Submission
No 27

CHILD PROTECTION AND SOCIAL SERVICES SYSTEM

Organisation: Monash University Department of Social Work

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Department of Social Work
Faculty of Medicine, Nursing and Health Sciences

11 December 2020

To: Parliament of New South Wales Committee on Children and Young People
Chair Matthew Mason-Cox

Re: Submission to the Parliament of New South Wales Committee on Children and Young People

From: Monash University Faculty of Medicine, School of Primary and Allied Health Care, Department of Social Work

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Dear Chair Mason-Cox and Committee Members:
In NSW and across Australia, the number of children reported for risk of significant harm, as well as the number of children residing in out-of-home care, have risen considerably over the past 10 years despite numerous reform efforts to improve the child protection system. These children and their families are among the most vulnerable and disadvantaged in our society, and the system designed to address child maltreatment concerns is full of good intentions but has not yet been able to deliver good outcomes.

In various configurations, our research group has been doing program evaluations and evidence syntheses in NSW for the past decade. These include large-scale evaluations such as the Premier's Youth Initiative to Prevent Homelessness, the Permanency Support Program evaluation, Keep them Safe, and various reviews for the Royal Commission into Institutional Responses to Child Sexual Abuse. We are not a consultancy. We are a university, and we often have to tell our funders news that they do not want to hear. Our DCJ evaluations have been highly applied, involving a mix of large-scale quantitative analytics using data from KiDS/ChildStory, CIMS/SHS and other DCJ sources, as well as qualitative and survey data measuring the effectiveness of individual programs, services and policies. We have also had the opportunity to look at the way these services and policies are implemented and, over the years, have come to understand a great deal about the way decisions are made on the frontline and how these are reflected in the data. We have now been involved with evaluating some aspect of at least three major reforms and an even larger number of initiatives, and yet the numbers remain relatively unchanged. Roughly 70 per cent of children and young people reported for a child protection concern who are at risk of significant harm are not seen by child protection. Why is this and what can we do about it?

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First, we believe it is important to take a step back and realise that child protection is a service that is deeply problematic in virtually every jurisdiction in Australia and internationally. While other systems may see close to 100 per cent of children and young people at substantial risk, this in no way means that children who are seen receive what they need, never to return as a result of a continuing or new concern. The outcomes of child protection involvement are not overwhelmingly positive. Anywhere. Second, child protection systems are not preventive – they are reactive – focusing almost exclusively on picking up children and families after things have gone terribly wrong. Recent years have brought a renewed focus on prevention, but the execution has not been particularly effective. Third, there are strong, structural forces such as poverty and disadvantage that drive involvement with child protection, and the system is ill-equipped to deal with these. Child protection and family services workers have to pick up the pieces when and where they fall, doing the best they can with what they know and what they have at their disposal. Finally, to the best of our knowledge, no jurisdiction has come up with a single 'magic bullet' that 'fixes' a perennially problematic child protection system. That said, some systems function better than others and progress has been made in terms of establishing the types of processes needed to improve the overall structure of agencies, their decision-making processes, the range of services offered at different points of involvement, the effectiveness of these services and, importantly, their quality of delivery. DCJ has begun a number of smart, well-intended reforms, but system-wide improvement in response rates and child and family outcomes remains elusive. There is much work to be done.

The nature of the problem

In 2019, more than 77,000 children and young people (CYP) were reported to be at risk of significant harm as a result of a child protection concern.[1] But when you dig just a little deeper, a more complicated picture emerges. These 77,026 CYP did not just show up out of the blue. They are often part of a flowing stream of families who happen to have had a maltreatment report last year. Although the rate of being seen for a face-to-face assessment is roughly only 30 per cent for each ROSH, a large proportion of CYP will have been seen before or will be seen later. Many will have been first reported in 2018 or earlier, many will be reported again in 2020 and beyond, and many will have been reported multiple times even in 2019. When looking even more closely, far fewer CYP are reported or seen for the first time in any given year, and these tend to be very young children (in other words, they hadn't yet been seen because they hadn't yet been born).

Our recent evaluation of the Homeless Youth Assistance Program (HYAP) for unaccompanied minors (age 13-15) at risk of homelessness provides a graphic example of what DCJ and range of family service providers are encountering when a family shows up for service.[2] When looking at CYP turning up for their first encounter at a HYAP provider, more than half (51.4%) had at least one prior ROSH report (Figure 1). Among these 1391 unique CYP, 82% had at least two or more prior ROSH reports and 19% had at least ten or more prior ROSH reports (that is not a typo). After receiving HYAP, this pattern continued with 78% receiving at least two other ROSH reports and 16% ten or more. Arguably, this is an extreme example using a group of very high-risk young people, but the pattern is the same across virtually every evaluation we have done. The strongest predictor of whether a CYP will have a ROSH report is if they have had a prior ROSH report.

[1] NSW Parliamentary Committee on Children and Young People, 2020

[2] Taylor D, Chakraborty S, Ng J, Rose V, Gyani A, Roberts J, Harrigan S & Shlonsky A. 2020. Evaluation of the Homeless Youth Assistance Program: Final Report, Centre for Evidence and Implementation, Sydney.

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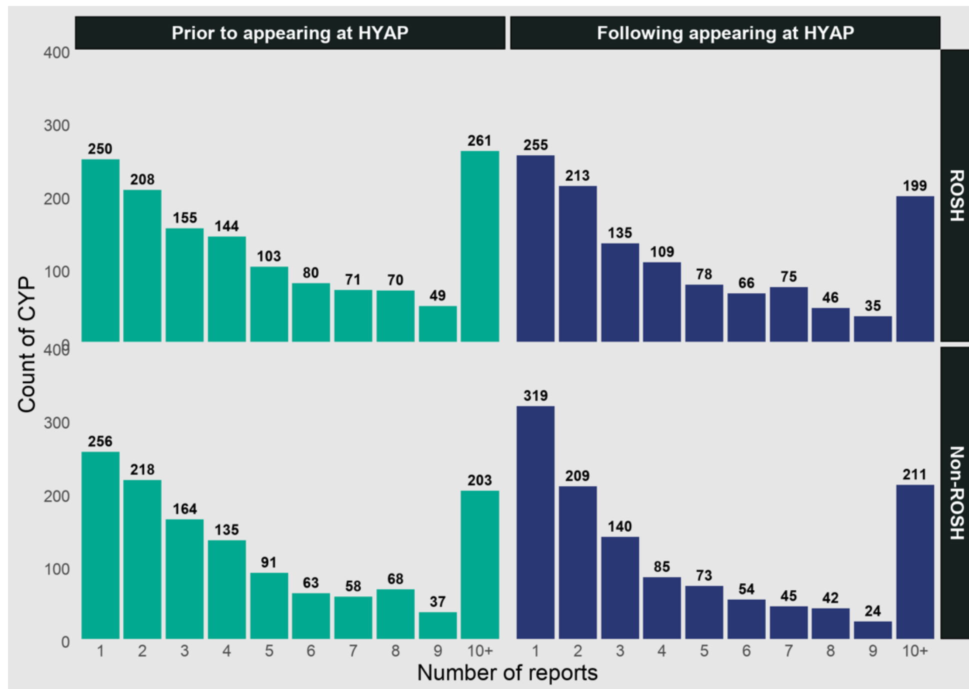
Figure 1: Frequency of ROSH & non-ROSH reports prior to HYAP, at the commencement of HYAP services, and following the completion of their HYAP service



But even that is not the whole story. Among the largest predictors of whether a CYP will have a first ROSH report is if they have a prior non-ROSH report. One of the largest predictors of whether a CYP gets placed in OOHC is a history of prior ROSH reports.

Of course, this does not occur in all instances. If a first interaction with the system is judged as very high risk, it's very likely to result in a face to face assessment. If an interaction is judged to be at a very low risk level, the case will not progress unless and until risk increases. Nonetheless, this patterning indicates a number of separate but related dimensions that describe the unique performance challenges at the front end of the NSW child protection system.

1. There is an overall pattern of interaction between children and families and child protection that is characterised by repeated, often similar responses *at each decision point* (e.g., decision to conduct a face-to-face assessment for a ROSH referral).
2. If interactions continue at a particular decision point, the service escalates to the next level (i.e., ROSH to face to face assessment; face to face assessment to OOHC), particularly if things worsen in terms of risk.
3. Seen another way, the number of ROSH reports becomes the risk factor that tips the case over the edge so a CYP is seen for assessment. In fact, this type of recurrence history is built into most statistical risk assessment models. So, in a very concrete way, the system itself, by not responding, is increasing the risk level even if the family keeps returning for the same problem.
4. This pooling at the same decision point in the service stream is known by the wider community and is compounded by the larger, related system of mandated and non-mandated reporters. Simply put,

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people will call until someone does something. As a result, the system is overwhelmed with additional calls and has to devote more resources to deal with these (e.g., increased desktop assessments of cases in order to prioritise; more hotline staff; more data gathering for decision-making tools). However, in dealing with the avalanche of calls, the system itself has fewer resources devoted to seeing children and families and providing them with services that might better address the issues that brought them to the attention of child protection in the first instance. More phone calls ensue, the families do not improve, and the capacity of the system to conduct face to face assessments does not improve or worsens.

5. Finally, when families are seen, it is unclear whether the services they are provided:
   a. have been rigorously evaluated and found to be effective
   b. even if judged to be effective, whether they are delivered well enough to actually be effective (i.e., poor implementation).

What can we do about this?
The answer is not, we don't think, to simply see all the children and young people who come to the attention of the child protection system. Even if successful, families will simply get more of the same. A better solution is to see them earlier, assess them well for the underlying issues that brought them to child protection in the first place, and use this information to invest in and enrich the set of available services so they better match existing need in the community, thereby decreasing repeated interactions. The good news is that there are some very positive steps that have been taken in NSW and other jurisdictions that can be built upon to create a more responsive system. The challenge is that some of the steps, while well-intentioned, are unlikely to change the system substantially as they stand. These include:

1. Structured Decision-Making. Implemented in 2010, this system of assessments, at its core, is designed to deal with an overwhelmed system by assessing risk using a reliable and valid risk assessment tool that predicts whether families are likely to return to child protection after an initial substantiated maltreatment referral. In theory, targeting those who are most likely to return will decrease the number of families needing services over time. Unfortunately, the strategy did not work for a number of reasons:
   a. Only 30% of families are seen and the essential assessment tool is designed to predict recurrence after an investigation of a family (i.e., the family is seen and assessed).
   b. The safety assessment component of the system can only be used if the family is seen.
   c. The tool is designed to predict, not assess underlying issues. There is a child and family strengths and needs assessment included in SDM, but this is not used. A risk level is generated but a proper assessment and corresponding services are not provided.
   d. At the end of the day, SDM identifies those who will return but not why they return.
2. While TFM was well-intentioned and put into play a number of services that have some level of evidence, these - on their own - are unlikely to solve the problem.
   a. Translation of empirically supported treatments / interventions / programs to the Australian context is often difficult, resulting in a number of failures of services that are often considered effective (e.g., the trial of MST-EA in NSW). Responding to the unique needs of Aboriginal and Torres Strait Islander families is particularly challenging without substantial adaptation, implementation support and most importantly community engagement and assent.
   b. The reach of these services is limited, particularly in remote areas.
   c. Some services can be quite expensive and are proprietary, often making the types of adaptations needed for the Australian context difficult.

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d. The level of training required to deliver many ‘evidence-based’ services does not match the level of expertise of the workforce.
e. Most evaluations of these potentially effective programs are based on comparisons between the empirically supported treatment and poor-quality treatment as usual. There are very few comparative effectiveness studies comparing them to high quality, locally developed and delivered services.

Recommendations

We recommend doing a stock take on existing reform efforts, including TFM, and bravely assessing their capacity to bring the results that parliament expects to see in the next 3-5 years. By bravely assessing, we mean using rigorous evidence synthesis and impact evaluation methods, including high quality implementation analyses, to understand what is being implemented, whether it will adequately address the needs of children and families, and whether these can be improved or there are other approaches that might better meet expectations. Moreover, we would recommend some very specific approaches.

1. Focus more closely, and expend more resources, on first interactions with the child protection and family services systems. Get families the help they need far earlier at major decision points. The first child protection interaction is likely the most important one. Too often, we focus on the those who are always there. If we do well the first time, families are unlikely to come back and, if they do, they will be far better off.
2. Develop an assessment framework and insist on using reliable and valid assessment screening tools for family functioning at investigation, followed by more detailed assessments as needed. If we do not know what the problem is, how can a service be matched to the problem? The first step in successful treatment is accurate assessment.
3. Identify and track, over time, the type, dose and timing of services children and families receive. This is a gaping hole in the administrative data. We are hard pressed to know which children and young people got which broad category of service at which time, and we certainly do not know more specific types of services they received (e.g., Cognitive Behavioural Therapy for depression). Perhaps just as important, the limited services data we do have tend to be focused on individual children and young people, not their parents. Data linkage efforts are promising in this regard, but we are still a long way off from knowing who got what specific service for what specific problem, how much they got, and whether it was delivered well.
4. Fund independent, transparent, rigorous evaluations that are published so that we can build knowledge and hold both government and providers accountable to supplying effective services. We would not, for a moment, hesitate to demand that assessments and therapies in healthcare are evaluated and discontinued if not beneficial or harmful. Why should a decision to take somebody’s child, or leave them in harm’s way, be any different?
5. Fund the development of effective services developed locally using Common Elements / Core Components. Manualised, empirically supported treatments are necessary and can be very helpful for some families, but they tend to be expensive to implement and administer, they sometimes do not translate to the Australian context, they can be difficult to adapt due to developer limitations placed on changes, and their treatment effects are often modest in size. But it turns out that they are largely comprised of a series of core or common practice elements that can be trained to, and these can be strategically adapted and adopted in regular services. Done well enough, they may begin to approach the effectiveness of approaches and may, in some instances, perform even better.
6. The creation of the Human Services Database (HSD) under TFM is a positive step. It will provide an analysis vehicle for understanding, broadly speaking, how children and families move through child

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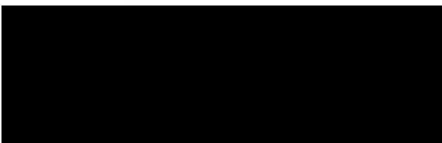
protection and related services. Unfortunately, the database only contains select information and is not created in real-time. We have been unable to use the database on more than one occasion because it did not contain the information we needed, the information it contained was not current enough, or both. Major advances in technology are finding their way into the healthcare field – and they are game changers. Real-time analytics are now possible using a massive array of data --- delivered to individual doctors, managers and evaluators at speeds that used to be unimaginable. In particular, we are now able to train AI over unstructured data such as case notes to find the answers to questions we did not even think to ask when building static databases. The future is not in a standalone database – it is in a secure, interactive environment that operates in real time. And the future is here. Australian universities are leaders in high-tech computing infrastructure and we have substantial content expertise – the two things needed to revolutionise the use of data. We would happily assist government to harness these data at a fraction of the cost charged by private providers because we can leverage our costs in other ways and the generation of knowledge is one of our basic functions.

7. Similarly, the workforce is often unable to deliver high quality services because they have not been trained well enough or in the right practices. Universities are realising that they need to produce work-ready graduates, including those working in child protection. If we are able to identify interventions and practice elements that are effective across a range of issues, we should be teaching them in our training programs.

Thank you for your time in reading this submission. Please contact us if you would like clarification on any of the recommendations we have made in this document.



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