Dilemmas in child protection

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Chapter 3

Improved decision making about suspected child maltreatment: Results of structuring the decision process

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Abstract

ORBA is a method that aims to improve decision making about suspected child maltreatment in Advice and Reporting Centres of Child Abuse and Neglect (ARCCAN). It structures the process of judging and deciding and makes it explicit by distinguishing separate steps, and by identifying the necessary information to consider and the judgments and decisions to be made in each step.

In this study it was investigated whether decision making in ARCANNs has become more systematic and transparent, since the implementation of ORBA. The contents of 100 case records from 2010 were analyzed, after ORBA had been implemented in all agencies, to see to what extent these records contained relevant information, and to what extent process steps and rationales for decisions could be identified. This was compared with the contents of 60 records of three agencies from 2005, before ORBA was implemented.

Analyses showed that in 2010 records more often contained relevant information and process steps that ORBA prescribes than in 2005. It was salient however that rationales for judgments and decisions were still often absent in 2010. While after ORBA's introduction the process has clearly become more systematic and more transparent, compared to 2005, more improvements are still called for, specifically in explicitly motivating decisions. Explanations and implications of our results are discussed.

1. Introduction

Judgments and decisions about suspected child maltreatment are delicate and should be made with great care. Decisions often have a large impact on the lives of children involved and their parents or caretakers. Therefore, judgments and decisions should be made in a transparent way and have clear rationales. At the same time, decision making in these cases is often complex. Information is often incomplete and not factual, and frequently contains inconsistencies. Decisions have to be made under time pressure and the available options usually all have disadvantages. Families often do not realize how serious the problems are, and they may initially be reluctant rather than motivated to be helped. In such complex situations judgments and decisions may be biased due to a tendency to rely on personal experiences, subjective preferences, and confirmatory information (see e.g. Arad-Davidzon & Benbenishty, 2008; Garb, 1998, 2005; Munro, 1999).

In the Netherlands, suspicions of child maltreatment should be reported to special agencies called Advice and Reporting Centres of Child Abuse and Neglect (ARCCAN; AMK in Dutch). These agencies advise informers, investigate cases, and refer cases to welfare organizations or child protection authorities for voluntary or involuntary interventions. There are fifteen ARCCANs, one in each larger region and in the largest cities. Social workers in ARCCANs first judge the severity and urgency of reported cases. Then they must decide between different courses of action: to advise informers how to provide support to a child or family, to tell informers to gather more information first, to start their own investigation to determine whether a child is indeed maltreated, or to immediately refer a case to the child protection authorities. In cases that are investigated, workers are expected to conclude whether maltreatment actually seems to take place and whether the case should be referred to a welfare organization or a child protection agency. Workers do not decide about cases individually, but they discuss them in an interdisciplinary team at least twice. A physician, a behavioural scientist or both are involved in the decisions about the actions to be taken.

Several studies have shown that previously decision processes in ARCCANs were suboptimal, in the sense that they lacked structure, were idiosyncratic, and lacked transparency (Bartelink, 2006; Inspection Youth Care, 2005; Van Gastel, Ten Berge, & Wolzak, 2009). To improve the quality of decision making, in 2006 a method for investigation, risk assessment, and decision making, named ORBA, was developed in close collaboration between researchers and practitioners. ORBA combines evidence-based scientific knowledge and practice-based knowledge from four theoretical and practical approaches: 1) effective child protection (Munro, 2002), 2) risk/general assessment and decision-making model (Dalgleish, 1997), 3) signs of safety (Turnell & Edwards, 1999) and 4) deciding on interventions in families (Van Montfoort, 2004). All these approaches emphasize the importance of making explicit judgments and decisions about the extent of (potential) danger for the child as well as the possibilities to guarantee safety and protection of the child in the family, through a structured decision-making process. First, researchers made an analysis of the decision process. Key decisions and underlying judgments were identified. Then, ORBA was further developed with practitioners in three pilot locations. On each pilot location eight to ten practitioners participated in ten meetings. These meetings concentrated on explication of the decision-making process, testing of existing instruments and development of easy to use checklists about child safety, risk and protective factors, and on effective interventions (Ten Berge & Vinke, 2006a, 2006b).

ORBA structures assessment and decision making in cases of suspected child maltreatment, aiming to make the process less vulnerable to subjective factors. ORBA's specific aims are to make

the decision process more systematic, transparent, uniform, and efficient. Systematic means that all relevant information is collected and considered, and that there are clear distinctions between the collection, organization, and analysis of information, and judging and deciding. Transparent means that it is clear to others what information is considered, what judgments and decisions are made, and what arguments are used to support those judgments and decisions. ORBA provides checklists for separate phases in the decision process (e.g. necessary information to gain from informers, for interdisciplinary decision making) and it offers a safety and risk assessment instrument called LIRIK. New workers in ARCCANs follow a training in working according to the ORBA-guidelines, leading to certification. Between 2007 and 2009 the method was implemented in all fifteen ARCCANs, and ORBA has been integrated in the digital case record system that is used by all ARCCANs.

A user evaluation of ORBA showed positive results (Ten Berge & De Baat, 2009). Practitioners believed that ORBA focuses on relevant judgments and decisions, that it helps them to structure their decision making process and to make it more transparent, and that it results in a good and complete overview of a family situation. Similarly, in an explorative study, clinicians judged structured risk assessment methods for child protection decisions as potentially useful (Bolton & Lennings, 2010). However, it has not yet been investigated whether ORBA actually results in a better decision making process.

It has been argued that in complex cases structuring the decision process will improve the quality of decision making, make decision makers less prone to biases, and lead to better interventions choices (e.g. Bolton & Lennings, 2010; Hodgkinson, Bown, Maule, Glaister, & Pearman, 1999; Léveillé & Chamberland, 2010; Munro, 2008; Shlonsky & Wagner, 2005; Wagner, Johnson, & Caskey, 2001). Other methods for structured decision making in child protection are the Victorian Risk Framework (VRF) in Australia (Armitage, Boffa, & Parker, 1999), and the Structured Decision Making (SDM) model in the US (Children's Research Center, 1999). These methods also assume that decision making will become more transparent and uniform when the process is structured and when workers are instructed about what information they need in order to make specific decisions. So far it has not been established whether these methods indeed do have the desired effects. Research on these methods focuses on the reliability and validity of the risk assessment instruments of the SDM model (Johnson, 2004; Loman & Siegel, 2004), or on a specific outcome (Wagner et al., 2001). For example, Wagner et al. (2001) found that in regions where SDM had been implemented, out-of-home placements of children appear more stable, compared to regions where SDM had not been implemented. The Framework for the Assessment of Children in Need and their Families (FACNF) is a broader model for child welfare and protection services that includes structured case assessments. A review of studies evaluating the effects of the FACNF indicates positive results regarding the quality of assessments made and intervention planning, but also concludes that there is yet too little evaluative research (Léveillé & Chamberland, 2010).

The aim of the current study was to see whether ORBA indeed leads to a more systematic and transparent decision making process about cases of suspected child maltreatment. This is an important and as yet unanswered question. This study is part of a larger research project into the effects of ORBA on the quality of the decision making processes in ARCCANs (Ten Berge, Bartelink, & De Kwaadsteniet, 2011). Materials were the contents of case records of ARCCANs in 2010, after ORBA had been implemented in all regions. Of course, case records do not show workers' actual cognitive decision processes. However, the decision processes are required to be transparent to

others, that is: clients (children, and/or their parents), colleagues, and referral partners. Thus, case records should reflect the decision processes from the moment that a case is reported, through investigation, until the decision that a case is closed. This means that records should show what information is collected and why, what arguments are considered in judging and deciding, and what judgments and decisions are made. Analyses in this study concerned 1) content aspects; 2) process aspects; and 3) rationales for conclusions and decisions in 2010 records. Results were compared with those of similar analyses of case records in 2005, before ORBA was implemented.

2. Method

In a previous study 60 case records from 2005 had been analysed. This baseline study preceded the development of ORBA, and was performed at the three pilot locations before they were involved in the development process (Bartelink, 2006). In the current study 100 records from 2010 were analysed. Apart from the same three agencies that had been included before, two additional randomly chosen agencies were included. In each agency, a random sample of 20 records was drawn. Only records of cases in which the agencies had performed an investigation were included, because ORBA was designed specifically for such cases. In 2010, ARCANNs performed investigations in 18076 cases, that is 29% of all 62001 reported cases. Of all reported cases, 12.1%was referred to a child protection authority (either directly or after investigation), and 59% of the investigated cases was referred for voluntary interventions (Jeugdzorg Nederland (Youth Care The Netherlands), 2011). A representativeness check showed that the relative frequencies in which the different kinds of maltreatment occurred in the sample records were similar to those of all investigated cases in 2010. Also, the relative frequencies of maltreatment being confirmed, not confirmed, or disconfirmed were similar in our sample and in all investigated cases (Jeugdzorg Nederland, 2011).

The questionnaire that was used both in 2005 and 2010 to assess the records was based on the initial analysis of the decision process performed for the development of ORBA (Ten Berge & Vinke, 2006b), on youth care protocols (a.o. Baeten, 2004), and on literature about decision making in cases of suspected child maltreatment (e.g. Dalgleish, 1989; Munro, 2008). The questionnaire addressed three main aspects of decision making: content, process, and rationales. In 2010, some questions were added, because records in 2010 were more elaborate than those in 2005, since the digital case record system now explicitly asked for more information. The questions were whether a specific content, process step, or rationale indicated by ORBA could be identified (yes/no). If so, the nature of it was further specified (for the complete questionnaires in Dutch, see Ten Berge et al., 2011). Records were analysed on location. Analysis of one case record took approximately one hour.

The 2010 records were assessed by an independent coder, who was unaware of the goals of this study and of ORBA. This coder also reassessed ten 2005 records, to establish interrater agreement for 2005. Ten 2010 records were also assessed by a second coder to establish interrater agreement. The average Cohen's kappa for the questions about the presence of specific aspects was .62 for 2010, which can be considered good, and .44 for 2005, which can be considered reasonable (Fleiss, 1981). For questions further specifying the nature of information that was identified average proportions of agreement were calculated, because these questions were often left unanswered because specific aspects were absent in records. These proportions were .84 for 2010 and .83 for 2005. On average, the coder who had analysed all 2005 records found aspects to be present slightly more often in 2005 records than the coder who analysed all 2010 records.

3. Results

3.1 Content aspects

It is important that workers collect all relevant information, to systematically arrive at judgments about whether a child is being maltreated and about the necessity and possibilities of voluntary or involuntary interventions. For a transparent process, it is important that this information is reported in the records. Table 1 shows percentages of records from 2005 and 2010 that include the specific content aspects that should be present according to ORBA to allow good judgments and decisions.

In 2010, the nature of the suspected maltreatment was always specified when it was decided to investigate a case. In most cases this was pedagogic neglect (54%), followed by physical neglect (29%), affective neglect or psychological abuse (27%), witnessing domestic violence (27%), physical abuse (25%), and sexual abuse (5%). After the investigation, 88% of the records mentioned the nature of the suspected or confirmed maltreatment again. Most often this was pedagogic neglect (35%), followed by witnessing domestic violence (28%), affective neglect or psychological abuse (16%), physical abuse (12%), physical neglect (10%), and sexual abuse (5%).

Table 1 shows that many important content aspects were present in the 2010 records. Risk assessment elements were more often mentioned than in 2005. In 2010, records more often than in 2005 contained protective factors and an estimation of the likelihood of maltreatment reoccurring. Risk factors were often mentioned both in 2005 and in 2010. On the other hand, relevant information was still lacking on certain aspects in 2010. For example, duration and frequency of maltreatment were hardly ever mentioned, and in many records the chance of a recurrence of maltreatment was not specified, nor were the possible harmful consequences for the child.

Table 1. Content aspects in records in 2005 and 2010 in percentages, and Z-values and two sided p-values of z-tests for independent proportions.

Element	2005	2010	z	p
First decision moment				
Nature of suspected maltreatment	90	100	*	*
Duration of suspected maltreatment	38.3	26	1.606	.108
Frequency of suspected maltreatment	8.3	9	-.0153	.878
Possibilities/limitations informer	11.7	38	-4.119	.000
Appointments role informer	-	87.5		
Risk factors	-	79		
Protective factors	-	69		
Final decision moment				
Nature of suspected maltreatment	100	88	*	*
Duration of suspected maltreatment	-	11.7		
Frequency of suspected maltreatment	-	7.8		
Estimation of chance of recurrence	3.3	46	-7.775	.000
Estimation of (possible) consequences	6.7	14	-1.540	.124
Ability/motivation for change	60	55	0.621	.534
Parents-child interaction	78.3	84	-0.882	.378
Child signals	81.7	87	-0.881	.379
Risk factors in child	-	64		
Protective factors in child	-	31		
Risk factors in parenting	85	87	-0.351	.726
Protective factors in parenting	13.3	36	-3.492	.001
Risk factors in family situation	80	61	2.675	.001
Protective factors family situation	1.7	52	-9.549	.000
Risk factors environment	21.7	30	-1.182	.237
Protective factors environment	13.3	34	-3.207	.001

Note. Empty cells indicate questions that were not part of the questionnaire in 2005. If a proportion is 0 or 100 no z-test can be performed.

3.2 Process aspects

It is important that information is properly organized and analysed, to systematically arrive at judgments and decisions. Workers should evaluate the quantity and nature of the information they have obtained, specify what information is still missing, and indicate how they plan to collect this information. For the transparency of the decision process it is important that these evaluations, as well as the conclusions that are derived and the decisions that are made, are reported in the records. Table 2 shows percentages of case records of 2005 and 2010 that include the specific process aspects that ORBA prescribes.

It is clear from Table 2 that the 2010 records contained many process aspects, and more aspects than in 2005. Use of the risk assessment instrument LIRIK was not reported in all cases. The LIRIK was developed specifically for ORBA to support systematic weighting of relevant information when estimating actual child safety and future risks, and when drawing a conclusion about the child's safety. One agency said that they did use the LIRIK, but they did not include or mention it in the records. Another agency used a different risk assessment instrument, which they did include in their records.

Table 2. Process aspects in records in 2005 and 2010 in percentages, and z-values and two sided p-values of z-tests for independent proportions.

Element	2005	2010	z	p
Judgment amount of information	-	78		
Judgment reliability of the information	-	78		
Urgency judgment at report	-	47		
LIRIK filled in and included in the record	-	46.3		
Research plan included	70	85	-2.171	.030
Conclusions about specific research questions	-	81		
Organization of information	0	94	*	*
Explanations	15	50	-5.147	.000
Conclusion about child maltreatment	100	88	*	*
Conclusion about necessity of help	20	79	-8.971	.000
Conclusion about voluntary basis of help	-	53		
Decision to investigate case	63.3	98	-5.441	.000
Decision to refer to protection authority	13.3	25		
Decision to refer to voluntary care	28.3	52		
Decision to close case	91.7	80	2.185	.029

Note. Some questions were not part of the questionnaire in 2005. Differences between the proportion of files that contained decisions to refer to a child protection authority or to voluntary care depend on the nature of the case, and are therefore not tested. If a proportion is 0 or 100 no z-test can be performed.

In 2010, the case record system provides four standard research questions, which should be investigated in each case. These questions ask whether a child is indeed maltreated, how the problems can be explained, whether help is necessary, and whether necessary help can be on a voluntary basis or should be imposed. While in 2005 all records contained the conclusion whether a child was indeed maltreated, in 2010 this conclusion was absent in 12% of the records. In 51% of the 2010 records child maltreatment was confirmed after investigation, in 26% it was not confirmed, and in 11% of the cases the conclusion was that the child was not maltreated. In 2010 half of the records contained explanations for the problems. A conclusion about the necessity of interventions was more often present in 2010 than in 2005. Further, in 2010 about half of the records contained the conclusion whether interventions could be on a voluntary basis or should be imposed. We note that this conclusion is only relevant in cases where interventions are judged to be necessary.

A well-defined plan for investigation is important to aid the systematic collection of relevant information. In 2010 records more often contained an investigation plan than in 2005, and these plans were much more elaborate, as is shown in Table 3.

In 2005, the plans often only consisted of an enumeration of persons or institutions that should be contacted. In 2010, most investigation plans also contained specific research questions and hypotheses. Further, most 2010 records contained explicit judgments and conclusions about these specific research questions. In 65% of the records all or most of the formulated research questions were answered, in 32% only partial answers were given, and in 3% of the cases the research questions were not answered (in 2005 this had not been assessed).

Table 3. Elements in investigation plans in 2005 and 2010 in percentages, and z-values and two sided p-values of z-tests for independent proportions.

Element	2005	2010	z	p
Concrete question(s)/hypothesis(es)	0	69.4	*	*
Information needed	16.7	67.1	-6.556	.000
Institutions/persons to contact	66.7	80	-1.571	.116
Include siblings under age 12 in investigation	4.8	34.1		

Note. Whether siblings under age 12 should be included in the investigation depends on whether a child has siblings of this age; differences between proportions of files that contain this element are therefore not tested. If a proportion is 0 or 100 no z-test can be performed.

The decision to investigate a case was present in almost all records. The decision to refer a case to a child protection agency or to a (child) welfare agency was more often found in 2010 than in 2005, but these decisions depend on the nature of a case.

We conclude that many process steps were present in case records in 2010, and more often than in 2005. However, it is remarkable that some crucial conclusions were still absent in the 2010 records.

3.3 Rationale for conclusions and decisions

For the transparency of the decision process it is crucial that workers give a rationale for their conclusions and decisions and record these. Table 4 shows percentages of case records of 2005

and 2010 that contain a rationale for the conclusions, and the kind of arguments that were used. Table 5 shows this for the decisions. Only the conclusion whether a child was indeed maltreated was motivated more often in 2010 than in 2005. Decisions appeared to be motivated less often in 2010, except the decision to refer to a welfare organization.

Table 4. Rationale of conclusions in records in 2005 and 2010 in percentages, and z-values and two sided p-values of z-tests for independent proportions.

Element	2005	2010	z	p
Rationale conclusion about child maltreatment				
Nature and seriousness of problems	6.7	38.6		
Consequences for child	1.7	4.5		
Explanations	1.7	17		
Risk factors	1.7	26		
Protective factors	0	8		
Other	0	12.5		
No rationale	93.3	39.8	8.720	.000
Rationale conclusion necessity of help				
Nature and seriousness of problems	41.7	16.5		
Consequences for child	33.3	5.1		
Explanations	8.3	11.4		
Risk factors	0	11.4		
Protective factors	0	12.7		
Other	16.7	6.3		
No rationale	33.3	54.4	-1.434	.152
Rationale conclusion voluntary of interventions				
Nature and seriousness of problems	7.5			
Consequences for child	0			
Explanations	3.8			
Risk factors	9.4			
Protective factors	9.4			
Motivation parents/caretakers	32.1			
Other	11.3			
No rationale	41.5			

Note. In 2005 conclusions about the possibilities of voluntary interventions were not investigated. Percentages concern only those records that contain a specific conclusion.

Table 5. Rationale of decisions in records in 2005 and 2010 in percentages, and z-values and two sided p-values of z-tests for independent proportions.

Element	2005	2010	z	p
Arguments for decision to investigate a case				
Nature and seriousness of problems	77.9	41.7		
Consequences for child	19.4	8.3		
Explanations	5.6	3.3		
Risk factors	19.4	56.7		
Protective factors	0	5		
Necessity of help	5.6	5		
(Im)possibilities of help	2.8	5		
Other	25	23.3		
No rationale	2.6	39.8	-6.669	.000
Arguments for decision to refer to child protection authority				
Nature and seriousness of problems	75	57.9		
Consequences for child	37.5	15.8		
Explanations	0	10.5		
Risk factors	75	57.9		
Protective factors	0	0		
Necessity of help	50	31.6		
(Im)possibilities of help	50	15.8		
Other	37.5	5.3		
No rationale	0	20	*	*
Arguments for decision to refer to welfare organization				
Nature and seriousness of problems	29.4	30.8		
Consequences for child	14.3	10.3		
Explanations	14.3	15.4		
Risk factors	0	30.8		
Protective factors	28.6	20.5		
Necessity of help	14.3	35.9		
(Im)possibilities of help	42.9	17.9		
Other	57.1	12.8		
No rationale	58.8	34.6	1.774	.076

Table 5. Rationale of decisions in records in 2005 and 2010 in percentages, and z-values and two sided p-values of z-tests for independent proportions (continued)

Element	2005	2010	z	p
Arguments for decision to close a case				
Nature and seriousness of problems	41.2	4.1		
Consequences for child	11.8	0		
Explanations	0	0		
Risk factors	13.7	6.1		
Protective factors	3.9	4.1		
Necessity of help	3.9	12.2		
(Im)possibilities of help	78.4	22.4		
Other	29.4	10.2		
No rationale	7.3	42.5	-5.377	.000

Note. Percentages concern records that contain a specific decision, and next records that justify this decision with one or more arguments (more options could be chosen). If a proportion is 0 or 100 no z-test can be performed.

4. Conclusion and discussion

We analysed case records in Advice and Reporting Centres of Child Abuse and Neglect to see how systematic and transparent the decision making process has become since the implementation of ORBA. The 2010 records show clear improvements in both content and process aspects, compared to 2005 records. Specifically, more risk assessment elements were present, more explanations for problems, more elaborate investigation plans, and more decisions. Given these improvements, it may be concluded that after implementation of ORBA, records demonstrate a more systematic and transparent decision making process, in line with ORBA's goals. But for most conclusions and decisions in the records we did not find more often a rationale, while these are also necessary for transparency. Further, not all relevant content and process aspects were present in the 2010 records. Conclusions about whether a child is indeed maltreated and whether help is needed, are necessary decision steps in ORBA. These conclusions do not appear in all records, neither do investigation plans and answers to research questions. In all, we conclude that although the decision making process appears to be more systematic and transparent after implementation of ORBA, further improvements are necessary.

Similar results were obtained from an analysis of referral reports to child protection agencies (Ten Berge et al., 2011), and in a user evaluation (Ten Berge & De Baat, 2009). In interviews, professional partners in youth welfare organizations and child protection agencies indicated that the decision processes in ARCCANs appear to have become better structured, more complete, and more transparent since ORBA was implemented. However, they also noted that the rationale or conclusions and decisions was not clear in all cases (Ten Berge et al., 2011).

The improvements found in this study may be specifically due to the implementation of

ORBA in all agencies and in the digital record system, but other developments may have had a complementing, reinforcing influence. The Dutch Youth Care Inspection has emphasized the necessity of good risk assessment and risk management, and a new protocol has been implemented for the communication between ARCCANs and child protection agencies.

Surprisingly, a rationale for conclusions and decisions was missing in many 2010 records, while ORBA stimulates workers to support their conclusions and decisions with arguments, in order to make these transparent. This lack of improvement may be explained by the fact that 2010 records contained a lot of relevant information and decision steps. Workers might see explicit motivations as repetitions of information they had already provided. Alternatively, judgments and decisions might be the result of implicit, intuitive processes rather than of deliberate decision processes (Hogarth, 2010; Kahneman, 2011). Explicit motivations may then be hard to give.

This brings us to an important limitation of this study. We could only rely on information that was visible in the case records. The fact that specific elements were missing in the records does not necessarily mean that those elements were not considered. Workers may not have reported everything they had considered. Similarly, workers may have had clear rationales for a decision without reporting them. Some referral partners indicated that decisions that were unclear in a referral report, could be verbally explained by workers in a consultation (Ten Berge et al., 2011). Similarly, Benbenishty, Osmo, and Gold (2003) found that explicit prompting increased the level of argumentation in rationales for child protection decisions. Thus, the case records may not be complete representations of actual cognitive decision processes of workers.

Here we raise two points. First, we believe it is difficult to disentangle workers' cognitive processes and the explicit formal decision process. In decision making literature it is claimed that decisions are often made unconsciously, and that reasoning about decisions is only done to justify these decisions afterwards, rather than that decisions follow a deliberate weighting process (Wegner, 2002; Wilson, 2002). But when workers decide about suspected child abuse or neglect, this is not a decision that is made at one specific point in time. The decision process spreads out in time, in which information is collected and others are consulted. Although this process will include implicit cognitive processes, the whole process, from report to deciding to close a case, is not completely implicit. In this study we are concerned with the quality of this process. This brings us to the second point, that case records should reflect how workers arrived at their conclusions and decisions, in order for the process to be transparent. Transparency to others is crucial given the important and delicate nature of decisions in this domain (see also Benbenishty et al., 2003). Furthermore, because of the subjective nature of conclusions and decisions (Britner & Mossler, 2002; Gold, Benbenishty, & Osmo, 2001; Rossi, Schuerman, & Budde, 1999; Ten Berge et al., 2011), the demand to make considerations of workers explicit becomes even more pronounced, so that these can be discussed and challenged in order to arrive at more agreement (cf. Arad-Davidzon & Benbenishty, 2008). In the development of ORBA and in the user evaluation (Ten Berge & De Baat, 2009) workers also said they believed that records should be accurate reflections of the decision process.

ORBA is not only aimed at a more systematic and transparent decision process, but also at a more efficient and uniform process. These aspects were not addressed in this study. During the analyses of the records in the five agencies, workers mentioned sometimes that they experienced a greater administrative pressure due to ORBA, specifically because its integration in the digital filing system is not yet optimal. We may tentatively conclude that the process appears to be

more uniform, notably due to the more elaborate filing system. However, there is currently no evidence that workers come to agree more about conclusions and decisions if the decision process is structured and made explicit. A vignette study into the interrater agreement on the conclusions and decisions of ARCCANs workers shows no clear improvements due to ORBA (Ten Berge et al., 2011). It seems that a more systematic and transparent decision process is a necessary condition for agreement, but not a sufficient condition.

To conclude, by structuring the decision making process and making it explicit, more systematic and transparent decision making about suspicions of child maltreatment cases can be realized. Our findings have implications for further improvement of the quality of decision making about suspected child maltreatment. We suggest that the transparency of decisions may benefit when in each case that is investigated workers are required to report an investigation plan, and conclusions and decisions with rationales about whether a child is maltreated, whether help is necessary, and whether help can be provided on a voluntary basis or not. This comprehensiveness may be realized through training, supervision, or more specific requirements in the digital filing system. In case conferences colleagues can be encouraged to think about their personal opinions underlying judgments and to make these explicit.

An important topic for future research is to study the extent to which structuring the decision process reduces subjectivity and leads to more uniform judgments and decisions. Furthermore, it should be investigated whether a more systematic and transparent decision process leads to better, that is: more valid decisions. It is difficult to establish whether a decision was indeed the best decision to be made in a specific situation, because it is a onetime decision and each decision will affect outcomes differently. We add here that workers in ARCCANs in the Netherlands do not usually learn about the outcomes of their decisions, what may lead to impaired learning from experience due to a lack of feedback (cf. Garb, 2005). This problem, inherent to clinical practice, makes it especially difficult to erase subjective factors, and therefore makes the demand to be transparent about judgments and decisions more important.