAM was most likely implemented with this specific CAS agency ("Inquest into starved baby reviews case worker training," 2001).

While holding workers accountable for their interventions through standardized decision-making was advanced as a response to increasing accountability, it can also be understood as underlining the belief that trust and credibility can be reinstated into the institutional system as a whole. In this light, managerial solutions can be perceived as symbolic for sustaining an expert-based system which comprises an infra-structure of rules, procedures and authority. In a modern paradigm, we as a society place our trust in the organization of scientific knowledge so when a 'failure' arises in the system, attention goes to what went wrong and who is to blame so that credibility and expertise can be restored. However, advancing the understanding that proceduralizing worker's decision-making, as evident in the ORAM, leads to 'better' accountability by preventing the deaths of children through reinstating credibility in the system, is erroneous.

The lack of involvement of children and families in the policy-making process shows that accountability is defined and constructed in a very top-down, linear manner. Alternative methods of accountability that include 'bottom-up' policy-making, participatory approaches and establishing trust and transparency as well as mobilizing communities to tackle other broader 'risks', such as poverty, are ignored (Callahan & Swift, 2006). The construction of 'accountability' that gets advanced in the ORAM, is one that is 'top-down', 'state-run', and within a system that blames the individual worker, rather than a 'bottom-up', community-centered and directed by service users in the system. The belief that the problem of child abuse and maltreatment is product of an

oversight by a worker is accepted with little recognition or acknowledgment that in reality, child abuse results from a complex process. The relationship between the death of a child and who is at fault is, in actuality, difficult to pinpoint and in fact quite blurred. However, in the case of Jordan Heikamp, it is clear that the worker is being blamed for this death and alternative contributing influences (such as, the experience of a single parent, lack of support) are ignored.

The assumption that more consistent and standard decision-making across workers will lead to more accountable practices raises questions on how values of 'good practice' are perceived and advanced. As an assumption of standardized decision-making becomes embedded, a consequence is that inconsistent decision-making reflects 'poor practice'. Principles of homogeneity, classification and absolutes are favored over beliefs of diversity, individuality and relativity. Inconsistent decision-making is in fact, perhaps an accurate reflection of the diverse backgrounds and experiences of each child welfare case. Providing a model of service delivery which enables workers to apply adaptable and case-centered practices, rather than a homogenously designed framework of risk as observable in the ORAM may actually cater more effectively to the specific case at hand. As a result, the lines drawn between accountability and liability are subject to how one interprets and believes that these phenomena can be achieved. The ORAM has been defended as a model for improving institutional accountability, but at the same time, it can also be defended as a liable procedure due to the fact that it discourages inconsistent (and therefore context-specific) decision-making.

The above discussion focused on the underlying assumptions and consequences of advancing a risk-based model of service delivery in child welfare and illustrates how the

operation of risk is tied to broader values and beliefs embedded in dominant ideologies. Rather than understanding it as an objective term it may be better understood as reflecting the primacy of scientific thinking and knowledge inherent in the institutionalization of the problem of child abuse. Risk is espoused within a modern paradigm as being able to be identified, managed and controlled, despite the reality that it is indeterminate and relative. Moreover, in the ORAM, managerial and administrative functions have been adopted and have led to an acceptance of proceduralization of workers duties, for the purpose of increasing accountability. However, it is shown that this leads to the advancement of a system which blames the individual and simplifies the problem. Moreover, espousing the ORAM as a tool that will lead to more accountability in the system becomes problematic because it fails to acknowledge the liabilities it creates alongside its implementation.

Implications on Service Delivery, Service Providers and Service Users

Increase in referrals; higher demand on the system

In the context of budget restraints, adopting risk as a central allocation principle in child welfare seemed attractive because not only would CASs be addressing the problem of child abuse and maltreatment but it would offer a framework that seemed to achieve 'more' (protect children from danger and harm) with 'less' (cutbacks in resources and funding). While implementing a risk management framework was viewed as a way to contain costs in service delivery, it led to an increase in referrals and admissions across CAS agencies in Ontario (Whitehead, Chiodo, Leschied & Hurley, 2004).

A possible explanation for this is that amendments made to the CFSA in 2000 also expanded the grounds for reporting a case to CAS. Prior to 2000, a worker or anyone

in the public was required to file a report if an incident of child abuse had occurred. In 2000, Bill 6 was passed which expanded the conditions of which child abuse was reported and placed a child's protection and safety as the paramount concern in child welfare. It became a legal obligation for a worker or anyone in the public to file a report if they have reasonable grounds to suspect that a child is abused or neglected or at risk of abuse or neglect. Once the report is made, CAS workers must review the grounds and investigate the case if they determined that the case was eligible. As a result, general interpretation of abuse extends beyond the observable incident and becomes subject to interpretation of suspicion of child abuse or risk of child maltreatment. This legislative change which resulted in a 'widening' of the net of children eligible for CAS, coupled with the narrow assessment of risk as delivered through the overly-simplistic risk factors of the ORAM, resulted in an increase rate of 'false positives', or an increased rate of referring and admitting cases who, although suspected, were not necessarily in reality at risk for future harm. Alongside this increase was also a general tendency of workers to assess conservatively (mainly due to the awareness that workers could potentially be charged criminally for any oversights in assessing for risk) to avoid the inclusion of 'false negatives' (death of children under the care of CAS) and consequently, the potential to be blamed for the death of a child.

As a consequence, the rise of referrals and admissions was reported to have led to an increasing unreasonable demand on CAS intake workers and services. The intention that the ORAM would lead to a cost-effective service was not realized. This illustrates how the advancement of the belief that experts and authorities can control and manage the risk of child abuse through managerial and administrative procedures, in response to a

broader curtailing of spending in the area of social welfare, actually led to an increased demand on the system which, in the end can be perceived to place children at risk anyway. Feedback received from CAS workers brought this issue to attention which led to the introduction of the Differential Response Model[7] (2005) in child welfare to better streamline cases and ease the workload. But as discussed below, while this new model addresses the issue of 'false positives', it reportedly leads to the same implications of applying a risk-based model for the purpose of distributing resources.

Services are front-line, investigative, short-term

The adoption of the ORAM, and a risk framework generally, in child welfare streamlines the nature and delivery of service through a lens of risk. The inclusion of managerial principles and an increased emphasis on administration practices, within the context of increased pressure for cost-effective services, made streamlining services attractive. Streamlining investigative functions had a particular appeal because there was a need to improve the allocation of resources during a time of widespread funding cutbacks (Rivers, Trocmé, Goodman, Marwah, 2002). The shift to a philosophical approach of child protection led to a shift to immediate and reactive approaches to reduce risk and ensure the safety of a child.

However, a prioritization of short-term interventions at the expense of long-term needs of families raises questions about how 'best practices' are conceptualized and the risks this may carry for children and families. Long-term services tend to be off-loaded

[7] According to the OACAS website, The Differential Response Model came into full effect across the province in April 2007 and differs from the ORAM in that it allows for a more 'flexible' response. It streamlines services based on severity of maltreatment, allows for more family collaboration and encourages professional judgment/clinical skills.

onto communities, and consequently, require a collaborative and coordinated system between CAS and community supports. For example, the Collaboration Agreement for the Children's Aid Societies and Violence Against Women Agencies of Toronto (2004) emphasizes the need for expanding the scope of CAS services by forming partnerships with other agencies to better serve the needs of families. While the introduction of the Differential Response Model (2005) has led to a decrease of false positives in the system, it hasn't changed the focus of resources on front-line, investigative CAS services. In an interview by Voices for Children (2005), Nico Trocmé, an academic researcher in the area of child welfare, points out that funding and resources are expanded at the front-line despite the reality that most cases that come into CAS care are in need of long term attention rather than immediate safety (see also Callahan and Swift, 2006). Moreover, mothers report that the most useful and positive experience with CAS occurred when workers demonstrated an understanding of intimate partner violence, the need for long-term support and the complexities of parenting, rather than working from an exclusively child-centered standpoint (Voices for Children, 2005).

As a result of front-loading resources to investigation, broader rehabilitative principles in child welfare get cast aside and families who are not posing an immediate or future risk to child maltreatment, as defined through the lens of risk constructed in the tool, struggle on their own to meet their own needs. Some have cited that this has also led to favoring punitive and controlling responses to child abuse at the expense of nurturing broader supportive services (Kufeldt, Simard, Thomas & Vachon, 2005; Febbraro, 1994). In this context, the notion of accountability becomes a subject of discussion: as mentioned previously, despite the belief that increased proceduralization of workers'

decision-making produces a more accountable system, as defined by preventing child mortality, the ORAM failed to achieve this goal. The idea that stronger collaboration is needed across community-based services and an increased focus on long-term, rehabilitative services for families, suggests a route for improved accountability (Parton, 1996).

Dehumanizing Relationships; Culture of Defensiveness and Mistrust

In the previous discussion, one of the assumptions identified in the ORAM is that the implementation of managerial procedures is expected to uphold institutional accountability. Not only are these procedures believed to provide more transparency in the work process thus, making worker's decision-making visible and accountable, but also these procedures are viewed as helping to restore public trust in the institution when it is perceived to have failed.

These claims raise a number of implications for child welfare workers. Situating worker accountability within a risk assessment framework creates a paradox (Cradock, 2004). While a worker's clinical expertise and judgment will inevitably shape a risk assessment, decisions are grounded in the use of the tool rather than in the worker's own assessment. As a result, while the ORAM has been advanced as a tool that will increase accountability because the decisions are more visible through documentation and claimed to be more consistent, at the same time the tool can assign greater liability to a worker who actually holds very little responsibility in being able to engage in discretional decision-making that relies on context specific information. This has been raised as a concern for workers with CAS agencies (see. Regehr, Bernstein & Kanani, 2001).

Workers have reported that there has been an increase of a culture of mistrust and blame with respect to their work environment. This has been reported as emerging from both the risk assessment tool itself and the processes that went behind its implementation. The increased media attention to child welfare worker practices and the conduct of inquiries which involved placing workers in a position of explaining their practices, led to a decrease in morale across a number of agencies (Kumove, 1997). While connections between the ORAM and an emergence of a 'culture of blame' across CASs is not explicitly made, the literature on risk assessment more generally makes associations between the development of a tool that addresses 'human error', which is present in the ORAM, and the rise of a defensive work environment across CASs. Fueling this concern is the anticipation that a worker can be civilly or criminally charged in practice given the increased attention to worker accountability. The implication is that workers operate and practice within a defensive culture that reinforces self-preservation rather than an environment of trust and mutual reciprocity (Callahan & Swift, 2006).

In addition, while the ORAM was intended to assess and manage risks to children, there are concerns that it leads to an objectification of the worker-client relationship, creating a situation where workers are spending less time with children and families and more time implementing paperwork (de Montigny, 2003). The increased paperwork that resulted from the introduction of the ORAM has increased the workload across CAS workers. In 2002, David Rivard, the Executive Director of the Sudbury-Manitoulin CAS, made the following comments:

> Workers are spending less time with families and more time with paperwork. City councilors in Sudbury reported that CAS caseworkers are spending about 70% of their time on paperwork and other studies report front-line staff are spending less than

> 30% of their time face-to-face with clients while the bulk of the workday is spent completing paperwork imposed by the province (St. Pierre, 2002).

This implication has also been widely documented in the position paper *Child Welfare in Ontario: Developing a Collaborative Intervention Model* by the Provincial Project Committee on Enhancing Positive Worker Interventions with Children and their Families in Protection Services. The report highlights that increased documentation for workers negatively impacts the time that workers have available to spend with families. The documentation arising from the ORAM interrupts time spent on actively listening to families and time used to engage in adequate reflection of the presentation of the case (Dumbrill, 2005, p. 161).

As a result, in the effort to control and manage risks and maintain safety through the ORAM, new vulnerabilities, such as a decrease in active listening and direct observation of families, correspondingly arise from the increased time spent on documenting.

Targeting Marginalized Groups and Parents

The issue of targeting marginalized groups has been widely cited as a problematic implication of including risk management in child welfare in Ontario. Margaret Manitowabi, from the Wikwemikong Unceded Indian Reserve and board member of Kina Gbezhgomi, which is a child and family service that is not a fully authorized/or mandated CAS, speaks to the issue of exclusion and discrimination in the process of child welfare reform. In response to Bill 210 during the hearings of the Standing Committee on Social Policy, she commented:

> Our communities were not consulted regarding the reforms in 2000, nor do we seem to be included in the reforms for 2005. Currently, 80% of the children in

> care of the children's aid society are from our seven First Nation communities. The current risk assessment tool is discriminatory of First Nation realities. The tool does not consider the economic realities of our communities. As you all know, most of the native communities, if not all, in Ontario do not have an economic base. The strengths of the families are not considered, nor the strength of the extended families or the community (Legislative Assembly of Ontario, 2005).

Documentation derived from the Assembly of First Nations also points out that Aboriginal children are investigated for maltreatment at twice the rate of non-Aboriginal children and are substantiated for maltreatment at 2.5 times the rate of non-Aboriginal children (Assembly of First Nations, 2006). This document suggests that risk assessment is partly responsible. Since the legislation has expanded to include a pattern of neglect, a risk of emotional harm and a reduced level of risk required to deem children in need of protection, there has been an influx of First Nations children in CAS care based on neglect. Neglect is closely linked to poverty, housing conditions and substance use conditions, which are all present at higher degrees amongst First Nations communities due to colonialism and ongoing oppressive practices (Walmsley, 2004). Thus, the ORAM, and overall child welfare systemic reform, has evolved through a narrow focus on risk and as a result, continues to target and oppress First Nations communities.

Moreover, a review of 693 cases from the London-Middlesex CAS found that poverty status is related to a higher risk score on the ORAM. Specifically, this study found that children with caregivers receiving social assistance scored higher on cumulative risk in comparison with caregivers who were employed. Poverty and family violence were also found to be the most significant predictors of a child's risk (Leschied, et al., 2003). In addition, 63% of the children helped at the Metro Toronto Children's Aid Society live at or below the poverty line (Metro Toronto Children's Aid Society,

Retrieved online). This suggests that the vast majority of parents who come under the gaze of CAS are living in poverty and suggests that single women who cope with some form of violence face a greater likelihood that their child will be brought into care[8].

In addition, cases investigated due to neglect also report higher rates of family moves which suggests that broadening the definition in legislation may not only target people living below the poverty line, but also newcomers and recent immigrants who are often living in shelters, motels, overcrowded housing or run-down apartments because of a shortage of affordable housing and discriminatory practices in the housing market (see Living on the Ragged Edges Report, 2003).

A report on First Nations Child Welfare points out that focusing solely on 'risks' overlooks the needs of families and communities and does not empower parenting or sustain broader family support (Assembly of First Nations 2006). In addition, risk assessment approaches have been criticized for their resemblance to the practices of the '60s Scoop'[9]. Walmsley (2004) discusses that risk assessment is similar in that it symbolizes an external or outside perspective through the application of Eurocentric values which are inherent in the construction of the ORAM. The issue of targeting Aboriginal children and communities is also viewed by some as an inevitable outcome of a risk assessment approach because of the broad definition of 'risk factors', such as neglect, and the considerable room for discriminatory bias in the judgments made by workers (Blackstock, 2005; Gough, Trocmé, Brown, Knoke and Blackstock, 2005).

---

[8] While the Risk Assessment tool in the ORAM does not consider exposure to violence as a 'risk factor' for children, current protocol of the CFSA dictates that it is mandatory for police (and others in the general public) to make a referral to CAS when children are subject to witnessing interpersonal violence.

[9] The 60s Scoop refers to when government officials invaded First Nation communities in the 1960s and removed aboriginal children from their families and community on perceived grounds of abuse and placed them under 'state' care in residential schools. Generally, outsiders, with minimal contact with the community, intervene to investigate and remove children with little involvement of the community itself.

Moreover, it is clear that standardizing decision-making across workers leads to homogenous approaches and responses to families and brings into question whether this leads to 'better practices' or practices that are misguided, flawed and obstructive to family experiences. However, it is not so much that 'new risks' are created, but rather that the application of a risk framework imposes a form of knowledge, ideology and philosophy that shapes and guides which risks are worthy of our attention. As discussed earlier, the use of the ORAM advances an individualistic and person-centered approach to child abuse which consequently targets parenting practices, particularly single mothers. Febbraro (1994) cautions that an increased emphasis on parenting or mothering skills as an area of change in single mothers who are suspected of child abuse overlooks the reality that these women are economically disadvantaged as well as socially subject to a patriarchal and capitalist society and therefore, these individualistic responses do not adequately serve this population.

The application of risk too readily becomes a one-size fits all approach which targets First Nations communities, immigrants and newcomers, single mothers and families in poverty, and disregards the specific needs of these populations. Moreover, the ORAM lacks a broader political, social and economic perspective in its assessment design which consequently, targets marginalized populations who do not neatly fit within the dominant ideals of society. Risks that are deemed worthy of attention are a reflection of the intersection and advancement of dominant ideas, knowledge and philosophical approaches and how this is perceived and interpreted by the assessor. Thus, it appears that the ORAM, through the dominance of its ethnocentric, scientific and individualistic

approaches, lacks an integrated cultural, gender and socio-economic base which can promote a more flexible and adaptable design of service delivery.

Closing Remarks on the ORAM and Risk in Child Welfare

The case study on child welfare shows how the scope of the problem of child mortality was exaggerated and publicly perceived as a result of inadequacies in the child welfare system, as both identified in newspaper articles and reports from inquiries and inquests. This, coupled with the need to increase the rationing of services due to limited resources, made the adoption of a risk assessment model in child welfare appealing. The idea that child mortality was increasing, despite that this is unclear, paved the way for the government and OACAS to implement a service-delivery model that would ration resources. My discussion argued that the ORAM advanced an individualistic and overly simplistic approach to the problem of child mortality. The application of risk factors led to an increase social exclusion of First Nations communities, racial and cultural minorities and women living in poverty, by targeting them through a lens of risk. Moreover, the outcome of increased referrals and admissions emerged as a problematic implication of the ORAM and demonstrated how the belief that risks can be managed and controlled leads to parallel problems. Aside from some academic articles, the majority of documents surrounding the ORAM are not critically reflective of the underpinnings of a risk management framework. It appears that, due to the intersection of the economic drive to do more (e.g. prevent deaths) with less (assessment of immediate risk and short-term investigations), joined with a political ideology of investing in children, an acceptance of evidence-based practices or scientific-thinking and a preference for

managerial and administrative principles, as reflected in the narrow development and implementation of the ORAM, led to the evolution of this risk-based policy with little attention to the above assumptions, consequences and implications. The next chapter presents the case study on the policy-decision to include and use CTOs in mental health.

Chapter 4: Risk as a Mechanism for Population Management

Background of Community Treatment Orders (CTOs)

Just as the notion of risk has been central to child welfare, it has also been integral in the area of mental health. Ryan (1996) points out that up until the early 20th century, risk was generally managed in asylums and 'madhouses' through the policies of confinement and incarceration. Since the late 1960s and early 1970s, Canada has been experiencing ongoing deinstitutionalization of mental health services which has meant that the management of risk increasingly occurs at an individual and community level for people diagnosed with a mental illness. The clearest example of this is the focus of this chapter: the recent adoption of Community Treatment Orders (CTOs) (2000) in Ontario which legislates certain mental health service users in the community who must follow a contract on medication and treatment or face hospitalization (Wilton, 2004). CTOs, or Bill 68, received widespread support as a safeguard in protecting society and an individual with a mental illness from risks of harm to themselves or others and an effective measure to decrease the number of hospitalizations for individuals.

CTOs became a legislative treatment option under the Ontario Mental Health Act in December 2000 and are generally applied to people who have received a diagnosis of a severe mental illness and who are 'able' to live in the community, but may lack the capacity to make decisions or may pose a risk to themselves or others (Campbell, Brophy, Healy, O'Brien, 2006). The CTO itself is designed like an 'order' or a contract that outlines certain stipulations for the service user. These include, but are not limited to: taking medications; attending appointments; living in certain environments; and/or receiving services from an Assertive Community Treatment (ACT) team or a Case

Manager[10]. In Ontario, while CTOs can be recommended by any mental health worker, they are issued by a psychiatrist or physician of a psychiatric institution. Six conditions must be met (which are required by law) before someone can be placed on a CTO. The conditions stipulate that: (i) the person has been diagnosed with a serious mental illness and has been hospitalized in the last three years on two or more occasions for a period of 30 days or have previously been on a CTO; (ii) the community plan is developed by the person or their substitute-decision maker (SDM)[11], the doctor and others involved in the person's care; (iii) the doctor has assessed the person 72 hours before the CTO is entered; (iv) the doctor has talked to all people who are named in the community treatment plan; (v) the doctor is satisfied that the person and his/her SDM have been consulted with a rights adviser and been informed on the person's legal rights; and (vi) the person or his/her SDM have consented to the plan (Psychiatric Patient Advocacy Office, 2003).

Unlike the ORAM, CTOs are not a highly structured risk assessment instrument designed to provide consistent decision making and standardized documentation processes. Rather, a person is deemed to be qualified for a CTO if, during the assessment that occurs 72 hours before assigning the CTO, a psychiatrist believes: (a) that the person is suffering from a mental illness and requires continuing treatment or care and supervision; (b) that if the person does not receive continuing treatment or care and supervision in the community, it is likely, because of his/her mental illness, that he/she

---

[10] ACT teams are a mobile community support system consisting of multi-disciplinary staff (psychiatrist, nurse, social workers, personal support workers) who provided care to people living in the community with a mental illness. Case Management services are assigned to individuals who voluntarily request intensive, one-on-one support in community reintegration and achievement of goals. Case managers operate out of various community-based mental health services and generally have education and experience in nursing, social work, psychology, education and community work.

[11] A substitute-decision maker (SDM) is an individual who is legally bound to make decisions around care for a person on their behalf. The person has a diagnosis of a severe mental illness and from a psychiatric evaluation, are found to be incapable of consenting to care on their own.

will cause serious bodily harm to him/herself or someone else or him/her will experience substantial mental or physical deterioration; (c) the person is able to comply with the plan; (d) the detailed care and treatment is available in the community; and (e) if the person is not part of the psychiatric facility, they meet the conditions for a psychiatric assessment issued through a Form 1[12].

The intended purpose of a CTO is to assist and support people in the community who would otherwise remain in institutional care or frequently return to a psychiatric institution if supports are not in place. Thus, while a CTO is not referred to as a 'risk assessment' procedure per se, it is considered to be part of a risk management framework because the intended purpose of a CTO is to reduce the risk of hospitalization, to reduce the risk of harm to oneself or others and to decrease the likelihood of future physical and mental deterioration by binding a person to supervisory care in the community.

Understanding the Driving Forces of CTOs

Similar to the ORAM, the emergence of CTOs in Ontario was also part of a broader reform agenda in mental health policy which involved legislative changes to the Mental Health Act in 2000. Newspaper coverage reveals that the provincial government announced their intention to legislate CTOs in 1999 after an extensive review of the Mental Health Act was launched in June 1998. According to the Ontario Ministry of Health (MoH) press release, the then Minister of Health, Elizabeth Witmer, states:

> Some people who are mentally ill are not getting the help they need. Our government will introduce changes to the law that will help families and health

[12] A Form 1 is issued within a psychiatric hospital and allows the doctor to hold you in the hospital for 72 hours to complete a psychiatric assessment which, is used to determine whether a person requires care and supervision within the hospital or can be safely discharged.

> professionals make sure their loved ones and patients get care and treatment (Ministry of Health and Long-Term Care, 2000).

Documents that deal with the initiation of CTOs highlight the deaths of community members that were committed by people known to have a mental illness. As was the case with child welfare, these deaths were viewed as a problem increasingly out of control in Ontario, as well as other jurisdictions such as the UK and the US (e.g. Kendra's Law in New York) (Brophy & McDermott, 2003). In Ontario, the death of Brian Smith in 1995, an Ottawa sports broadcaster, was widely cited as a driving force in the implementation of CTOs in newspaper coverage and in documents that discuss the debate of CTOs. In fact, the legislation that implemented CTOs is usually referred to as "Brian's Law". Other influential deaths include that of Edmond Yu, identified in the news as a "diagnosed schizophrenic", who was shot and killed by a Toronto police officer after he was reported as acting out aggressively on the TTC in February 1997. As well, the death of Zachary Antidormi, a child killed in 1997 by his neighbour who, like Edmond Yu, was reportedly struggling with schizophrenia.

The need for CTOs emerged partially as a response to the perception that homicides committed by people with a mental illness were on the rise and that these deaths would have been prevented if there had been a compulsory treatment regime in place in the community. This point was explicit in the recommendations that resulted from the inquest into the death of Brian Smith. Moreover, the link between mental illness and violence, while observable in these select cases, was exaggerated in newspaper coverage as a reason to introduce CTOs. Claims were made that CTOs would protect the public and people diagnosed with a mental illness from violence towards themselves or others, with little attention to the fact that this relationship is problematic.

The relationship between mental illness and violence is complicated by a number of confounding factors, such as substance abuse, the particular nature of the illness and the history of violent behaviour. Currently, there is no consistent evidence to support the hypothesis that mental illness is a significant and isolated risk factor for violent behaviour (Arboleda-Flórez, Holley, & Crisanti, 1996). Studies have found that the proportion of violent crimes committed by people diagnosed with a mental illness is quite small (Angermeyer, 2000). In addition, the majority of violent crimes committed in society are not committed by the mentally ill (Centre for Addiction and Mental Health, 2004). In fact, one nurse from the Centre for Addiction and Mental Health (CAMH) illustrates this point in her comments to the Standing Proceedings on Bill 68:

> The fact that violence among the mentally ill is a myth, or that there is a greater danger there, has led me to question the motivation behind this proposed legislation. I think it's political rather than rooted in deep compassion and a real desire to help people who are mentally ill (Legislative Assembly of Ontario, 2000a).

It appears that the perceived dangerousness of people with a mental illness is largely misplaced and a 'moral panic' was generated that linked violent behaviour to mental illness. This increases attention to issues of public safety and security, despite the research that has shown that the dangerousness associated with people diagnosed with a mental illness is a misconception. In conjunction with this construction, the problem of homelessness has also been politicized to serve to legitimize CTOs. While some psychiatrists acknowledge that CTOs are not the solution for complex social problems such as homelessness and violence, the problem of homelessness is repeatedly politicized by the government as a social problem that can be partly alleviated through the use of CTOs. In a Toronto Star article, *Will allow forced treatment for people in danger,* the

conservative government is reported saying (in reference to people living on the streets) "many of them 'need' medical or psychiatric help, but are refusing it or can't understand their own problems" (Boyle, 1999). This suggests that so long as people who live on the streets follow their CTO and take their medication, the problem of homelessness will subside. Broader issues such as the state of housing across group homes and boarding homes, commonly referred to as 'community warehousing', and barriers to employment such as misplaced identification, transient housing and stigma/misconceptions are ignored and overlooked.

Therefore, similar to the initiation of the child welfare reform agenda, and the subsequent recommendation for risk assessment, extensive attention to the incidents of homicides committed by people diagnosed with a mental illness in conjunction with the belief that these deaths could be prevented, led to the decision to apply a risk management framework through community treatment orders in mental health care. Moreover, politicizing the problem of homelessness as a 'crisis' which would be partly resolved through the use of CTOs also functioned to mobilize public acceptance of this policy. Paul Leduc Browne (1997) describes this as the 'politicalization of folk devils' where demonizing a category of people acts as a way to unify citizens in order to promote a particular political agenda. In this case, people with mental illness were constructed to be 'risky' while the general public was categorized as 'non-risky' or in need of protection. Creating an illusion of divisions between the 'risky' and 'non-risky' citizen allows for a defined and structured understanding of a social problem and legitimizes the advancement of a policy that addresses this defined problem.

The promotion of a link between violence and mental illness, alongside the advancement of the categorization of homelessness and mental illness as 'risky', was reinforced with the ongoing movement of the deinstitutionalization of mental health services, the preference for evidence-based practices in mental health care and the adoption of CTOs in other jurisdictions. The provincial government reports that the Newman report, *2000 and beyond: Strengthening Ontario's Mental Health System,* which discussed restructuring services into the community, and subsequent internal reviews by the Ministry of Health and Long Term Care (MHLTC), played a major role in initiating CTOs and broader legislative reform (Ministry of Health and Long-Term Care, 2000). In addition, reports from the Canadian Mental Health Association (CMHA) (1998) and Psychiatric Patient Advocate Office (PPAO) (2003) highlight how CTOs reflect an overall political agenda to restructure mental health services into the community, which is observable through the release of a number of key policy documents from the provincial government beginning in the late 1980s.

Simultaneously, clinical trials on the effectiveness of CTOs conducted in North Carolina and New York City and the development of compulsory treatment in other jurisdictions also legitimized the use of CTOs as 'most-effective' and 'best' care. In the PPOA Anniversary Report, David Goldbloom, then Chief of Psychiatry at the Centre for Addiction and Mental Health (CAMH) in Toronto, mentions both studies as influential, and the North Carolina study was also referred to by Ian Musgrave, Psychiatrist of Assertive Community Treatment Ontario during the legislative committee proceedings. The clinical trial in North Carolina is frequently cited as the 'most encouraging data' regarding CTOs at the time of their development in Ontario. This study suggests that if

CTOs are applied for a period of more than six months, they lead to benefits of reduced hospitalization rates, shorter lengths of stay, fewer episodes of violence and arrest, and fewer incidents of victimization. Furthermore, the MHLTC states that CTOs have been in effect in Saskatchewan (1995), Manitoba (1997) as well as the United States (41 states), Australia, New Zealand and the UK (Ministry of Health and Long-Term Care, 2000).

In this policy context, it is clear that scientific-thinking and the medicalization of mental illness are dominant beliefs embedded in the adoption of CTOs. As in the case of child welfare, it advances a belief in the 'expert' system, and that this system can be restored with an increased emphasis on 'best-practices' and a renewed response to regulating people with a mental illness in the community. What is overlooked however, is the way that risk is constructed and the definitions of 'harm' and 'safety' that are being advanced. In this case, the message is clear: some people with a mental illness in the community need to be certified to a CTO to minimize harm and ensure safety to the public and CTOs are 'proven' to be the best way to achieve this goal. Deinstitutionalization laid the foundation for the government's proposal for CTOs and the 'hard evidence' deriving from clinical studies in the US, as well as a Western trend of adopting compulsory community treatment, was espoused to confirm their effectiveness. Situating these activities within the broader political and economic agenda of the province provides insight into how these driving forces were easily endorsed.

Literature suggests that the cost of maintaining and operating psychiatric hospitals was perceived to be increasingly difficult to manage during the mid to late 1990s (Nelson, 2006). Beginning in 1996, the Ontario Health Services Restructuring Committee (HSRC) recommended to the Ministry of Health (MoH) that 6 out of the 10 provincial

psychiatric hospitals be closed. As indicated previously, the Harris government initiated widespread cuts in health and social funding and documents indicate that the purpose of the HSRC was to make recommendations to the Ministry of Health on how to better ration health services (Bezanson & Noce, 1999). Thus, the activities of the HSRC are understood to be part of a wider health care restructuring process that was occurring in Ontario at that time which resulted in the closure or amalgamation of a number of hospitals in primary and psychiatric care for the purpose of providing more cost-effective service delivery.

The closures of these hospitals, alongside the deinstitutionalization movement of mental health services, have frequently been cited as a driving force for adopting CTOs. The gradual offloading of mental health services to community-based organizations which, did not receive the corresponding funds from the government to serve this demand, in light of increased attention to homicides committed by people with a mental illness, led to increased concerns around 'supervision' of 'disorderly' people who were now living freely in the community. An article from the Globe & Mail entitled, *Sick, untreated and on the streets,* indicates that there is a mental-health crisis in the majority of Canadian cities where "an observer cannot fail to notice the hordes of obviously ill people who wander aimlessly on our streets" and there has been a recent appearance of "a spate of incidents in which mentally ill individuals have picked people at random and pushed them in front of subway trains" (O'Reilly, 1998, p. A15). Not only does this article criminalize people with a mental illness, but it also implies that the non-institutionalization of people with mental illness leads to public disorder and subsequent incidents of homicide. While data was not available for Ontario, a longitudinal study

conducted in New Zealand explored the relationship between deinstitutionalization and homicide rates and found that deinstitutionalization has not led to an increase in homicides and questions the correlation between these two phenomenon (Simpson, Mckenna, Moskowitz, Skipworth, & Barry-Walsh, 2004).

Nonetheless, the introduction of CTOs within the context of the deinstitutionalization of mental health services appeared to be an attractive option of 'treatment', as defined by mechanisms of 'monitoring' and 'supervision', because they 'allowed' the service user to be less dependant on hospital care and 'enabled' individuals to take more responsibility for their actions and behaviours. Langan (1998) describes this as a neoliberal rhetoric of 'consumerism and choice', which legitimizes funding cutbacks in social welfare services by emphasizing greater responsibility on individuals and communities. As Wilton (2004) describes, the incidents of homicide committed by people with a mental illness were not considered or perceived to be as a result of under-funding of direct mental health service and broader social services such as, social benefits, employment and housing. Rather, constructing a link between mental illness and violence, and the subsequent initiation of 'monitoring' and 'regulating' this relationship in CTOs, situated risk within the individual and reallocated responsibility of 'risk' onto consumer/survivors. Thus, CTOs were not only expected to ease the burden of cost on the state and legitimize the economic agenda of the government, but were also a means of promoting and advancing neoliberal principles of individual choice and control (Rose, 1996).

While risk management has always been central to mental health, its specific operation through CTOs emerged from the interaction of several social, political and

economic trends. The mythic advancement of people with a mental illness as 'dangerous' and the belief that the risk of danger could be prevented served to promote the adoption of CTOs. Alongside these processes, the use of CTOs was substantiated and validated through the results of clinical trials showing their effectiveness and by the use of CTOs in other jurisdictions, reflecting the movement towards 'evidence-based' practices and the dominance of scientific thinking. The imperative to restrain resources in hospital care laid the grounds for deinstitutionalization and this was legitimized through co-existing neoliberal principles of individual choice and self-actualization, and at the same time, these principles acted to support cutting costs in the area of social welfare more generally. Thus, identifying these events and tracing these processes deepens the understanding that, despite active resistance to CTOs by consumer/survivor advocacy groups, the policy decision to legislate CTOs derives from the intersection of a number of complex broader influences.

Development Process of CTOs

In contrast to the area of child welfare, where the emergence and implementation of risk assessment received little opposition, the adoption of CTOs created considerable controversy. This is apparent in the documents I reviewed, including publications from key organizations, newspapers and in the transcripts of legislative debates. Unlike the ORAM, service users/consumers of mental health services were very involved in the discussion of overall mental health reform as well as the debate around CTOs. In child welfare, the most active grassroots voice came from First Nations communities while child and family advocacy associations were largely underrepresented. In contrast,

consumers and service users across mental health services were very vocal in the development period of CTOs but there was little documentation representing the perspectives of First Nations communities, cultural and visible minorities and/or recent immigrants.

For the most part, those who opposed the use of CTOs argued that CTOs were unjust and represent a violation of the Charter of Rights and Freedoms. For example, the Psychiatric Patient Advocate Office (PPAO) claimed:

> To detain someone for refusing to take a treatment which they have a legal right to refuse arguably violates their right to freedom protected under s.7 of the Charter, and their right not to be arbitrarily detained, which is protected under s.9 (Legislative Assembly of Ontario, 2000b).

Service users who identified with the consumer movement, along with advocacy groups (CMHA, PPAO) and a number of practitioners in the field, believed that the changes to legislation were coercive. In contrast, those who supported CTOs were mainly of the view that they can enhance medication compliance which protects against the risks of harm to self or others. This view also cut across practitioners (physicians, psychiatrists), mental health advocacy groups (The Schizophrenia Society of Ontario (SSO)) and service users (most often families). Thus, divisions between those who supported and those who opposed the CTO are determined by differently posed concerns-- CTOs represent a right to treatment or they represent a violation of the right to refuse treatment.

CTOs were debated at length and with vigor in the Ontario Legislative Assembly during May and June 2000. A close examination of the transcripts suggests that, in comparison to the ORAM, the discussion and debate around its implementation was more

dynamic and involved MPs, parents, practitioners and consumer survivors. However, as was the case with the ORAM, there appeared to be a fairly dominant institutional voice and an under-representation of services and organizations outside the mental health field. For example, during the second reading of Bill 68 on June 7, 2000, physicians and psychiatrists who presented and were questioned by MPs were allotted 30 minutes while consumers/service users were only given 10 minutes. Also interesting was the presence of members of families who had been victimized by a person known to have a diagnosis of mental illness and the absence of those who might potentially 'qualify' for a CTO were not. This suggests that the development of CTOs was mainly driven by public institutions and family victims and raises the question of the extent to which public and institutional protection was prioritized at the expense of appropriate and adequate care for mental health service users.

Brad Clark, former MPP and Parliamentary Assistant to the then Ministry of Health, provided the following remarks regarding the government's intention in embarking on mental health reform:

> We are taking responsible action to balance the needs of patients with public safety. Input gathered from the consultations will assist in the design of legislation that will support a comprehensive and integrated mental health system. The government is moving forward with its Blueprint commitment to propose legislative changes that will ensure that people with serious mental illness get the care and treatment they need in a community-based system (Ministry of Health and Long-Term Care, 2000).

The public information that is accessible on the MHLTC website indicates that the Ministry conducted a number of consultations in London, Hamilton, Toronto, Ottawa, Kingston, Thunder Bay and Sudbury. While the Ministry claims that these consultations guided the design of the legislation, there is no information available regarding their

specific influence. The consultations were by invitation only but who was invited is not known.

Consultations did span geographically across the province but occurred only in urban settings. Perhaps stakeholders from surrounding rural areas were invited, but this is not made explicit. Detailed information about how these consultations were facilitated, who was represented, and how frequently they occurred, were not available. There was also no mention if efforts were made to consult with First Nations communities or any other marginalized groups, such as racial and cultural minorities, women's groups and individuals living in rural/remote areas.

Although much of the academic literature highlights Saskatchewan's influence on the design of the CTOs (e.g. Campbell, Brophy, Healy, O'Brien, 2006) the discussion that took place regarding what would be adapted and modified was not accessible. The reasons why Ontario, unlike Saskatchewan, requires consent to CTOs is simply unclear. A possible explanation for the rejection of involuntary CTOs is that the government was responding to pressure from consumer/service user advocacy groups such as the CMHA and the PPAO.

Based on information available, it appears that there was a lively debate that included physicians, psychiatrists, government MPs, consumers and families victimized by a person known to have had a mental illness. However, there is no evidence to suggest that individual survivors/consumers qualifying for a CTO, First Nations communities, racial and cultural minority groups, women's groups and rural/remote communities were involved in the development process of CTOs. Moreover, deference given to medical opinion was also obvious in reviewing the readings of the Bill 68.

Underlying Assumptions and Consequences

In a 1997 headline, the *Ottawa Citizen* asked: "Could this violent act have been prevented? Those who support community treatment orders think it could" (Deighton, 1997). This article reports the death of Mona Hamilton, an elderly woman in Ottawa who was stabbed by a man reported to have schizophrenia and argues that her death could have been prevented. Most of the newspaper coverage of CTOs refers to the deaths of Brian Smith and Zachary Antidromi, and other violent acts committed by a person living in the community with a diagnosis of mental illness and, similar to the ORAM, suggest that these deaths could have been prevented. As discussed in the previous section on driving forces, CTOs have been espoused for a number of reasons. However an important underlying assumption is that they can function, at least partly, to contain the risks of self harm and harm to others which are perceived to be associated with people living in the community with a diagnosis of mental illness. The representation of CTOs in newspaper coverage, legislative debate and academic articles that support the 'treatment option' of CTOs all make reference to deaths committed by people who were known to have a mental illness and indicate that there is a relationship between risk and violence or dangerousness. While the documents that support the use of CTOs do not make explicit claims that CTOs will prevent violence, as the *Ottawa Citizen* headline suggests, it is clear that CTOs have been framed in this way.

CTOs operate on the assumption that there is a relationship between mental illness, risk of violence, and community supervision/care. As a consequence, mental illness is constructed as a problem of social disorder requiring regulation and management of violent behaviors. However, the assumption that CTOs will achieve the

goal of decreased dangerousness appears to be optimistic. There are large variations in the quality of community treatment programs, the communities themselves, and in the profile of the person which makes it incredibly difficult to measure the effectiveness of CTOs. Moreover, the relationship between a risk management framework and the prevention of harm to self or others is also problematic. Munro & Rumgay (2000) investigated the findings from public inquiries into homicides committed by people known to have a mental illness in the UK, and found that an assessment of dangerousness or known risk of violence in advance plays a limited role in preventing these homicides and that more attention to enhancing and expanding supportive services was suggested as more likely to prevent these deaths.

An investigation of these inquiries illustrated that, in some cases, even though it was suggested that the homicide could have been prevented, an exploration of a patient's history revealed that some never indicated that they might be violent. Moreover it became clear that the assessment of 'risk of violence' was difficult to determine because all patients have a complex case history and assessment of 'dangerousness' is subject to change over time. Munro & Rumgay (2000) point out that the link between mental illness and 'dangerousness' was prioritized on the UK policy agenda and argue that this consequently led to an increase of avoidance of false negatives (violence committed by people diagnosed with a mental illness) by professionals and policy-makers. As the threshold for assessment becomes more conservative and is lowered to achieve an avoidance of false negatives, at the same time, the number of false positives (patients inaccurately assessed as potentially dangerous) increases (Munro & Rumgay, 2000).

The effectiveness of CTOs in Ontario is partly measured within the narrow criteria of 'preventing dangerousness' and it is possible that this could lead to ethical concerns around an increase of false positives through the avoidance of false negatives. Wilton (2004) highlights how the CMHA and other advocacy groups raised concerns that in practice, CTOs could be applied to a number of people who do not pose a danger to themselves or the community. Adopting CTOs as a means to 'increase public safety' also has consequences on how people with a mental illness are perceived and how notions of public safety are conceptualized and responded to. Goodwin (1997) explains that while CTOs are advanced as a way to increase community security it simultaneously perpetuates the criminalization of people diagnosed with a mental illness. The message is that there is an increased possibility that people living in the community with a mental illness will be unstable due to less monitoring, and therefore the underlying message is that community integration is perceived as a risk and regulation of this population is needed.

CTOs also advance the problem of mental illness, and the perceived 'disorder' that arises from it, as a medical issue requiring psychiatric care. The explicit risks considered by a physician and psychiatrist when assigning a CTO include, (a) previous hospitalizations, (b) previous history of non-compliance with medication regimes, (c) failure to keep appointments and (d) previous history of aggression. Non-compliance of medications and failure to attend appointments are emphasized in CTOs and if any extra supports are included, they are mainly designed to decrease the risks associated with medication non-compliance and re-hospitalization.

Similar to the assessment and conceptualization of risk factors in the ORAM, CTOs advance a construction of risk factors that are value-laden despite that they are argued to be neutral and objective. Risk is perceived to be objectively measured through the eyes of a psychiatrist or a physician but this perspective derives from the belief system of scientific thinking which endorses values of objectivity, neutrality, reasoning and stability. The risk factors identified promote values of mental health care that are rooted in scientific thinking and the perception and judgment of 'risk' behind a CTO occurs within a 'top-down' process, as directed by the psychiatrist or mental health worker, and through a framework of the medical model.

The construction of risk that gets advanced is one that is grounded in the medicalization of mental illness and as a result, advances an overly simplistic and narrow understanding of health and well-being. There is less emphasis on social and economic determinants of health and an increased focus on pharmaceutical and policing tactics. The appropriateness of CTOs for people who have high social and economic needs, such as those living in transient accommodation and those who are refugees and new immigrants is challenged because needs related to income, housing, employment as well as social and recreational activities fall out of the scope of attending appointments and taking medications. Thus, the medicalization of mental illness consequently leads to an increased stigmatization of marginalized populations (Brophy & McDermott, 2003).

The adoption of CTOs and a risk management framework in mental health more generally, reflects an overall shift in mental health policy which constructs the problem of mental illness as one of self-regulation and personal responsibility as well as symbolizes a mechanism for rationing health resources. Those who are judged to be 'high risk' of

dangerousness and re-hospitalization, and subsequently contracted on a CTO, become individually responsible for meeting the criteria in their contract to sustain their health, as defined by psychiatric expertise. Wilton (2004) describes that although the discourse of 'choice' in mental health care, as legitimized by neoliberal principles of individual health management began to be popularized in mental health field, and through the use of CTOs, the underlying power relations of patriarchy and paternalistic relations inherent in the dominant paradigm of a medical model, remain in the mental health system at large.

In addition, people who are not high risk and therefore do not qualify for a CTO, are discharged into the community and consequently, face the same pressures of sustaining individual health in that the onus is on them to reach out for community supports and care to maintain their own well-being. Not only is a person individually responsible for their care, but this also raises questions around what resources and care are available to those who are not deemed 'risky' and, equally worthy of CTOs, such as people who are not violent, compliant with medications and living on their own in the community. Francis Lankin, NDP Member of Provincial Parliament (MPP), highlights this in the House Proceedings around Bill 68:

> We have seen, and I have to point to things like making services work for people, where the whole exercise about integrating services in a whole range of areas under the Ministry of Community and Social Services has ended up being an exercise in rationing services, not in providing equitable access to services. I fear that the possibility-in fact, without massive infusion of resources, the reality will be that individuals seeking treatment and comprehensive resources voluntarily will be moved to the bottom of the list (Legislative Assembly of Ontario, 2000c).

It is clear that the operation of CTOs goes beyond immediate issues of individual safety and well-being. An underlying function of CTOs is that they become a mechanism for prioritizing limited institutional resources to those who are most 'in need', as defined

by those who are most 'at risk', and raise ethical concerns around access to care for those who do not fall into the 'high risk' category. Similar to the area of child welfare, a risk management framework in mental health, as evident with CTOs, advances rationing principles of service and serves to legitimize a broader economic agenda of providing cost-effective and efficient services.

Related to this point, are the consequences CTOs have on how human rights issues are framed. At the centre of the debate is the issue of whether, and in what circumstances, the state and institutions can be given the authority and professional control to intervene in people's lives. The passing of Bill 68, and the implementation of CTOs, support the notion that in the event that a person is at risk of harm to themselves or others in the community, as judged by a physician or psychiatrist, the state is permitted to intervene. In Ontario, service users or their substitute decision-maker need to consent to a CTO, thus it is argued that this acts as a safeguard in protecting any infringement on civil rights. In addition, CTOs encompass stipulations on medication compliance which have been framed as an individual rights issue – the right to a life free of mental illness as defined by psychiatric care.

However, these assumptions raise a number of concerns regarding how human rights are framed and whose rights are protected. While the intervention of the state and police has been argued to not interfere with individuals rights because there is a requirement of a person (or SDM) to consent to the CTO, this perspective overlooks the infringement of rights that arise from the use of the CTO itself. For example, one of the legislative changes from Bill 68 was that assessment of harm to self or others no longer needed to be rooted in observable and immediate behaviours. Instead, assessment could

be based on the likelihood that harm can occur in the future due to a perception that an individual is dangerous. This leaves a large amount of discretionary power with the police, and the public at large, as to what behaviours they consider worthy of psychiatric assessment and could subject specific populations, such as those who appear 'disorderly' or unpredictable, like the homeless, to increased targeting in the community Dawson, Romans, Gibbs & Ratter, 2003).

In addition, the dominance of the medical model and the coercive elements of CTOs contrast the values of individual rights and autonomy which are embedded in the deinstitutionalization of mental health services and the consumer/survivor movement. These values advocate that individuals are free to make choices and engage in autonomous decision-making, free of state authority, so long as they do not come into conflict with established laws (Chamberlin, 1998). What emerges is an ongoing conflict for people who are assigned to CTOs. Not only are they subject to a broader oppressive ideology of mental illness as dangerousness and violence, but they are subject to a paternalistic system that limits their choices in making decisions over their own care; yet at the same time, are encouraged to take on more individual control of their well-being.

For example, CTOs highlight the use of medication as the primary means of care and legitimize it as a right to treatment through legislation. In reality, however, CTOs don't increase autonomy and choice because they inhibit alternative options, limit individual self-control, hinder independence and suppress risk-taking – all elements that have been advocated as potentially leading to wellness and recovery from a mental illness (Mead & Copeland, 2000). As a result, the strongest argument for CTOs is that they are liberating because they become a mechanism to allow people with a mental illness to live

in the community rather than be institutionalized in psychiatric hospitals. However, on the other hand, CTOs operate within a paternalistic framework and embed coercive elements which hinder individual autonomy and alternative treatment options, thus restricting individual rights.

There is also an assumption that CTOs reduce hospitalization and therefore, reduce overall costs on the health care system. Although there has been little research on the actual outcomes and implications of CTOs, some studies do suggest that CTOs reduce hospital admissions (Campbell, Brophy, Healy & O'Brien, 2006). Reducing hospitalizations has been perceived as addressing the need to minimize the 'revolving door' syndrome which suggests that generally, the same individuals are repeatedly admitted and discharged from the hospital only to return again and create an ongoing cycle. Despite the concerns that were initially raised about whether CTOs would be effective in reducing these costs, it was generally assumed that CTOs would help ease the financial burden on state psychiatric care by reducing hospital admission, but we have no way of ascertaining whether this is the use.

Although it is assumed that CTOs are more cost effective and provide 'better' treatment than institutional care (by decreasing the 'revolving door' syndrome), they nonetheless fall short in addressing other dimensions of achieving cost-effective services. In Ontario, there is little data available on who is receiving a CTO and how long a person is staying on the order, so it is not clear as to whether they are, in the long-term, more cost-effective. When someone is placed on a CTO they are most often contracted to receive services from either an ACT team or a case manager and sometimes this can lead to years of being part of the 'system' and thus, continue to place costs on the mental

health system. While exact figures on the cost effectiveness of CTOs is unknown in Ontario, a review of worker's perceptions of CTOs in Victoria, Australia revealed that in most cases, people are ending up on CTOs for a year or more when all they needed was perhaps a week in the hospital (Dawson, 2006). In addition, while CTOs are supposed to be a solution to the 'revolving door' syndrome, this assumption ignores how people can sometimes end up assigned to an ACT team for years or a case manager indefinitely, and overlooks the fact that waiting lists appear for both services. The report, *Mental Health in Ottawa: An "orphaned child" – Summary of Panel Discussion on Mental Health Services in Ottawa,* submitted by the Health and Social Services Advisory Committee to the Councilors of the City of the Ottawa, indicates that, in 2004, there was an approximate 8 months wait list for access to ACT services in Ottawa (Nelson, 2004). This in itself becomes costly to the system and consequently, pressures to 'discharge' people remain, it is just that this is transferred onto community workers instead of the institution. Thus, while CTOs are argued to cut costs on hospital care, they at the same time, are potentially costly in other sectors of health care and the system at large.

Implications on Service Delivery, Service Providers and Service Users

"Old Wine in New Bottles"

There has been little documentation of the implications CTOs have on service delivery. However, they have been criticized as CTOs as "old wine in new bottles", suggesting that community-based services are maintained and operated through an institutional paradigm despite the fact that services are not delivered within the walls of institutional confinement (Nelson, 2006). The movement towards community-based mental health was not necessarily about the growth of rehabilitation-focused community

services, but rather about the restructuring of institutionally-based psychiatry because of the high costs perceived to be associated with inpatient beds. While clients are now discharged 'in' the community, they are not necessarily 'part' of the community. This is evident in the fragmentation of services addressing the ongoing needs of people with a mental illness, such as employment, language training, education, social and life skills, as well as the trend of 'community warehousing' where people living with a mental illness reside in run-down boarding homes and unmanaged group homes with little support and access to improving their well-being in other life dimensions, such as physical health, employment, housing, social support, nutrition and recreation (Nelson, 2004).

In the province, some consumer/survivor advocacy groups such as, *The No Force Coalition*, highlight on their website that the adoption of CTOs reflects an investment towards sustaining institutional services rather than expanding support in community-based approaches. However, overall there has been little research or exploration of this trend, or other problematic implications of CTOs on service delivery in Ontario, and it is clear that more attention needs to be directed in this area.

Social Protection; Not Rehabilitation

The specific implications of CTOs on social work, or mental health workers, in Ontario have not been documented. Broader literature suggests that because CTOs embrace a risk management framework, and thus support the control and avoidance of risk, a philosophical approach of social protection is favored over more rehabilitative principles (Brophy & McDermott, 2003). This is partly a direct result of the fact that risk

is equated with a notion of 'dangerousness' or 'harm' and as a result, risk-taking behaviours, such as a gradual decrease from medications or taking personal risks in employment or volunteer work, get discouraged at the expense of reinforcing safety, as defined by risk-avoidance. However, how CTOs impact the social work relationship specifically is not documented. Some literature suggests that CTOs have a 'deskilling' effect on mental health workers because rehabilitative approaches are downplayed due to the perceived preference for medication compliance and administrative functions of CTOs (Brophy & McDermott, 2003). Personal communication with mental health workers who work with clients on CTOs indicate that they believe CTOs can interfere with the therapeutic relationship. In particular, one community case manager revealed that the process of reinforcing the stipulations outlined in the CTO resulted in her client perceiving her as part of the 'supervisory' system, rather than as his independent, rehabilitation worker. However, this suggestive but anecdotal evidence clearly needs to be further explored and researched to determine the impacts on the relationship between CTOs, mental health workers and client outcomes/satisfaction.

Targeting marginalized groups

Similar to the case of the ORAM, there is evidence that CTOs can lead to targeting specific populations and increased stereotyping of people with mental illness. CTOs do not address the needs of language training, settlement issues, housing or employment and strictly advance a medical response to mental illness. The medicalized response advances Eurocentric values and norms, and suggests that CTOs are not

compatible with First Nations communities because the values embedded are at odds with the values of aboriginal communities. In Australia, Brophy & McDermott (2003) reported that there is a disproportionate presence of young men and indigenous people on CTOs. Comparable data are unavailable in Ontario but the Ontario Federation of Indian Friendship Centres (OFIFC) reports that the overall mental health reform process of the late 1990s, which included the introduction of CTOs, has negatively impacted Aboriginal peoples. Specifically, the use of the definition of 'serious mental illness' in the current mainstream mental health services (which is also considered in assigning CTOs) does not apply to First Nations communities (because of diverging views of 'health') and there is currently an over-representation of Aboriginal peoples in this 'category' of mental illness (Ontario Aboriginal Health Advocacy Initiative, 2001).

CTOs have also been argued to target marginalized populations including the homeless. A lawyer from the Parkdale community of Toronto explains during the debate:

> Most individuals are not homeless because they are mentally ill; they are mentally ill while being homeless. The proposed community treatment orders target the most marginalized population in our communities, people who are isolated from supports and who are living in transience (Legislative Assembly of Ontario, 2000a).

Data on whether CTOs target other marginalized groups is unavailable, but given that research shows that there is a high correlation between poverty, poor housing, the migration experience and racial discrimination (e.g. Access Alliance Multicultural Community Health Centre, 2005), the use of CTOs raises questions about targeting recent immigrants, visible minorities and other culturally disadvantaged groups. Since the role of CTOs is limited and does not include resources nor the mandate to tackle the poverty and housing crisis that surrounds the majority of people who have a mental illness, they

are likely to be, at best, minimally effective for a significant proportion of the population. As well, they do not respond to the mental stress associated with migration and settlement issues and may be ineffective for a number of minority groups using services.

Closing Remarks on CTOs and Risk in Mental Health

In the above discussion I critically analyzed the assumptions and underpinnings of CTOs and demonstrated the concerns that are linked to the construction of the problem of mental illness and the consequences this has on the attitudes, beliefs and values embraced in society. I suggest that CTOs advance a narrow bio-medical conceptualization of the problem of mental illness and operate within a limited understanding of achieving health and well-being. As a consequence, the pharmaceutical industry is embraced as an appropriate response at the expense of considering the significance in a broader social response. Moreover, CTOs are promoted as protecting human rights because they provide access to medications, but they do not address the infringements of rights that arise from the use of a CTO itself. While documentation reveals that CTOs were heavily resisted by advocates and service users during the phase of initiation and development, there has been less attention to the implications of advancing the underpinnings of a risk management framework in CTOs. CTOs have been criticized as operating as a 'mobile institution' in the community and potentially targeting marginalized groups, although implications on service delivery, social work practice and service users has been relatively unexplored.

Chapter 5: Risk as a Channel for Prediction and Prevention

Background of the Ontario Domestic Assault Risk Assessment (ODARA)

While risk assessment and risk management have been in operation in various ways to assess for risk of domestic violence in the criminal justice system, it is only beginning to emerge as a predominant approach within the area of violence against women[13] in Ontario. The McGuinty Government recently announced the development and implementation of the Ontario Domestic Assault Risk Assessment (ODARA), a tool designed to predict the risk or likelihood of "male offender re-assaulting of a current or previously co-habitated female partner" (Ministry of Community Safety and Correctional Services, 2004). This risk prediction instrument, along with other similar instruments (e.g. the Domestic Violence Screening Inventory (DVSI), Williams and Houghton, 2004; and the Spousal Assault Risk Assessment Guide (SARA), Kropp, Hart, Webster & Eaves, 1994) are considered by many to be actuarial measures which isolate 'risk factors' which have predictive validity. Hilton Harris, Rice, Lang, Cormier & Lines (2005) asserts that "ODARA is the only true actuarial risk assessment in the domestic violence field because it was based on analysis of an extensive criminal justice database of abusers and it prospectively examined reported re-assault from that same database" (Campbell, 2005, p. 658 – 659).

The Ontario Domestic Assault Risk Assessment (ODARA) was introduced in Ontario in 2004 and was specifically developed to assist police and crown attorneys in

[13] Terms such as wife battering, domestic violence, interpersonal violence, wife assault and violence against women have all been used to describe this problem. The ODARA adopts the term 'wife assault' which signifies male violence against a woman within a heterosexual marriage. The term 'wife assault' has both been advocated for and challenged. Groups who advocate for the term claim that it recognizes the direction of violence within the relationship and exposes how the violence is directed towards women. Those who criticize the use of the term claim that it is discriminatory against non-heterosexual relationships and relationships that are not recognized in a union of marriage.

decision-making regarding whether or not an accused should receive bail. The purpose of the ODARA is to not only prevent future incidents of wife assault, but to also protect women and children from harm and maintain their safety (ODARA Handbook, 2005).

The ODARA is currently implemented as a pilot study across a number of services within the province, including sexual assault treatment centres in order to test its validity outside the domain of law enforcement. It is distributed upon request and payment across Canada, US, Asia and Europe and is currently used by a variety of domestic assault services, family services, hospitals and custodial and community corrections[14]. The ODARA tool was researched and developed by the Mental Health Centre Penetanguishene (MHCP) under a Social Sciences and Humanities Research Council (SSHRC) grant and is a quantitative actuarial assessment tool. Specifically, it ranks the identified perpetrator amongst previously accused in terms of risk for re-assault (ODARA Handbook, 2005, p. 6). The ODARA consists of 13 items which are assessed and scored as 1 or 0. Items assessed include "domestic and non-domestic criminal history, threats and confinement during the index incident, children in the relationship, substance abuse, and barriers to victim support" (p. 6). The scores are added together and the decision of whether an accused is likely to re-offend is based on the sum of the scores. The development of the ODARA was an outcome of collaboration between the Ontario-Provincial Police (OPP) and the Mental Health Centre Penetanguishene (MHCP). The MHCP research team reviewed 589 files known to the OPP in situations of men assaulting female partners or ex-partners; these cases were followed for 51 months. The team discovered that during this period, 30% of these men were reported for at least

[14] Personal Communication with Zoe Hilton, Senior Researcher at MHCP and developer of the ODARA

one other incident of domestic violence. These cases were statistically analyzed to determine characteristics that "strongly and independently predict recidivism" and were included in the ODARA (ODARA Handbook, 2005, p. 5).

Unlike the ORAM and CTO, the developmental process of the ODARA is still underway. This tool is considered to be an actuarial risk assessment instrument because it is purposely designed to categorize offenders into risk-based groups according to shared characteristics.

Understanding the Driving Forces for the ODARA

Unlike the ORAM and CTO, there is very little secondary documentation that addresses the driving forces of the initiation of the ODARA. The majority of documentation retrieved derives from press releases and government reports by the McGuinty government and the Ministry of Health and Long-Term Care (MHLTC) as well as publications made by the Mental Health Centre Penetanguishene (MHCP). This can partly be understood by the fact that the ODARA is relatively new.

Similar to the ORAM and CTOs, documentation reveals that the ODARA emerged as part of a broader provincial government initiative entitled the "Domestic Violence Action Plan" which was announced in December 2004 to address the problem of domestic violence. Press releases state that the assessment tool surfaced from the Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services as part of the government's Domestic Violence Action Plan, in collaboration with local police services and community agencies.

As was the case with the ORAM and CTOs, the initiation of the ODARA appears to be partly driven by increased attention towards deaths resulting from interpersonal male violence. Examination of newspaper coverage reveals that a number of incidents of male and family violence from the late 1990s to the early 2000s received considerable attention in mainstream and community newspapers. Examples include the death of Arlene May by her former intimate partner Ray Isles in 1998. In 2000, Gillian Hadley was shot and killed by her recently separated husband, Ralph Hadley, who then later turned the gun on himself. Other high profile deaths include the death of Bohumila Luft and her four children by her husband Bill Luft, Lori Dupont by her ex-intimate partner, and Francine Mailly and her three children by her estranged husband.

Spousal homicide is reported to account for approximately 15% of all homicides in Canada (Statistics Canada, 1993). However, according to statistics released by Statistics Canada, the homicide rate for women dropped from 16.5 in 1974 to 8.1 victims per million married women in 2002 (Statistics Canada, 2004) It is clear that, while the problem of domestic violence homicide is serious, it has likely been sensationalized to mobilize public support for resources aimed at preventing domestic violence. In the majority of articles, there is a clear spin that the deaths of these women and children are evidence that we, as a society, are still not doing enough to prevent domestic violence and that these incidents could be prevented with the adoption of risk assessment techniques. This claim is reinforced in *What can we do about domestic murders?*, an article published by Zoe Hilton, head of the ODARA research team. It presents high profile deaths covered in the media as a way to 'set the stage' for the article and justifies the use of the ODARA as a means of preventing future domestic violence homicides.

Therefore, the emergence of the ODARA is partly driven by framing these deaths as 'proof' that, despite all previous efforts of placing domestic violence on the public agenda, the current system continues to fail women and children.

My review of the documents retrieved also suggests that the inquiries conducted into these deaths served to legitimize and advance these concerns as well as the Ontario government's decision to create a provincial action plan and subsequently, a structured risk assessment tool. Documents produced by the MHCP, for example, make explicit links between the May/Isles and Hadley inquiry and the initiation of the ODARA. The ODARA handbook reports that implementing a risk assessment tool was one of the many recommendations made in the May/Isles inquiry in 1998 (ODARA Handbook, 2005). The report released by the Domestic Violence Death Review Committee to the Chief Coroner reviewed 11 deaths of women/and or children in 2004 and reported that most deaths could have been predicted and prevented if risk factors were analyzed in advance. The introduction of a structured risk assessment tool to assist in identifying and preventing repeated acts of interpersonal violence was also recommended by the Joint Committee on Domestic Violence to the Attorney General of Ontario in 1999.

Similar to the area of child welfare and mental health, these inquests reflect broader themes that, as a society, we posses the ability to craft a solution to the problem of domestic violence homicide. Inquests and inquiries not only serve to support the claim that we (humans) have the ability to identify, predict and prevent, but they also advance the belief that an 'expert system' can execute 'easy' and 'simple' policy solutions, as reflected in the increased emphasis on the ODARA in the Domestic Violence Action Plan.

However, in contrast to the areas of mental health and child welfare, variations of risk assessment measurements had already been implemented by some police forces within the province. The Toronto police were already using a risk assessment 'checklist' and a form of 'threat assessment', particularly in cases of stalking, to help determine the likelihood of future harassment and assault (Monsebraaten, 2000). In addition, the Ontario Provincial Police (OPP) uses the Domestic Violence Summary Report (DVSR) to assess the likelihood of further assault. Other tools, such as the Spousal Assault Risk Assessment (SARA), which measures risk of a repeated spousal assault, and the Danger Assessment, which assesses risk of domestic violence resulting in murder, are also already developed and in use. Thus, the idea of a structured risk assessment instrument to measure the likelihood of a future or recurrent interpersonal violent act is not a novel idea in the area of violence against women, particularly across stakeholders who work within a crime prevention model. However, the influence of evidence-based practices and the shift to guide decision-making through an empirically tested structured risk assessment tool appears to be just as strongly linked to this policy context as in the area of child welfare and mental health.

Academic articles published on the ODARA by the research team emphasize the empirical nature of this risk assessment tool while the handbook describes this tool as "the most accurate risk assessment published to date" (ODARA, 2005, p. 7). As was the case in child welfare and mental health, decision-making around risk of recidivism and threats to safety within interpersonal violence has largely been decided through clinical judgment or general guidelines that have not been empirically validated (Dutton, 2006). It appears that the ODARA was introduced to be a 'better' risk assessment tool that would

increase consistency and standardization in assessment and decision-making of re-offending. As with child welfare and mental health, the move to the ODARA was easily accepted due to the overall trend towards evidence-based practices and the dominance of scientific-thinking in the social service realm.

Similar to the previous case studies, the political and economic backdrop of the province also functioned to drive the broader government initiative of the Action Plan and consequently, the ODARA. During the mid-late 1990s, the Harris government expanded the 'get tough on crime' agenda which shifted attention to the accused and the use of the criminal justice system as an appropriate response to domestic violence. A report released by the Ontario Association of Interval Transition Houses (OAITH) criticizes the Harris conservative government for significant cuts across social services in 1994-1995, including prevention/education initiatives in violence against women, male batterers programming and transitional housing (OAITH, 1996).

Alongside these cuts, public safety was taking precedence in the correctional agenda and parole was framed as a privilege rather than a right (Moore & Hannah-Moffat, 2002). Moreover, the 'get tough on crime' agenda advanced by the conservative rhetoric led to favoring of principles of efficiency and deterrence in crime prevention. The OAITH claims that these cuts in 1995, combined with rising costs and demands for service, led to program and staff cuts that lessened the ability to meet the needs of women and children who required safety and support (OAITH, 2003). They advocate for increased funding and resources in shelters as well as employment and education programs to better enable women to lead lives free from violence. While the McGuinty Domestic Violence Action Plan publicly announced a financial commitment to fund

women's shelters, the OAITH has criticized this commitment as mere public relations. Requests to meet with the Minister, Brenda Elliott, to discuss the impact of previous funding cuts to shelters, have been declined (OAITH, 2003).

A government press release claims that the ODARA is the "tool that will help police and Crown attorneys better protect women and their children from domestic violence" (Ministry of Community Safety and Correctional Services, 2004). It is clear that the prioritization of cost-effective strategies and a 'get tough on crime' philosophy is the impetus behind the government's response to meeting the needs, as defined as 'safety', of women and children. The identified need to increase safety and protection of women and children through better risk assessment procedures functions to support a more punitive response to domestic violence generally and endorses a cost-effective agenda. As a result, the adoption of an actuarial risk assessment procedure may be viewed, to a large degree, as driven by broader neo-conservative ideologies of investing less in social welfare while at the same time, endorsing strategies that are more punitive in nature.

Overall, it appears that, similar to the area of child welfare and mental health, the ODARA emerged out of an interaction of a number of social, economic and political processes. Fear and concern around the problem of domestic violence homicide, as fueled by newspaper coverage, alongside the operation of inquiries into these deaths, led to a prioritization of the ODARA, and risk assessment generally, on the government's agenda. There was little resistance because there was already a degree of openness to actuarial risk assessment in the criminal justice system. Coupled with the broad movement towards empirically tested procedures, the ODARA also appeared to meet both the cost-effective

demands and a prioritization of the 'getting tough on crime' philosophy which lingered on from the Harris government. Examining these trends provides a better understanding of how and why the McGuinty government has prioritized risk assessment in the Domestic Violence Action Plan and how the ODARA has been advanced with relative ease and acceptance.

Development Process of the ODARA

Documentation on the development of the ODARA can be classified into two different, but overlapping, categories: documents that address the process of the Domestic Violence Action Plan (DVAP) and documents that address the research processes involved in the development of the ODARA. While my specific focus is to explore the development of the ODARA, attention will also be given to the development of the DVAP since this process is still ongoing and heavily implicated in the ODARA.

In preparation for the DVAP, Laurel Broten, MPP and Parliamentary Assistant, participated in 30 roundtables involving more than 180 experts and front-line workers. As well, the Minister of Community and Social Services met with representatives of second-stage housing, shelters and counseling services for women to determine how to best improve community supports for women. Findings from the Domestic Violence Death Review Committee Report were also considered when developing the plan (Ministry of Citizenship and Immigration, 2005). No available material addresses who was represented on the committee or who was involved in other capacities in the Domestic Violence Death Review Committee but some critics report that the review occurred 'behind closed doors and the review itself did not involve the public' (Laucius, 2006).

Moreover, an article published in *Community Action*, a community based newspaper, discusses the role of CAS in preventing domestic violence and states that there was no representation of CAS on the review committee as well as notes that it mainly consisted of police, justice officials and regional coroners who have connections with social services, such as women's shelters and advocacy groups, but not the representatives themselves ('CASs lacking risk reduction plan in review of domestic violence deaths,' 2005). The report from the Domestic Violence Death Review Committee states that the group consisted of "a multi-disciplinary advisory committee of experts" but does not go on to state who specifically attended and who was involved in this review process (Office of the Chief Coroner, 2005).

In addition, a provincial Domestic Violence Symposium was held, consisting of community leaders, experts and service providers and the Ministerial Steering Committee on Domestic Violence, which focused and prioritized domestic violence as an issue deserving leadership and attention. While this is documented as part of the process of developing a broad domestic violence initiative, there is no information regarding who attended or that detailed this process. In fact, an open letter to the provincial government from OAITH stated that no representatives from women's independent community-based organizations had been invited to sit on the committee (OAITH, 2004).

An article produced by the Mental Health Centre Penetanguishene Research Department in 2004 acknowledges that female victims of violence by intimate male partners can themselves accurately predict the likelihood of future assaults. It notes that the ODARA is currently undergoing assessment by women to test the validity and reliability of the tool (Hilton, 2004, p. 11). So, while the current version of the ODARA

excludes women's perspectives it may be undergo revisions to include women's perceptions that have largely been ignored in the process of developing this tool. However, there is no information on how this is being facilitated and who is involved. In contrast, police services are repeatedly identified for their involvement in the initiation and development of the ODARA. In the ODARA handbook, the Ontario Provincial Police (OPP), York Regional Police Services, Peel Regional Police Services and the Durham Regional Police Services have been acknowledged as making contributions to the research around developing the ODARA.

Overall, it appears that the development of the DVAP was not made visible to numerous groups who could have been involved in the process. In addition, information as to who attended the roundtable discussions is not available. Most documents report that the discussions involved a number of 'experts', but this may have been at the expense of independent community-based women's groups who advocate and provide services to women and children. Instead, there is an over-representation of police and justice officials which, results in a fairly selective discussion and narrow leadership.

Underlying Assumptions and Consequences

The ODARA handbook explains that the risk factors identified in this tool derive from an analysis of a database of men who have come to the attention of police as perpetrators of violence in intimate relationships. While the ODARA makes no claims to 'solve' the problem of domestic violence through its implementation, it does assume that male characteristics lie at the root of the problem of why men re-assault and potentially commit a domestic violence homicide. Thus, the ODARA reflects a government response to domestic violence which embraces an individualistic approach that targets male

characteristics and behavior and situates risk within individual pathology. While recommendations from the Hadley inquest did point to the need for increased funding towards social housing, shelters and increasing the welfare rates of women, Eileen Morrow, Coordinator of the OAITH, reports that these recommendations have largely been ignored (Laucius, 2006).

Similar to the ORAM and CTOs, what results is an overly simplistic government 'solution' to the problem of domestic violence, and consequently, the advancement of a limited understanding of the nature of the problem. In the ODARA, the criteria identified to assess for violence refer to acts of physical violence only. On page 8 of the ODARA handbook, it defines violence through 15 examples which include, but are not limited to: (a) held her down; (b) threw something at her that could hurt; (c) twisted her arm or hair; (d) pushed her; (d) shoved her; (e) grabbed her; etc... In the last criteria, 'other severe violence', it refers to examples such as head-butting her, pushing her down the stairs and biting her (ODARA, 2005, p. 8). While there is no uniform definition of violence against women or domestic violence, one of the most widely used definitions today is provided by The United Nations Declaration on the Elimination of Violence Against Women (1993). It defines violence against women as:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations, 1993).

In addition, an article published by the Centre of Excellence for Children's Well-Being expands the definition of psychological violence to include emotional violence which is defined as "blaming or hurting the other partner emotionally and through

domination, in which a partner exerts a negative influence on the spouse to achieve compliance or dependence, or isolates the spouse from family and community" (Chamberland, Leveille & Baraldi, 2006, p. 3).

It is clear that the ODARA definition of violence only acknowledges physical acts of aggression and does not include emotional, verbal or psychological abuse or other forms of destructively asserting power or controlling behaviour. This represents an underdeveloped definition of violence within the tool which, in turn, demonstrates a tolerance of emotional and psychological abuse by not recognizing it in the assessment or understanding re-assault only within a perspective of physical acts.

Narrowing risk factors to physical acts of aggression also advances a simplified assessment of future incidents of domestic violence. Despite some research that shows that previous physical aggression is the strongest predictor for future homicide in an intimate relationship, other studies point to more broader socio-economic indicators. In a multi-case US study on interpersonal violence, researchers interviewed family members and close acquaintances of 230 female victims of homicide and found that unemployment and access to firearms were the strongest predictors of female homicide (Campbell & Wolf, 2003). What is of interest is that the researchers used dynamics and characteristics of the relationship as well as other socio-economic and environment influences as a starting point of investigation and applied this alongside to gathering information on the nature, type and frequency of violence. The finding that unemployment is a strong predictor of future incidents of male-perpetrated violence suggests that physical aggression emerges from a more complex picture. The 'crisis of masculinity' theory (e.g. Jefferson, 1994) which approaches male violence and aggression through a lens of

gender, specifically accounts for these behaviors as a product of male victimization of broader dominant masculine societal ideals, such as machoism, dominance and physical strength or intimidation. The theory argues that if these 'masculine ideals' are threatened in a young man it can lead to acting out aggressively in a way that allows them to reassert their dominance in society. In applying this theory to domestic violence, it suggests that an unemployed male would likely feel powerless in achieving his role of 'provider' and 'protector' and thus, be prone to act out in violence to re-affirm his ability to achieve his masculine role in society.

The ODARA advances a belief system on domestic violence that reinforces the misguided assumption that domestic violence is strictly a result of individual male pathology and aspects of gender, socio-economic conditions and dimensions of power are overlooked. Risk factors are limited to physical acts of aggression and aspects of unemployment, dominance and machoism are not included. As a result, it appears that the 'rational-actor' theory of criminal behavior is endorsed in the ODARA, and actuarial risk assessments of male violence at large, which advances the belief that a person 'chooses' to engage in destructive behaviors. Therefore, responses are directed towards the individual, rather than from a broader understanding such as, considering the influence of hegemonic masculinity[15].

The adoption of the ODARA also advances a criminological construction of domestic violence that assumes the problem of domestic violence is situational where intimate violence is a result of the immediate environment and altering this situation will lead to deterrence and self-discipline. This is illustrated in the outcome of the use of the

[15] Hegemonic masculinity is a term that refers to the 'ideal' masculine role prescribed to men as defined by a particular society. It refers to the 'masculine norm' that is most commonly endorsed in society, although is not necessarily the most present in reality.

ODARA - penalizing a male perpetrator and providing a safety plan for a female victim – which inadvertently demonstrates that risk is perceived as a concept that needs to be controlled and regulated at an individual level only. It reflects a government response that favours crime prevention over other approaches to the problem. O'Malley (2006) suggests that the situation of risk at the individual level, and the assumption of the individual making rational choices, as influenced by his or her immediate environment, reflects and is aligned with, a neoliberal governance framework where each individual is responsible for gaining an awareness of their risk and then taking the appropriate action to manage it.

In addition, the assumption that repeated domestic violence can be prevented by locating and managing risk at the individual level, and the consequent advancement of situational and rational-choice beliefs of behavior, overlooks the gender and cultural aspects of domestic violence. An extensive training model for domestic violence released by the Ontario Council of Agencies Serving Immigrants (OCASI) raises a number of interesting questions regarding the construction of risk assessment through a Eurocentric framework. In this case, the manual works from a framework of reducing barriers of oppression to women and children as well as striving for equality in assessments, intervention and collaboration. It understands domestic violence as a dynamic problem, rather than a simple case of physical abuse, and incorporates indicators of gender, race, culture and immigration and refugee status in the foundation of the assessment.

The OCASI model includes 'High Risk Resource Kit' developed by the Toronto Women's Council of Abuse which integrates a different approach to risk. This model

builds its framework from the needs of women and children and recognizes the *relationship* of women and children at the centre of all interventions. It makes explicit that assessment needs to be flexible and adaptable and highlights the importance of understanding and accepting diversity in the needs of women and children in each individual case and that these needs are to be met. In addition, rather than focus on the male's individual characteristics as risk factors for physical aggression, this model includes indicators that represent a broader understanding of domestic violence. It provides 15 indicators that capture both male behaviours and circumstances and situations that may indicate a high risk of future violence and the potential for lethal violence. These indicators include, but are not limited to, 'presence of a weapon', 'change in male's behaviour (as perceived by the woman)', 'a preoccupation or obsession with the victim', 'threats or injury to pets', 'lack of remorse of behaviour' and 'woman has made attempts to leave the situation' (Ontario Council of Agencies Serving Immigrants, 2006, p. 55).

Another area of interest in the OCASI Prevention of Domestic Violence Training Manual is that areas of intervention are determined by the needs of women and children as identified by the woman, not an 'expert'. These needs are then supported in a way that considers the woman and children's broader community and socio-economic circumstances. Campbell & Wolf (2003) adopted a similar 'bottom-up' approach in that they had conversations with people close to the female victim to gather information on their perceptions of the problem (e.g. did they notice changes in his or her behaviour? what triggers did they perceive as potentially leading to violence) and then used this information to inform the development of assessment of risk in contrast to, the ODARA

which identified individual male risk factors based on a database of men known to police. The top-down approach inherent in the development of identifying risk factors and in the execution of assessment of risk raises concerns around the appropriateness of the ODARA for women and children, although its validity is currently being tested with the Ontario Sexual Assault Network. Heckert & Gondolf (2004) also point out that women's perceptions of risk are often a stronger assessment of future abuse in contrast to structured risk assessments which reveals a major limitation of the ODARA.

The ODARA also assumes that lethal violence is a matter of police investigation and reporting. This is problematic because not only does the ODARA fail to recognize the processes that determine which men end up in the criminal justice system to begin with, but it neglects the fact that a number of women who experience abuse and re-abuse often do not come into contact with the police. A report released by the OAITH stated that in 1997-1998, only 24 % of women in shelters had contacted police about their abuser and generally, an astounding number of women seek other services (e.g. shelters, counseling) rather than make contact with police (OAITH, 1999).

In addition, the erosion of the social safety net in the province often forces women to stay in abusive relationships. *Walking on Eggshells*, a study conducted on the experiences of abused women in the Ontario Welfare system reports how women are commonly mistreated and humiliated within the welfare system and the very design of Ontario Works (OW) leaves many women and their children with inadequate benefits to be on their own (Woman and Abuse Welfare Research Project, 2004). Specifically, the report states that 17 of 35 responded welfare administrators surveyed stated that they were aware of women who left welfare to return to an abusive relationship because she

was unable to adequately support herself and her children and for many women, even considering returning to an abusive relationship was on the radar (p.5).

It is not only that narrow understandings of domestic violence and limited approaches to conceptualizing risk results in an overly simplified response, but it also advances a particular response over another. The majority of literature on actuarial risk assessment tools in the area of domestic violence emphasizes that validity and accuracy in prediction derives from statistical calculations grounded in sound research. The ODARA handbook explicitly states that, in comparison to other existing risk assessment tools, it has the strongest predictive validity because it has been developed through statistical analysis (ODARA Handbook, 2005). Although the ODARA is currently being piloted with women, there has been less emphasis on the subjective perception and experience of women in cases of domestic violence, which is problematic since a number of studies have shown that a woman's perception of risk of abuse is strong predictor. It is clear that the ODARA reflects a preference for developing objective risk factors through a knowledge-base of statistics which supports the perspective of expert-opinion. Consequently, this leads to a broader acceptance of principles embedded in scientific-thinking and institutionalism and the advancement of norms, values and beliefs rooted in these philosophies of though while, attention to subjective perceptions of risk, grassroots approaches and an understanding of the role gender plays in social problems is swept aside and largely neglected.

Implications for Service Delivery, Service Providers and Service Users

Not extensively documented

Since the ODARA is still being piloted, implications are not documented. Most criticisms surrounding the ODARA and actuarial assessments focus on the empirical flaws in the actual instruments (Dutton, 2006; Hilton & Harris, 2005) but do not seek their complete elimination. Rather, they argue that these limitations can be overcome by strengthening the empirical validity and reliability of these instruments. Some advocates have spoken out about concerns regarding the introduction and implementation of the ODARA. For example, one newspaper article reports that the ODARA overlooks people who have not come into contact with the law and also overlooks people from various cultural backgrounds who do not trust authority figures (Whitnall, 2004). It is currently being piloted with the Ontario Sexual Assault Network to assess whether it is helpful for the clientele and see whether health effects related to domestic violence are associated with risk. While this is just a pilot study, the website makes no claim of any concerns regarding this tool.

Closing Remarks on the ODARA and Risk in Interpersonal Violence

In the above discussion I provide a critical analysis of the assumptions and underpinnings in the ODARA as well as the broader provincial government response to the problem of domestic violence. While documentation on the ODARA is sparse since it has only been recently introduced, it is clear that it advances an underdeveloped understanding of domestic violence which consequently reflects a limited response from the government. Risk factors strictly reflect a measurement of types of physical aggression by the male abuser and locate risk within the pathology of a man which, consequently leads to an individualistic approach to domestic violence homicide. In

addition, the ODARA focuses on the idea and belief that objective risk factors can be identified through statistical analysis which consequently advances a system of institutionalism and expertise. It assumes that lethal violence can be determined by what is reported to police and fails to account for the fact that majority of women do not report incidents of violence to police. What results is a lack of an integrated framework that involves the subjective experience of women and children and a disregard for cultural and community diversity.

Chapter 6: Understanding the Emergence of Risk Management in Social Policy

The politicalization of the emergence of 'risk'

My analysis of the driving forces of all three case studies reveals that all three risk management frameworks – the ORAM, CTOs and the ODARA - appeared to develop within a broader initiative of system reform. The ORAM, CTOs and the ODARA were all initiated by the provincial government in response to publicized adverse events as evident in my review of newspaper coverage. In the case of child welfare, child mortality was politicized to be a 'symptom' of a failing child welfare system and became a frame of reference for the prioritization of a risk-based model and overall system reform. My review of CTOs revealed that homicides committed by people with mental illness, although rare in occurrence, were politicized to justify the need to include a risk management framework to manage and regulate people living in the community with a mental illness. Similarly, the emphasis on domestic violence homicide as a indicator that society still has not addressed the problem of violence against women rationalized the adoption of the ODARA as a tool to predict and prevent future male perpetrated re-assaults.

The politicalization of these deaths, as evident in newspaper reports, inquest and inquiry reports and broader documentation promoting the use of all three tools, operated alongside the dominance of scientific thinking which advanced and supported the belief that humans possess the ability to identify, predict and prevent adverse events. Risk management strategies were put forth as the most appropriate response to these identified problems because they were perceived to be the most effective way to control and manage the 'risks' of child mortality, homicides committed by people with a mental

illness and domestic violence homicide. The focus on including evidence-based practices and 'empirically valid' assessment techniques not only reinforce the belief of human ability to regulate risks, but also reflects a clear preference for values and norms underlying scientific approaches. The need for increased standardization and consistency in worker's decision-making as a means to control risks for child mortality was central to the initiation of the ORAM. CTOs were widely promoted as reflecting 'best practices' in mental health due to the 'hard evidence' emerging from clinical trials in the U.S. Moreover, the ODARA prides itself on increasing its statistical validity of prediction through its design in actuarial probabilities.

It is also clear that the above activities were legitimized by the operation of a neoliberal political ideology combined with the conservative political platform of the province in the mid to late 1990s which curtailed social spending and prioritized meeting the needs of corporate investment. The inclusion of market-based approaches in the restructuring of the welfare state, advanced business principles and managerial practices which led to the adoption of risk as a divisionary concept to organize service distribution for the purpose of containing costs. Consequently, the initiation of these policies reflects and reinforces the displacement of values of universal need or rather, a redefinition of need through a lens of risk.

My analysis shows that cost-effective and cost-efficient rationales were operating behind the provision of social service delivery within all three case studies. With respect to the ORAM, it was widely documented that this risk assessment model was initiated at a time where CAS agencies across the province were facing widespread cutbacks in funding and resources. A closer look at the design of the ORAM reveals that the risk-

based model served a cost-efficient agenda by rationing and allocating resources through a lens of risk. For CTOs, the off-loading of costs onto communities through the closures of hospital care and overall mergence of a number of health care programs, exposes that pressures to maintain low costs in service delivery was also an influential factor in the initiation of CTOs. Those who are deemed to be most 'risky', as defined by potentially 'dangerous' or likely to not keep taking their medications, become eligible for a CTO while those who are not 'risky' are discharged into the community and left with the responsibility to manage their own health and seek out long-term supports. Even though the ODARA has emerged almost ten years after the province-wide cuts in social welfare during the mid to late 1990s, the fact that women and children are still facing extreme poverty and economic strain due to these cutbacks can be understood as a continuance of these ideologies. Despite the widespread calls for funding for community-based shelters, housing and employment assistance for women, the government has focused on risk of a male re-offending in interpersonal violence and a more conservative crime prevention response because it serves to maintain cost-effective and cost-efficient principles of service provision.

My exploration of the developmental process of the ORAM, CTOs and the ODARA also contribute to the understanding of how and why risk has emerged in these areas of social service by showing that the processes behind the development of each policy is not only related to how they were initiated, but also that they have implications on how risk is constructed and advanced in each domain. One of the common themes across each case study is that documentation of this process in all three areas was limited and not easily accessible. Drawing on the assumption that documents reflect and

communicate a political process, the very fact that information about this process is limited in documents suggests that this process is not overly transparent and inclusive. Also noticeable in the data analysis was that the process of development involved a fairly narrow range of people and occurred in a top-down direction. For the ORAM, the initiation and development of the risk assessment model mainly included the Ministry, OACAS and CAS agencies with some, although selective, representation of the ANCFSO. The exact process of how CTOs developed was not described from the available data, but tracing how they were driven suggests that they were narrowly developed within a medical and business (cost-effective) framework. While the ODARA suffered from the most serious lack of documentation, there was a prioritization of criminal justice officials who openly advocated for the risk assessment tool at the expense of women's groups, who supported other alternatives.

In all three cases, it was clear that the development of these policies involved dominant voices and perspectives and reflected an indifference to a broad range of groups and perspectives that are equally impacted by these policies. In the data that was available in all three case studies, there was a clear under-representation of groups who would be impacted as service users, including, but not limited to, people from First Nations communities, recent immigrants and refugees, people living in poverty, women and racial and cultural minority groups. Consequently, the advancement of risk in these policies can be understood to be partly an extension of the processes behind the initiation and the development. In the following section I draw on the common themes emerging from the initiation and development of risk management in all three case studies, as

outlined above, and discuss how this contributes to an understanding of the operationalization of risk in each area.

Who is 'risky'? Who is 'protected'?

This thesis shows that who is considered risky and who is considered protected in reality is vulnerable to subjectivity, relativity and interpretation. The aim of this work was not to arrive to a definitive definition of what 'risk' is and whether it exists – but rather explore how risk has come to surface and be understood in social policy. These case studies reveal that risk reflects a process of social construction and derives its meaning from, the norms, values and assumptions embedded in the process of initiation, development and operationalization. The analysis of these case studies uncovers how risk gets constructed through the dominant ideals and values embedded in the ideologies of scientific-thinking, business principles and overall Western beliefs of social problems. The operation of risk through these risk-based tools consequently, advances philosophies of social problems which result in a narrow, individualistic construction of risk. This leads to problematic implications on how services are delivered, what interventions are adopted and who is considered 'risky' and who is considered 'protected'. The advancement of the belief of an 'expert' system, as reflected in 'evidence-based' practices and managerial solutions, and an overall neglect of considering how risk is a site of advancing these ideals, leads to the embracement of homogenous constructions and responses to complex social problems at the expense of understanding that risk is relative, subjective and process-driven.

Exploring who supports and opposes the development of these tools, and who was included and excluded from this process, reveals that these divisions are not straightforward. Divisions around who supports and who opposes risk management can be understood as those who identify and align themselves with the perceived advantages and disadvantages of advancing a risk management agenda. Stakeholders who support the ORAM rationalize it because of the perceived advantages of standardizing decision-making and strengthening managerial aspects of service delivery. While it is not explicitly stated, there appears to be an implicit relationship between increasing consistency across decision-making and upholding institutional accountability. Those who oppose the ORAM identify and align themselves with the perceived negative implications of advancing a framework that simplifies the problem, leads to an underdeveloped response and increases targeting of marginalized populations.

For CTOs, those who embrace a medical model of mental illness and identify with the perceived dangerousness of 'unsupervised' individuals living in the community with a mental illness, believe that CTOs provide a right to treatment to those who would otherwise be in the community with little monitoring. On the other hand, advocates of social and economic determinants of mental health view CTOs as an unnecessary infringement on human rights in that they do not provide access to housing, employment and social benefits which are argued to be influential factors to maintaining a person's wellness. In the case of the ODARA, supporters of the tool argue that this is the long-awaited response to tackling the problem of male perpetrated re-assault in domestic violence which is interpreted as a major risk factor in domestic violence homicide. However, women's groups and advocates who conceptualize the re-occurrence of

domestic violence as a problem of structural barriers to women point to inadequate social benefits, housing, financial independence and lack of access to shelters as a major contributor to re-abuse.

Thus, the line between who is 'risky' and who is 'protected' depends on what perceptions of norms and values underlie the definitions of these groups and how this separation is perceived, understood and interpreted. For example, in the area of child welfare, the Ministry and other supporters of the ORAM, perceived the tool to be an appropriate mechanism of protecting children. Who was 'risky' (parents) was neatly separated from who was 'protected' (children). However, an alternative perception is that children are at 'risk' because the ORAM simplifies and reduces the individuality and context-specific aspects of the case of abuse to the extent that the ORAM becomes irrelevant to some groups (as shown in the discussion on implications). In addition, the operation of a risk-based model in child welfare can serve to protect the institution because it develops 'safeguards' in procedures to 'prevent' the occurrence of adverse events, but correspondingly, the institution becomes risky because it has simplified procedures so much that they inadvertently create new risks due to the homogenous underpinnings in risk assessment and risk management. Child protection workers are also on the one hand protected because they have specific guidelines that direct their decision-making and therefore accountability is perceived to be situated in the tool, but they are equally considered risky because these guidelines do not leave room for context-specific decision-making, or inconsistent decision-making, which can also improve accountability in the worker.

The same can be observed for the area of mental health and violence against women. CTOs are argued to be a mechanism for protecting the public from people living in the community with a mental illness who are deemed 'dangerous' by contracting them to medication compliance, but at the same time, CTOs are also a risk for the public because they advance the illusion that violent behaviour can be regulated and controlled, when in reality, it is fairly unpredictable and not necessarily related to medication compliance. CTOs have also been argued as a means to

In the case of the ODARA, male perpetrators of interpersonal violence are considered to be risky and protected. On the one hand, since the ODARA focuses on individual risk factors within these men, they are targeted as 'risky' and 'not risky' depending on the risk factors they present. At the same time, since this is such a narrow definition of what is risky and it is only limited to men who are reported to police, and unintentionally protects a number of male perpetrators of violence who do not posses these risk characteristics and consequently, won't be followed in the same way. Thus, while the aim of the ODARA is to protect women and children, it also at the same time does not protect them because it overlooks women who do not come into contact with police, ignores the risk of involving police to begin with and does not address circumstances for women, such as supportive counseling, housing and financial independence, which were previously highlighted as equally important in a response to stopping abuse.'

Alternative Direction: Questions for Reflection

There will always be tensions involved in initiating, developing and implementing a policy in the social welfare arena. Policies involve and affect a number of different

stakeholders and therefore, are considered sites of conflicting opinion and agenda, contradictory values, norms, morals and beliefs, and a reflection of unresolved issues and concerns. It is inevitable that, for change to occur conflict needs to happen and the advancement of one opinion or perspective over another are unavoidable. What is of significant importance is whether there is a process of critical reflection during the evolution of the initiation, the process of development and the course of implementation of risk-based policies. The following is a collection of questions that have been raised and informed by the analysis of these case studies, to provide guidance around a critically reflective process to risk-based policy-making.

- What is the political agenda behind how a problem is identified and constructed?
- If advanced, what constructions are being favored over others?
- During the development, are all groups given equal weight in the process?
- Is the development process open to be questioned and is the process being critically appraised, or does it occur in a vacuum, behind closed-doors and advanced unchallenged?
- What definitions of 'inclusiveness' are being advanced and how could they be challenged?
- Are groups anticipated to be impacted by a risk-based policy consulted for their perspective in the developmental process?

These questions shed light on the importance of understanding risk as process-driven and as a symbol of a process of social-construction. It is clear that how risk is constructed in these three case studies reflects an advancement of assumptions, values and norms which inevitably impact and shape the operations of social service provision. Consequently, these findings suggest that risk has an impact on the nature of social work, the organization of social service delivery and the experience of service users which warrants future in-depth exploration of the experiences of social workers and service users in the area of child welfare, mental health and violence against women, who have been subject to the operations of a risk management framework.

References

Access Alliance Multicultural Community Health Centre of Toronto (2005). Racialized groups and health status: A literature review exploring poverty, housing, race-based discrimination and access to health care as determinants of health from racialized groups. Retrieved Sept 15, 2007, from www.ceris.metropolis.net/events/seminars/2005/August/LiteratureReviewRGHS.pdf.

Ainley, P., Barnes, T., & Momen, A. (2002). Making connexions: A case study in social policy. Critical Social Policy, 22 (2), 376 – 388.

Angermeyer, M. C. (2000). Schizophrenia and violence. Acta Psychiatric Scandinavia, 102 (Supplement 407), S63 – S67.

Arboleda-Flórez, J., Holley, H. L., & Crisanti, A. (1996). Mental illness and violence: Proof or stereotype? Calgary World Health Organization Collaborating Centre for Research and Training in Mental Health. Prepared for the Public Health Agency of Canada, Health Canada. Retrieved May 16, 2007, from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/fvstereotype_e.html.

Assembly of First Nations. (2006). Leadership Action Plan on First Nations Child Welfare. Retrieved July 08, 2007, from http://www.afn.ca/misc/afn-child.pdf.

Bala, N. (1998). Reforming child welfare policies: Don't throw out the baby with the bathwater. Policy Options, 19, 28-32

Beck, U. (1992). Risk Society: Towards a New Modernity. London: Sage.

Bezanson, K. and Noce, L. (1999). Costs, closures and confusion: People in Ontario talk about health care. Toronto: Caledon Institute of Social Policy.

Blackstock, C. (2005, September 30). Voices from the Field – First Nations Children in Care. First Nations Child and Family Caring Society of Canada, Centre of Excellence for Early Childhood Development. Retrieved March 20, 2007, from http://www.excellence-earlychildhood.ca/documents/BlackstockANG.pdf.

Boyle, T. (1999, March 16). Laws to target mentally ill: Will allow forced treatment for people in danger. The Toronto Star, Retrieved October 31, 2007 from http://www.qsos.ca/qspc/nfc/news.html.

Brophy, L. & McDermott, F. (2003). What's driving involuntary treatment in the community? The social, policy, legal and ethical context. Australasian Psychiatry, 11 (supplement), S84-S88.

Browne, P. L. (1997). Déjà Vu: Thatcherism in Ontario. In D. Ralph, A. Régimbald & N. St-Amand (Eds.), Open for Business, Closed to People. (pp. 37-44). Halifax: Fernwood Publishing.

Callahan, M. & Swift, K. (2006). Back to the Present: Rethinking Risk Assessment in Child Welfare. In A. Westhues (Ed.), Canadian Social Policy: Issues and Perspectives, Fourth Edition. (pp. 203-221). Waterloo: Wilfrid Laurier University Press Canada.

Campbell, J., Brophy, L., Healy, B., & O'Brien, A. M. (2006). International perspectives on the use of Community Treatment Orders: Implications for mental health social workers. British Journal of Social Work, 36, 1101- 1118.

Campbell, J. (2005). Assessing dangerousness in domestic violence cases: History, challenges and opportunities. Criminology Public Policy, 4 (4), 653 – 672.

Campbell, J., & Wolf, A. D. (2003). Risk factors for femicide in abusive relationships:

Results from a multi-site case control study. American Journal of Public Health, 93 (7), 1089-1097.

Canadian Mental Health Association. (1998, June). Position statement regarding the use of community treatment orders for persons with mental illness. Policy Paper, Ontario Division.

Carter, S. (1995). Boundaries of danger and uncertainty: An analysis of the technological culture of risk assessment. In J. Gabe (Ed.), Medicine, Risk and Health. Oxford: Blackwell Publishers.

CASs lacking risk reduction plan in review of domestic violence deaths. (2005, May 23). *Community Action.* Retrieved August 17, 2007, from http://findarticles.com/p/articles/mi_m0LVZ/is_9_20/ai_n13822267.

Centre for Addiction and Mental Health (2004). News media perpetuate the myth about mental illness and violence. Crosscurrent Journal. Retrieved on October 2, 2007, from, http://www.camh.net/Publications/Cross_Currents/Summer_2004/newmediamyth_crcusummer2004.html.

Chamberland, C., Leveille, S. and Baraldi, R. (2006). Gender differences in perceptions of domestic violence. Centre of Excellence for Children's Well-Being, Information Sheet #44E. Retrieved March 25, 2007 from, http://www.cecw-cepb.ca/files/file/en/dvgenderdiff44E.pdf.

Chamberlin, J. (1998). Citizenship rights and psychiatry disability. Psychiatric Rehabilitation Journal, 21 (4), 406 – 408.

Children in Limbo: Report of the Children in Limbo Task Force. (1996). Ottawa:

Sparrow Lake Alliance.

Christie, A., & Mittler, H. (1999). Partnership and core groups in the risk society. Child & Family Social Work, 4 (3), 231-240.

Clarke, T. (1997). The transnational corporate agenda behind the Harris regime. In D. Ralph, A. Régimbald & N. St-Amand (Eds.), Open for Business, Closed to People. (p. 28-36). Halifax: Fernwood Publishing.

Collaboration Agreement for the Children's Aid Societies and Violence Against Women Agencies of Toronto (2004, April). Retrieved June 16, 2007 from www.cassa.on.ca/SC/casvawcollagtrning.doc.

Cornwall, A. & Gaventa, J. (2001). From users and choosers to makers and shapers: Repositioning participation in social policy. Brighton, England: Institute for Development Studies.

Cradock, G. (2004). Risk, Morality and Child Protection: Risk calculation as guides to practice. Science, Technology & Human Values, 29 (3), 314-331.

Crane, N. (1998). A Toronto Star report exposed serious flaws in Ontario's child protection system. Some social workers say the simplistic coverage bring new risks to vulnerable children. Ryerson Review of Journalism, Spring. Retrieved April 15, 2007, from http://www.rrj.ca/issue/1998/spring/254.

Culpitt, I. (1999). Social Policy and Risk. London: Sage Publications.

Curry-Stevens, A. (2006). Rooting social policy advocacy in social movements: Adapting to the demise of rationality in the policy-making process. Canadian Review of Social Policy, 56, 113-130.

Dawson, J. (2006). Fault-lines in community treatment order legislation. International

Journal of Law and Psychiatry, 29, 482-494.

Dawson, J., Romans, S., Gibbs, A., & Ratter, N. (2003). Ambivalence about community treatment orders. International Journal of Law and Psychiatry, *26*, 243 – 255.

Deighton, S. (1997, April 21). Time for province to take mental illness seriously. The Ottawa Citizen, p. D5.

De Montigny, G. (2003). Textual regulation of child welfare. Canadian Review of Social Policy, 52, 33-50.

Douglas, M. (1992). Risk and Blame: Essays in Cultural Theory. London: Routledge.

Douglas, M. (1986). Risk Acceptability According to the Social Sciences. London: Routledge and Kegan Paul.

Dumbrill, G. (2005, July). Child Welfare in Ontario: Developing a Collaborative Intervention Model. Position Paper submitted by the Provincial Project Committee on Enhancing Positive Worker Interventions With Children and their Families in Protection Services. Toronto, Ontario.

Dutton, D. G. (2006). Risk Assessment. In Donald G. Dunton (Ed.), Rethinking Domestic Violence. (pp. 273 – 287). Vancouver: UBC Press.

Edwards, R., & Glover, J. (2001). Risk and Citizenship: Key Issues in Welfare. London: Taylor & Francis Group.

Elliot, A. (2002). Beck's sociology of risk: A critical assessment. Sociology, 36 (2), 293 – 315.

Evans, P. (2002). Downloading the welfare state, Canadian style. In G. Schaffner-Goldberg & M. Rosenthal (Eds.), Diminishing welfare: A cross-national study of social provision. Connecticut: Auburn House.

Febbraro, A. R. (1994). Single mothers "at risk" for child maltreatment: An appraisal of person-centered interventions and a call for emancipatory action. *Canadian Journal of Community Mental Health, 13 (2),* 47 – 60.

Filippelli, J., & Goodman, D. (2001). Child welfare and civil liability in the 21st century: Issues and next steps. Canadian Social Work. Retrieved October 18, 2006 from http://www.casw-acts.ca/library/goodman_abs_e.pdf.

Foucault, M. (1977). Power/Knowledge: Selected interviews and other writings. In P. Rabinov (Ed.), The Foucault reader. New York: Pantheon Books.

Fox, N. J. (1999). Postmodern reflections on 'risk', 'hazards' and life choices. In D. Lupton (Ed.), Risk and Socio-cultural theory. Cambridge: Cambridge University Press.

George, A. L., & Bennett, A. (2005). Case Studies and Theory Development in Social Sciences. Chicago: MIT Press.

Ghosh, J. (2002). Globalization, export-oriented employment for women and social policy: A case study of India. Social Scientist, 30 (11/12), 17-60.

Giddens, A. (1990). The Consequences of Modernity. Cambridge: Polity Press.

Giddens, A. (1999). BBC Reith Lectures. BBC Radio 4.

Gough, P., Trocmé, N., Brown, I., Knoke, D., & Blackstock, C. (2005). Pathways to the overrepresentation of Aboriginal children in care. Centre of Excellence in Child Welfare Information Sheet, #23E. Retrieved March 25, 2007, from http://www.cecw-cepb.ca/files/file/en/AboriginalChildren23E.pdf.

Goodwin, S. (1997). Independence, risk and compulsion: Conflicts in mental health policy. Social Policy and Administration, 31 (3), 260-273.

Green, D. (2004). The Risk Society and the Protection of Rights: Implication for an ethical practice. Forum on Risk and Right: Redressing the Imbalance. Retrieved August 20, 2006, from www.publicadvocate.vic.gov.au.

Grove, W. M., & Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical-statistical controversy. Psychology, Public Policy, and Law, 2, 293-323.

Guba, E. G., & Lincoln, Y. S. (1989). Fourth Generation Evaluation. London: Sage Publications.

Hannah-Moffat, K. (1999). Moral agent or actuarial subject: Risk and Canadian women's imprisonment. Theoretical Criminology, 3 (1), 71-95.

Heckert, D. A., & Gondolf, E. W. (2004). Battered women's perceptions of risk versus risk factors and instruments in predicting repeat reassault. *Journal of Interpersonal Violence, 19(7)*, 778-800.

Hilton, N. Z., Harris, G. T., Rice, M. E., Lang, C., Cormier, C. & Lines, K. J. (2005). A brief actuarial assessment for the prediction of wife assault recidivism: The Ontario Domestic Assault Risk Assessment. Psychological Assessment,16, 267–275.

Hilton, Z. N., & Harris, G. T. (2005). Predicting wife assault: A critical review and implications for policy and practice. Trauma, Violence and Abuse. 6 (1), 3-23.

Hilton, Z. N. (2004, Winter). What can we do about domestic murders? Mental Health Centre Penetanguishene, Research Department. Retrieved June 23, 2007, from http://www.mhcva.on.ca/entrenouspdf/Winter_2003_2004/Page11.pdf.

Houston, S., & Griffiths, H. (2000). Reflections on risk in child protection: Is it time for a

shift in paradigms? Child and Family Social Work, 5, 1-10.

Hudson, B. (2006). Beyond white man's justice: Race, gender and justice in late modernity. Theoretical Criminology, 10 (1), 29-47.

Hudson, B., & Bramhall, G. (2005). Assessing the 'Other': Constructions of 'Asianness' in risk assessments by probation officers. The British Journal of Criminology, 45, 721 – 740.

Inquest into starved baby reviews case worker's training (2001, February 27). CBC news. Retrieved on September 9, 2007, from http://www.cbc.ca/news/story/2001/02/27/tor_jordan022701.html.

Iversen, R. R., Gergen, K .J., & Fairbanks, R. P. (2005). Assessment and social construction: Conflict or Co-Creation? British Journal of Social Work, 0, bch200v1.

Jefferson, T. (1994). Theorising Masculine Subjectivity, In T. Newburn & E. Stanko (Eds.). Just Boys Doing Business? Men, Masculinities and Crime. London: Routledge.

Kanani, K., Regehr, C., & Berstein, M. M. (2002). Liability considerations in child welfare lessons from Canada. Child Abuse and Neglect, 26, 1029-1043.

Kasperson, R. E., Renn, O., Slovic, P., Brown, H. S., Emel, J., Goble, R., Kasperson, J. X., & Ratick, S. (1988) The social amplification of risk: A conceptual framework. Risk Analysis, 8 (2), 177-187.

Kemshall, H. (2002). Risk, Social Policy and Welfare. Buckingham: Open University Press.

Kemshall, H., Parton, N., Walsh, M., & Waterson, J. (1997). Concepts of risk in relation

to organizational structure and functioning within the personal social services and probation. Social Policy and Administration, 31 (3), 213 – 232.

King, C.B., Leschied, A.W., Whitehead, P.C., Chiodo, D. & Hurley, D. (2003, October). Child Protection Legislation in Ontario: Past, Present and Future? Education and Law, 13(1), 105 - 126.

Knoke, D. & Trocmé, N. (2004). Risk assessment in child welfare. Centre of Excellence for Child Welfare, Information Sheet #18E. Retrieved March 25, 2007, from http://www.cecw-cepb.ca/files/file/en/RiskAssessment18E.pdf.

Kufeldt, K., Simard, M., Thomas, P., & Vachon, J. (2005). A grassroots approach to influencing child welfare policy. Child and Family Social Work, 10, 305 – 314.

Kropp, P. R., Hart, S. D., Webster, C. D., & Eaves, D. (1994). Manual of the Spousal Assault Risk Assessment Guide (2nd ed). Vancouver, Canada: British Columbia Institute on Family Violence.

Kumove, L. (July 14, 1997). Paint-by-numbers child welfare. Community Action, v 12, p. 1.

Langan, M. (1998). Welfare: Needs, Rights and Risks. New York: Routledge Publishing.

Lash, S. (1993). Reflexive modernization: The aesthetic dimension. Theory Culture Society, 10, 1-23.

Laucius, J. (2006, April 8). We should be outraged these deaths are continuing unabated. The Ottawa Citizen, p. E.1.

Legislative Assembly of Ontario. (2005, December 13). Committee Transcripts: Standing Committee on Social Policy. Bill 210, Child and Family Services Statute Law Amendment Act. Retrieved on February 20, 2007, from

http://www.ontla.on.ca/committee-proceedings/transcripts/files_html/2005-12-13_SP004.htm

Legislative Assembly of Ontario. (2000a, May 29). Committee Transcripts: Standing Committee of General Government. Bill 68, Brian's Law (Mental Health Legislative Reform). Retrieved February 20, 2007, from http://www.ontla.on.ca/committee-proceedings/transcripts/files_html/2000-05-29_G015.htm.

Legislative Assembly of Ontario. (2000b, May 15). Committee Transcripts: Standing Committee of General Government. Bill 68, Brian's Law (Mental Health Legislative Reform). Retrieved February 20, 2007 from http://www.ontla.on.ca/web/committeeproceedings/committee_transcripts_details.do?locale=en&Date=20000515&ParlCommID=847&BillID=&Business=Bill+68%2C+Brian%27s+Law+%28Mental+Health+Legislative+Reform%29%2C+2000

Legislative Assembly of Ontario. (2000c, June 20). House Proceedings L075A. Bill 68, Brian's Law (Mental Health Legislative Reform). Retrieved February 20, 2007 from http://www.ontla.on.ca/house-proceedings/transcripts/files_html/2000-06-20_L075A.htm#P597_126564.

Legislative Assembly of Ontario. (1999, May 3). House Proceedings L006B. Bill 6, Child and Family Services Act (Child Welfare Reform). Retrieved on February 20, 2007, from http://www.ontla.on.ca/web/house-proceedings/house_detail.do?Date=1999-05-03&Parl=36&Sess=3&locale=en.

Leonard, P. (1997). Postmodern Welfare. London: Sage.

Leschied, A.W., Chiodo, D., Whitehead, P.C., & Hurley, D. (2003, October). The

association of poverty with child welfare services and child and family clinical outcomes. London: University of Western Ontario.

Leslie, B., & O'Connor, B. (2002). What are the products of the Ontario Risk Assessment Tool? Ontario Association of Children's Aid Societies, 46 (4), 2-9.

Living on the Ragged Edges, Immigrants, refugees and homelessness in Toronto – Forum Summary (2003, March 28). Toronto: Metro Hall Conference.

Lupton, D. (1999). Introduction: Risk and socio-cultural theory. In D. Lupton (Ed.), Risk and Socio-Cultural Theory. Cambridge: Cambridge University Press.

Lupton, D., & Tulloch, J. (2002). 'Life would be pretty dull without risk': voluntary risk-taking and its pleasures. Health, Risk and Society, 4 (2), 113-24.

Mackey, E. (1999). Constructing an engendered nation: Risk, race and rationality in Australia's native title debate. In D. Lupton (Ed.), Risk and Socio-Cultural Theory. (pp. 108-130). Cambridge: Cambridge University Press.

Maton, K. I., & Salem, D. A. (1995). Organizational characteristics of empowering community settings: A multiple case study approach. American Journal of Community Psychology, 23 (5), 631-656.

Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. Community Mental Health Journal, 36 (3), 315 – 328.

Metro Toronto Children's Aid Society. Fast Fact. Retrieved on October 3, 2007, from http://www.torontocas.ca/2007/03/08/child-poverty-in-ontario-on-the-increase-campaign-2000-calls-for-ontario-poverty-reduction-strategy.

Ministry of Citizenship and Immigration. (2005). Domestic Violence Action Plan for

Ontario. Retrieved July 25, 2007, from http://www.citizenship.gov.on.ca/owd/english/resources/publications/docs/dvap.pdf.

Ministry of Community and Social Services Backgrounder. (2005, March 8). A Domestic Violence Action Plan for Ontario. Retrieved September 6, 2007, from http://www.mcss.gov.on.ca/mcss/english/news/backgrounders/050308.htm.

Ministry of Community and Social Services. (October 1997). Risk Assessment Model for Child Protection in Ontario.

Ministry of Community Safety and Correctional Services Press Release. (2004, November 12). McGuinty government launches new tool to assess risk of domestic assault..Queen's Printer for Ontario. Retrieved June 28, 2007, from http://ogov.newswire.ca/ontario/GPOE/2004/11/12/c2408.html?lmatch=&lang=_e.html.

Ministry of Health and Long-Term Care Press Release. (2000, March 22). Ontario to introduce stronger mental health law this spring to help patients and protect communities. Toronto: Publication of the Province of Ontario.

Ministry of Health and Long-Term Care Public Information. (2000). Brian's Law (Mental Health Legislative Reform) Community Treatment Orders. Retrieved on March 30, 2007, from http://www.health.gov.on.ca/english/public/pub/mental/treatment_order.html

Ministry of Health Promotion. (2006a). Ontario's Action Plan for Health Eating and Active Living. Toronto: Queen's Printer for Ontario, Province of Ontario.

Ministry of Health Promotion. (2006b). Smoke-Free Ontario Strategy. Retrieved on

October 5, 2006, from http://www.mhp.gov.on.ca.

Monsebraaten, L. (2000, June 23). Risk assessment by police urged; Men charged with domestic abuse can be stopped, counselor says. The Toronto Star, p. A. 19.

Moore, D. & Hannah-Moffat, K. (2002). Correctional Renewal Without the Frills: The Politics of "Get Touch" Punishment in Ontario. In J. Hermer and J. Mosher (Eds.), Disorderly People: Law and the Politics of Exclusion in Ontario. (pp. 105-121). Halifax: Fernwood Publishing.

Munro, E. (2004). A simpler way to understand the results of risk assessment instruments. Children and Youth Services Review, *26, 9*, 877-887.

Munro, E., & Rumgay, J. (2000). Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry, 176, 116-120.

Nelson, G. (2006). Mental health policy in Canada, In A. Westhues (Ed.), Canadian Social Policy: Issues & Perspectives, Fourth Edition. (pp. 244 – 266). Waterloo: Wilfrid Laurier Univeristy Press Canada.

Nelson, R. (2004, September 2). Mental Health in Ottawa: An "orphaned child" – Summary of Panel Discussion on Mental Health Services in Ottawa. Health and Social Services Advisory Committee. Retrieved on September 14, 2007, from http://ottawa.ca/calendar/ottawa/citycouncil/occ/2004/10-13/hrss/ACS2004-CCV-HSS-0003.htm.

Newman, J., & Clarke, J. (1994). Going about our business? The managerialisation of public services. In J. Clarke, A. Cochrane and E. McLaughlin (Eds.), Managing Social Policy. London: Sage.

O'Brien, A-M., & Farrell, S. (2005). Community treatment orders: Profile of a Canadian

experience. Canadian Journal of Psychiatry, 50, 27-30.

O'Malley, P. (2006). Risk and criminology. In S. Walklate & G. Mythen (Eds.), *Beyond the risk society: Critical reflections on risk and human security.* New York, Open University Press.

O'Malley, P. (2002). Globalizing risk? Distinguishing styles of 'neoliberal' criminal justice in Australia and the USA. Criminal Justice, 2 (2), 205 – 222.

O'Malley, P. (1992). Risk, power, and crime prevention. Economy and Society, 21 (3), 252-275. Office of the Chief Coroner (2005). Domestic Violence Death Review Committee, Annual Report to the Chief Coroner, submitted by Chair Al. J.C. O.Marra. Retrieved on August 17, 2007, from http://www.mcscs.jus.gov.on.ca/English/publications/comm_safety/DVDRC_2005.pdf.

Ontario Aboriginal Health Advocacy Initiative. (2001, October). Issues Paper on The Mental Health Reform Process in Ontario. Ontario Federation of Indian Friendship Centres. Retrieved on October 20, 2007, from http://www.ofifc.org/oahai/Acrobatfiles/mentalhealth.pdf.

Ontario Association of Children's Aid Societies. (2000). Risk assessment model for child protection in Ontario: Eligibility spectrum, risk assessment model for child protection in Ontario. Toronto, Ontario.

Ontario Association of Children's Aid Societies. (1997). Developing a common risk assessment tool for use in child welfare. Journal of the Ontario Association of Children's Aid Societies, 4 l(l), 8.

Ontario Association of Children's Aid Societies. (1996). [No longer available in online

publications]

Ontario Association of Interval Transition Houses. (2004, November 25). An Open Letter to Premier Dalton McGuinty and the Ontario Government. Retrieved on September 12, 2007, from http://www.oaith.ca/pdf/OAITH_Open_Letter_to_Dalton_McGuinty.pdf.

Ontario Association of Interval Transition Houses, Press Release. (2003, May 20). Province of Ontario gives PR response to Hadley implementation – women's shelters. Retrieved on August 17, 2007, from http://www.whiteribbon.ca/press/default.asp?aID=892.

Ontario Association of Interval Transition Houses. (1999). Ten Years for Montreal: Still Working for change. Toronto: Ontario Association of Interval and Transition Houses.

Ontario Association of Interval Transition Houses. (1996, November). Locked In, Left Out: Impacts of the Progressive Conservative Budget Cuts and policy initiatives on abused women and their children in Ontario. Retrieved on September 20, 2007, from http://www.oaith.ca/pdf/Locked.pdf.

Ontario Council of Agencies Serving Immigrants. (2006, November). Prevention of Domestic Violence Against Immigrant Women: Prevention Through Intervention Training, Resource Book. Government of Ontario, Ontario Women's Directorate. Retrieved on February 20, 2007, from http://www.ocasi.org.

Ontario Domestic Assault Risk Assessment (2005, Handbook). General Scoring Criteria. Penetanguishene: Research Department, Mental Health Centre.

Ontario Mental Health Act (2000). Bill 68 (Brian's Law), R.S.O. 1990, c. M-7.

O'Reilly, R. L. (1998). Sick, untreated and on the streets. The Globe and Mail, p. A15.

Parton, N., & Mathews, R. (2001). New directions in child protection and family support in Western Australia: A policy initiative to re-focus child welfare practice. Child and Family Social Work, 6 (2), 97-113.

Parton, N. (1998). Risk, advanced liberalism and child welfare: The need to rediscover uncertainty and ambiguity. British Journal of Social Work, 28 (1), 5-27.

Parton, N., Thorpe, D., & Wattam, C. (1997). Child Protection: Risk and the Moral Order. Basingstoke: Macmillan Press.

Parton, N. (1996) Social Work, Risk and "the Blaming System". In N. Parton (ed.) Social Theory, Social Change and Social Work. London: Routledge & Kegan Paul.

Powell, J. (2003). Risk and youth: A critical sociological narrative. International Journal of Sociology and Social Policy, 23 (12), 81-94.

Prior, L. (2003). Using Documents in Social Research: Introducing Qualitative Methods. London: Sage Publications.

Psychiatric Patient Advocate Office (2003, April). Community Treatment Orders. Retrieved on March 14, 2007, from http://www.ppao.gov.on.ca/inf-com.html.

Regehr, C., Bernstein, M. M., & Kanani, K. (2001). Liability for child welfare social workers. Canadian Social Work, 3(2), 57-67.

Rice, J. J. & Prince, M. J. (2000). Changing Politics of Canadian Social Policy. Toronto: University of Toronto Press.

Rivers, B., Trocme, N., Goodman, D., & Marwah, I. (2002). Reporting and beyond: Current trends in childhood neglect call for broader reforms. Voices for Children

Newsletter – Child Abuse and Neglect in Ontario. Voices for Children: Toronto, ON.

Robson, K. (2005). "Canada's most notorious bad mother": the newspaper coverage of the Jordan Heikamp inquest. The Canadian Review of Sociology and Anthropology, 42 (2), 217 – 233.

Rose, N. (1999). Powers of Freedom: Reframing Political Thought. Cambridge: Cambridge University Press.

Rose, N. (1996). Governing 'advanced' liberal democracies. In A. Barry, T. Osborne and N. Rose (Eds.), Foucault and Political Reason: Liberalism, Neo-liberalism and Rationalities of Government. London: UCL Press.

Ryan, T. (1996). Risk management and people with mental health problems. In H. Kemshall & J. Pritchard (Eds.), Good Practice in Risk Assessment and Risk Management, Volume 1. London: Jessica Kingsley Publishers.

Scourfield, J. & Welsh, I. (2003). Risk, reflexivity and social control in child protection: New times or same old story? Critical Social Policy, 23 (3), 398-420.

Simpson, A.I.F., Mckenna, B., Moskowitz, A., Skipworth, J., & Barry-Walsh, J. (2004). Homicide and mental illness in New Zealand, 1970 – 2000. British Journal of Psychiatry, 185 (5), 394.

Stalker, K. (2003). Managing risk and uncertainty in social work. Journal of Social Work, 3 (2), 211-233.

St. Pierre, D. (2002, January 20). Resolve CAS cash crunch, city tells province. The Sudbury Star, p. A1.

Statistics Canada (2004, July). Family Violence in Canada. A Statistical Profile 2004.

Canadian Centre for Justice Statistics. Ministry of Industry. Retrieved on August 12, 2007, from http://www.statcan.ca/english/freepub/85-224-XIE/85-224-XIE2004000.pdf.

Statistics Canada (1993, November 18). The Violence Against Women Survey. The Daily. Retrieved on August 17, 2007, from http://www.statcan.ca/english/Dli/Data/Ftp/vaw.htm.

Taylor, B. J. (2006). Risk management paradigms in health and social services for professional decision-making on the long-term care of older people. British Journal of Social Work, 36, 1411-1429.

Taylor-Gooby, P., Dean, H., Munro, M., and Parker, G. (1999). Risk and the welfare state. British Journal of Sociology, 50 (2),177-194.

The Children in Limbo Task Force (2000, November). A Canadian Approach to Permanency Planning and Management for Children in Long term Care. Retrieved on March 20, 2007, from http://www.sparrowlake.org/taskforces/reports/index.htm.

Top priority to protecting children: Eight Hamilton children have died in the last 18 months. A recent Toronto Inquest into a child's death called for a major overhaul of the child protection system in Ontario. (1997, May 21). The Hamilton Spectator, p. A11.

Trocmé, N., & Lindsey, D. (1996). What can child homicide rates tell us about the effectiveness of child welfare services? Child Abuse & Neglect, 20*(3),* 171-184.

Trocmé, N., Mertins-Kirkwood, B., MacFadden, R., Alaggia, R. & Goodman, D. (1999).

Ontario Risk Assessment Model, Phase 1: Implementation and Training, Final Report. Centre of Excellence for Children's Well-Being. Toronto: Centre for Applied Social Research, Bell Canada Child Welfare Research Unit, Faculty of Social Work, University of Toronto.

United Nations. (1993, December 20). Declaration on the elimination of violence against women. Proceedings of the 85th Plenary Meeting. Geneva: General Assembly.

Voices for Children (2005, October). Just another dramatic statistic? Looking behind and beyond the startling rise in Canadian child abuse numbers. Interview with Nico Tromcé. Retrieved on February 20, 2007, from http://www.voicesforchildren.ca/documents/voices_for_children_%20child-abuse-incidence-study-dr.-trocme-interview.pdf.

Walmsley, C. (2004). Talking about the Aboriginal Community: Child protection practitioners' views. First Peoples Child & Family Review, 1 (1), 63-71.

Waterson, J. (1999). Redefining community care social work: Needs or risks led? Health and Social Care in the Community, 7 (4), 276-279.

Wharf, B. & McKenzie, B. (2004). Connecting Policy to Practice in the Human Services, Second Edition. Toronto: Oxford University Press.

Whitehead, P. C., Chiodo, D. G., Leschied, A. W., & Hurley, D. (2004). Referrals and admissions to the Children's Aid Society: A test of four hypotheses. *Child and Youth Care Forum, 33 (6),* 425 – 440.

Whitnall, C. (2004, November 15). Assault assessment lauded. Lindsay Daily Post, p. 1 (front).

Williams, K. R. & Houghton, A. B. (2004). Assessing the risk of domestic violence

reoffending: A validation study. Law and Human Behavior, 28, 437-455.

Wilton, R. D. (2004). More responsibility, less control: Psychiatric survivors and welfare state restructuring. Disability & Society, 19 (4), 371 – 385.

Woman and Abuse Welfare Research Project. (2004, April 5). Walking on Eggshells: Abused Women's Experiences of Ontario's Welfare System. Final Report of Research Findings. Retrieved on October 5, 2007, from http://dawn.thot.net/walking-on-eggshells.htm.

Yin, R. K. (1988). Case Study Research: Design and Methods. London: Sage Publications.

Appendix: List of specific organizations and agencies searched for documents

Access Alliance Multicultural Community Health Centre
Access to Justice Network
Amnesty International Canada
Assembly of First Nations
Association of Native Child and Family Services of Ontario
Canadian Centre for Policy Alternatives
Canadian Council of Social Development
Canadian Mental Health Association
Centre for Addiction and Mental Health
Centre of Excellence for Research on Immigration and Settlement (CERIS)
Centre for Research on Violence against Women and Children
Centre of Excellence for Child Welfare
COSTI (formerly Centro Organizzativo Scuole Tecniche Italiane) Immigrant Services
Disabled Women's Network Ontario
Federal-Provincial Working Group on Child and Family Services
First Nations Child and Family Caring Society
International Social Service Canada
Joint Center of Excellence for Research on Immigrant and Settlement
National Child and Family Advocacy Council of Canada
National Clearinghouse on Family Violence
Native Child and Family Services of Toronto
North American Resource Centre for Child Welfare
Ontario Association of Interval and Transition Houses
Office of Child and Family Service Advocacy
Ontario Aboriginal Health Advocacy Initiative
Ontario Association of Children's Aid Societies
Ontario Community Support Association
Ontario Council of Agencies Serving Immigrants
Ontario Federation of Indian Friendship Centres
Ontario Human Rights Commission
Psychiatric Patient Advocacy Office
Queen Street Patients Council
The FREDA Centre for Research on Violence against Women and Children
The No Force Coalition
Schizophrenia Society of Ontario
Voices for Children
White Ribbon Campaign
Women Abuse Council of Toronto
Woman Against Violence Against Women
Youth in Care