Understanding harm experienced by children and young people in care during 2015/16

RESEARCH REPORT

ORANGA TAMARIKI
Ministry for Vulnerable Children

CONTENTS

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EXECUTIVE SUMMARY

In order to improve the safety of children and young people in care, insight into the extent of harm, how this manifests, and the nature of children/young people's experiences is essential. By generating this understanding, Oranga Tamariki can undertake more focused and effective work to prevent future harm, and improve the safety of children/young people in care.

Both internationally and within New Zealand, past approaches to measuring 'harm', or the safety of children/young people in care, have relied on findings of substantiated maltreatment[1]. However, this approach is increasingly recognised as limited, as some forms of harm may be excluded. Given these constraints, New Zealand and other international jurisdictions do not currently have an accurate understanding of the harm experienced by children/young people in care.

The harm experienced by children and young people in care is complex, and presents in diverse ways. Children/young people may experience a broad spectrum of harm, ranging from emotional distress to severe physical injury. This harm may be physical, emotional and sexual, or involve neglect, and can occur either within a caregiver's home (or in a residence), and in the community. Harm can also be perpetrated by a range of people, including parents, caregivers, and other children/young people.

In response to these issues, throughout 2016/17, an exploratory research project designed to better understand the safety of children/young people in care was undertaken. The project began under Child, Youth and Family, and has since been completed by Oranga Tamariki. The research involved reviewing the case notes of a representative sample of children/young people in care during the 2015/16 financial year. The research also applied a broad definition of harm. These innovative methodological improvements were designed to provide a more accurate and complete understanding of safety in care.

The research found that 85 children/young people in care experienced an incident of harm during the 2015/16 financial year, out of the total sample of 698. As a representative sample, this overall extent of harm can be extrapolated across the full population of children/young people in care during 2015/16. Due to methodological improvements, the extent of harm identified within this research is higher than in historically reported rates.

The research found that the number of Māori experiencing harm was higher than non-Māori, and that most children/young people were five years and older at the time harm was perpetrated. The research also found variation in the types, perpetrators and context of harm, and that children/young people's experience of harm differed across placements. Due to the sampling approach used and the nature of the research, these findings only relate to the 85 children/young people identified as experiencing an incident of harm and cannot be extrapolated to the full 2015/16 care population.

While this research is historic in nature, reviewers followed a process to ensure the safety of children/young people identified as being at risk of harm. This process involved safety checks examining changes in circumstances, and whether continuing perpetrator risk was present. These reviews did not identify any immediate safety concerns relating to caregivers or children/young people in the study.

[1] Substantiated maltreatment relates to instances where allegations of harm are made, a formal investigation or assessment by social workers or Police is undertaken, and maltreatment is found to have occurred.

This research has identified the need for a different approach for measuring and reporting on the safety of children/young people in care. As demonstrated by key research findings, past measurement approaches are likely to have under-reported the extent of harm, and failed to capture the broad range of harm experienced by children/young people in care. Oranga Tamariki will establish an expert group to discuss the findings and implications of this research, and propose a sustainable and robust future measurement and reporting approach. It is important to recognise that future use of a new measurement approach, along with practice improvements and an increase in the statutory care and protection age, is likely to identify an increased rate, at least in the short-term.

The research also highlights the importance of Oranga Tamariki's on-going transformation programme, which includes a range of initiatives to address drivers of harm and improve the safety of children/young people in care. Relevant projects already underway include an emphasis on child-centred practice, work to improve the quality of care, a focus on caregiver support and recruitment, and work to strengthen the quality and availability of different care placements. The new Oranga Tamariki Practice Framework also establishes standards to support quality social work practice. By implementing these initiatives, Oranga Tamariki can better protect and promote the wellbeing of children/young people in its care.

INTRODUCTION

New Zealand's care and protection system has faced a number of challenges

Oranga Tamariki was established in 2017, and is the agency responsible for supporting the wellbeing of any New Zealand child or young person at risk of harm. In the past, the organisation previously responsible for the New Zealand care and protection system – Child, Youth and Family (CYF) - was subject to a number of historic reviews. More recently, in 2014, the Office of the Chief Social Worker (OCSW) undertook the *Workload and Casework Review*, which identified several challenges facing the organisation, along with a number of key areas for change and improvement.

Following this review, in 2015, the Minister for Social Development established an Expert Panel, tasked with reviewing the existing CYF operating model, and providing a blue-print for a modernised care and protection system. In its final report, the Panel proposed a series of operational, design and policy changes – including the establishment of Oranga Tamariki as an independent care and protection agency – in response to significant limitations identified within CYF.

This review forms part of an on-going strategy to protect and promote the wellbeing of children and young people

The Panel's recommendations are substantial and wide-ranging, and will guide a long-term strategy to transform how care and protection services are delivered within New Zealand. As part of this shift, a particular focus of on-going work must be ensuring the safety of those children/young people formally placed within the care of the Chief Executive. As legal custodians, the Ministry has a responsibility to both ensure that children/young people are safe and to care for them day-to-day.

This research seeks to better understand the complex nature of harm experienced by children and young people in care

As highlighted in past reviews, although the Ministry is responsible for ensuring safety, a number of system, service and practice limitations mean that some children/young people will experience further harm while in care. As in other jurisdictions, this harm presents in several ways, with different contexts, perpetrators and forms. While some harm may be formally investigated – including by Police – other experiences may receive a less serious response. In order to ensure that all children/young people in care are safe, a better understanding of these issues is essential.

'Case note review' was used to investigate harm experienced by children and young people in care during 2015/16

This exploratory research used case note review to better understand the nature and extent of harm experienced by children/young people in care[2]. The research involved reviewing the case notes of a representative sample of 698 children/young people, in order to understand the extent of harm experienced by all children/young people in care during the 2015/16 financial year. The nature of harm incidents across different placement types was also examined. It is important to note that this review is historic in nature, and relates to children/young people under the care of CYF.

[2] This refers to children/young people in the statutory custody of the Chief Executive of Oranga Tamariki. Children/young people can enter care in a number of ways, including through court orders or with agreement from parents. The full list of custody orders considered within this review, which provide an indication of how the child/young person entered care, is set out in Appendix Two.

An innovative approach was used in this research, which involved manually reviewing all case notes entered in CYRAS[3] for a child/young person within the 2015/16 financial year. Reviewers assessed whether each child/young person experienced an incident of harm, and where this occurred, they examined the extent, nature and context of the most significant harm incident. The research was undertaken in partnership between OCSW and the Research and Evaluation team within Oranga Tamariki, and involved a team of four experienced social workers.

For more detailed information on the methodology and limitations of the research, see Appendix One.

By better understanding the nature and extent of harm, Oranga Tamariki can improve the safety of children/young people in care

The use of a case note review approach, which applies a broad definition of harm, is intended to provide a more complete and accurate understanding of safety in care. In contrast to past approaches, this work provides deeper insight into the extent of harm, how this manifests, and the nature of children/young people's experiences. By generating this new understanding, Oranga Tamariki can undertake more focused and effective work to prevent future harm, and improve the safety of children/young people in care.

Structure of the report

The report first highlights the context for this exploratory work, including the complex nature of care and harm, limitations associated with past measurement approaches, and the rationale for using case note review. The report then sets out a number of key research findings. The first finding relates to the overall extent of harm identified. Overall findings relating to the nature of harm are then discussed. Further descriptive findings relating to harm within specific placement types are then highlighted. The report concludes by noting implications and future work associated with the research.

Interpreting research findings

The sampling approach used within this research allows for the overall extent of harm identified to be generalised to the full population of children/young people in care during 2015/16. All other findings are descriptive only; they relate to those children/young people identified as experiencing an incident of harm and cannot be extrapolated to the full care population. This includes findings relating to demographics, the overall nature of harm, and placement specific findings. To enable these findings to be generalised would have required a different sampling approach and a significantly larger sample size, which was out-of-scope of the current research project.

[3] CYRAS is the CYF/Oranga Tamariki case management system. Case notes refer to all content entered within CYRAS for an individual child/young person, including notes created by social workers and other professionals.

SETTING THE SCENE

Care and harm are complex

Definitions, and children/young people's experience of 'care', are diverse

This review involved children/young people under the statutory custody of the Chief Executive, irrespective of their legal status, the duration of time they spent in care, or their living circumstances.

In this review, a broad definition of being 'in care' was applied. Definitions of care include the full range of formal and informal custody arrangements, ranging from informal temporary care agreements, through to those children/young people in court-ordered long-term custody. The full list of custody arrangements included is set out in Appendix Two.

The length of time children/young people spend in care varies; some placements may be of an emergency, short-term nature (e.g. a place of safety warrant), while other children/young people may be in permanent care over the full financial year. Children/young people were included in this review regardless of the duration of their care experience.

This experience of care may also be varied. While in care, children/young people's living circumstances may alternatively be settled or volatile. Some children/young people may experience a stable placement with a caregiver who meets their needs, whereas others will have numerous placements and no primary care relationships.

A number of different placement types were examined within this review

To reflect the complexity of care, and accurately capture the broad range of harm experienced by children/young people, this review examined several different placement types[4]. All identified incidents of harm were included in this review, regardless of where the child/young person was placed at the time. A description of each placement type examined is included below.

Whānau placement: a caregiver who has a biological or legal relationship or significant psychological attachment, or is the child/young person's whānau or other culturally recognised group. This can include a former or current de-facto partner of a natural parent and step-parents.

Non-whānau placement: a caregiver who is not related to, or part of the family, whānau, hapū, iwi or family group of the child/young person.

Return/remain home placement: describes instances where a child/young person returns to the environment where initial care and protection concerns were raised, while remaining under the formal care of the Chief Executive; or, instances where children/young people are formally placed in care, but remain living within the environment where initial care and protection concerns were raised.

Group home settings, including Residence and Family Group Home placements: care within a residence provides a safe and stable placement for children/young people when they cannot be placed in the community, and has a structured and educative regime. Family Group Homes typically offer caregiver-run provision for multiple children/young people, including sibling groups, within a community setting.

[4] This review did not exclude any placement types; all placements for children/young people in care were exmined.

Child Family Support Service (CFSS) placement: describes several placement arrangements, such as an individual child/young person being placed with a caregiver, or a number of unrelated children/young people living within a group home. These placements are defined as CFSS because they have different administrative arrangements (e.g. payments, contracts and monitoring). While placements are organised by an s.396[5] approved provider, children/young people remain under the legal custody of the Chief Executive.

Independent living placement: describes situations where a young person may wish to live by themselves, in a flatting arrangement with other young people, with a family friend, an older sibling, or member of their support network.

The nature of, and response to, harm can be understood on a spectrum

While public perceptions commonly emphasise incidents of a physical or sexual nature, children/young people in care may experience a broad spectrum of harm, with these incidents receiving a corresponding range of responses. At one end, some harm may be sufficiently serious to constitute a criminal offence, necessitating forensic investigation by Police. Alternatively, other allegations of harm may not be substantiated, and are managed more informally by social workers.

This review defined harm using CYF classifications and thresholds

The harm experienced by children/young people in care is complex, and presents in diverse ways. Children/young people may experience a broad spectrum of harm, ranging from emotional distress to severe physical injury. This harm may be of a physical, emotional and sexual nature, or involve neglect. When considering harm, this review focused on case notes containing sufficient evidence that an incident occurred. Reviewers recorded any incident that met CYF practice guidelines relating to the definitions of physical, sexual, and emotional abuse, or neglect, or the Child Protection Protocol[6].

A summary of each type of harm is included below.

Physical: a situation where a child/young person has sustained an injury or was at serious risk of sustaining an injury. Injuries may be deliberately inflicted or the unintentional result of the perpetrator's behaviour (e.g. shaking an infant). Physical harm may result from a single incident, or combine with other circumstances to justify a physical harm finding. Physical harm does not include a light smack or where a child/young person is handled in a manner a little rougher than is desirable.

Emotional: a situation where a child/young person's mental health, social and/or emotional functioning and development have been damaged by their treatment. This often results from repeat exposure to negative experiences, particularly in a context of insecurity. Witnessing adult-to-adult family violence may constitute emotional harm if the functioning, safety, or care of the child/young person has been adversely affected or put at risk.

[5] This section is set out in the Oranga Tamariki Act, and empowers the 'approval of iwi social services, cultural social services, and child and family support services'.

[6] The Child Protection Protocol relates to serious incidents of harm against children/young people that may constitute a criminal offence. For more information, see https://practice-mvcot.ssi.govt.nz/documents/policy/assessment-and-decision-making/child-protection-protocol-2016.pdf.

Sexual: any action where an adult or a more powerful person (which could include another child/young person) uses a child/young person for a sexual purpose. Sexual harm doesn't always involve body contact. Exposure to inappropriate sexual situations or to sexually explicit material can be sexually abusive, whether touching is involved or not. Children/young people may engage in sexualised behaviour involving other children/young people as part of normal experimentation; this is not considered sexual harm.

Neglect: failure to provide for a child/young person's basic needs – physical (adequate food or clothing), emotional (lack of emotion or attention), supervisory (leaving a child home alone), medical (health care needs not met), or educational (failure to enrol or chronic inattendance at school). Neglect can be a one-off incident, or may represent a sustained pattern of failure to act.

Harm can occur in a variety of contexts, both within placements and in the community

Incidents of harm were included in this review whether they occurred within or outside a placement. Where harm is said to occur 'in placement', this covers the caregiver's home, or a group home setting. Incidents of harm classified as 'outside placement' occurred within a community setting, such as the school or mall.

Harm can be committed by a range of perpetrators

Rather than being exclusively perpetrated by caregivers, the harm experienced by children/young people in care may involve a range of people. To capture this range, the current review categorised perpetrators into the following groups:

- Whānau caregiver (other than parent)
- Non-whānau caregiver
- Child and Family Support Service (CFSS) caregiver[7]
- Parent (as caregiver)
- Parent (not as caregiver)
- Non-related adult
- Child or young person (in placement)
- Child or young person (not in placement)
- Other/Unknown

Understanding and reporting on harm is challenging and variable

There is no consistent international approach to reporting on harm

Measuring and reporting on the harm experienced by children/young people in care is difficult. Most studies acknowledge that as children/young people may not disclose harm, accurate measurement is not possible. Further, when harm is disclosed, not all information is recorded or formalised into an allegation. Those incidents that become allegations are not always investigated and variation in thresholds within and between jurisdictions compromises measurement. In addition, records are sometimes inaccurate or incomplete, again confounding accurate measurement of harm.

[7] See description of Child and Family Support Service placement type for more information (pg. 8).

Due to recording and reporting limitations, many jurisdictions report artificially low rates of harm

Internationally, studies on harm experienced by children/young people in care often rely on 'substantiated maltreatment'. Substantiated maltreatment relates to instances where allegations of harm are made, a formal investigation or assessment by social workers or Police is undertaken, and maltreatment is found to have occurred. However, this approach to defining and measuring harm is increasingly recognised as limited (for example, see Kohl et al., 2009).

A number of common critiques against a reliance on substantiated maltreatment are set out below. Overall, these methodological limitations mean that reporting on substantiated maltreatment may identify artificially low rates of harm.

- Substantiated and unsubstantiated cases may present similar risk factors and rates of subsequent re-referral, suggesting that the experience of harm does not meaningfully differ across these cases (Hussey et al., 2005).
- Substantiated maltreatment excludes allegations of harm that do not meet high evidence thresholds, but which are nevertheless likely to be traumatic and harmful for children/young people (Radford et al., 2014).
- Judgements about maltreatment are subjective, and the decision to substantiate an allegation of maltreatment may be unrelated to the actual experience of harm. For example, factors that influence decision-making may include social worker education, level of site office centralisation, lack of child disclosure, fear of personal liability, protective measures being taken by a non-offending parent, amount of time spent in investigations, and parents' willingness to change (Connell et al., 2007; Chabot et al., 2013).
- Reporting often excludes harm that occurs outside of a placement (e.g. while a child/young person is absconding or in the community) and within some placement types (e.g. kin care or return/remain home placements) (Biehal et al., 2014).
- Substantiated maltreatment may exclude incidents of harm perpetrated by people other than caregivers, e.g. non-caregiving natural parents, biological siblings, other children in the care placement, and peers (Biehal et al., 2014; Biehal and Parry, 2010).

Reporting of harm in New Zealand has been subject to the same methodological constraints

Historically, New Zealand reporting on the safety of children/young people in care has been limited by many of the same methodological constraints identified in international literature. Past public reporting has included rates of substantiated maltreatment perpetrated by caregivers only[8]. Other internal reporting has included harm perpetrated by caregivers, parents, other adults, and children/young people; however, these rates have only included substantiated maltreatment within cases of serious harm[9].

[8] From 2012 to 2015, these rates have ranged from 0.7% to 0.8% of the total care population. For more information, see past Annual Reports available at https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/annual-report/.

[9] These rates have ranged from 2.3% to 2.5% of the total care population.

These limitations mean that in the past it is likely that New Zealand has under-reported rates of harm. As previously discussed, the nature of harm is complex; children/young people in care experience a broad spectrum of harm, which may present in numerous ways, occur in a variety of contexts, and be perpetrated by a range of people. Past reporting approaches have taken a narrow view to defining and measuring this harm, and as a result, present a poor understanding of the safety of children/young people in care.

This exploratory research is designed to produce a more comprehensive understanding of harm

Case note review, and the application of a broad definition of harm, produces a more accurate understanding of the safety of children/young people in care

A case note review approach was applied within this exploratory research as it provides a better understanding of the nature and extent of harm experienced by children/young people in care. Case note review resolves many of the reporting challenges discussed within the previous section. For example, using this approach, the identification of harm is independent of the assessment or actions taken by the original social worker. However, some harm – e.g. that not disclosed by a child/young person, or not recorded within case notes – still cannot be captured

As previously discussed, within this research, 'harm' was broadly defined. Rather than relying on 'substantiated maltreatment', the research identified all instances of harm recorded within case notes. This approach includes harm not formally investigated, occurring both within and outside of a placement, perpetrated by a range of people –e.g. parents, caregivers, or other children – and manifesting as physical, emotional, and sexual incidents, or neglect. Together, these innovative methodological improvements provide a more accurate and complete understanding of the safety of New Zealand children/young people in care.

Only the most significant harm incident experienced by each child/young person was reviewed

This project investigated only the most significant harm incident for each child/young person; in cases where a child/young person was harmed more than once, only one incident of harm was recorded. A key intent of this research was to understand the extent of harm experienced by children/young people. This approach involves identifying whether a child/young person did or did not experience harm; therefore, focusing on only the most significant harm incident was considered appropriate.

KEY RESEARCH FINDINGS

Overall extent of harm

This review identified more incidents of harm than previously reported

This research found that of the sample of 698, 85 children/young people in care during 2015/16 experienced an incident of harm. The extent of harm highlighted in this research is higher than in historically reported rates, and represents a more accurate and complete understanding of the safety of children/young people in care. This finding is associated with improvements in the methodology used; specifically, the use of a case note review approach and application of a broad definition of harm.

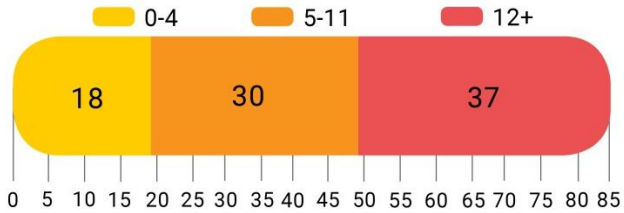
As previously discussed, the overall extent of harm identified here can be generalised to the full population of children/young people in care during 2015/16. The following research findings set out in this report, which relate to demographics, overall nature of harm and placement specific findings, are descriptive only. This means that they cannot be generalised beyond the 85 children/young people identified as experiencing an incident of harm. For a fuller discussion of these limitations, see Appendix One.

Demographics of those experiencing harm

Most children/young people were aged five years and older at the time harm was perpetrated

Figure One shows that of those children/young people who experienced harm, the largest proportion were aged 12 and older (n=37 children/young people or 44%), followed by those aged between 5 and 11 (n=30, 35%). The smallest proportion was children aged under five (n=18, 21%).

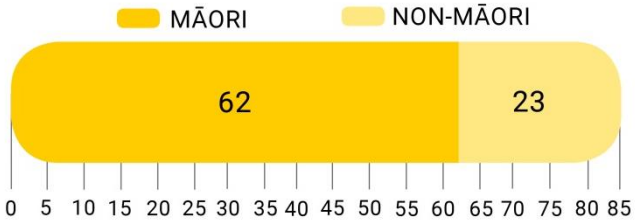
Figure 1: Number of children/young people harmed, by age at the time harm was perpetrated



Of those who experienced harm, the number of Māori was higher than non-Māori

Figure Two shows that of those children/young people who experienced harm, the number of Māori was higher than non-Māori[10]. Sixty-two Māori children/young people experienced harm (73%), compared with 23 who were non-Maori (27%).

Figure 2: Number of Māori and non-Māori children/young people harmed



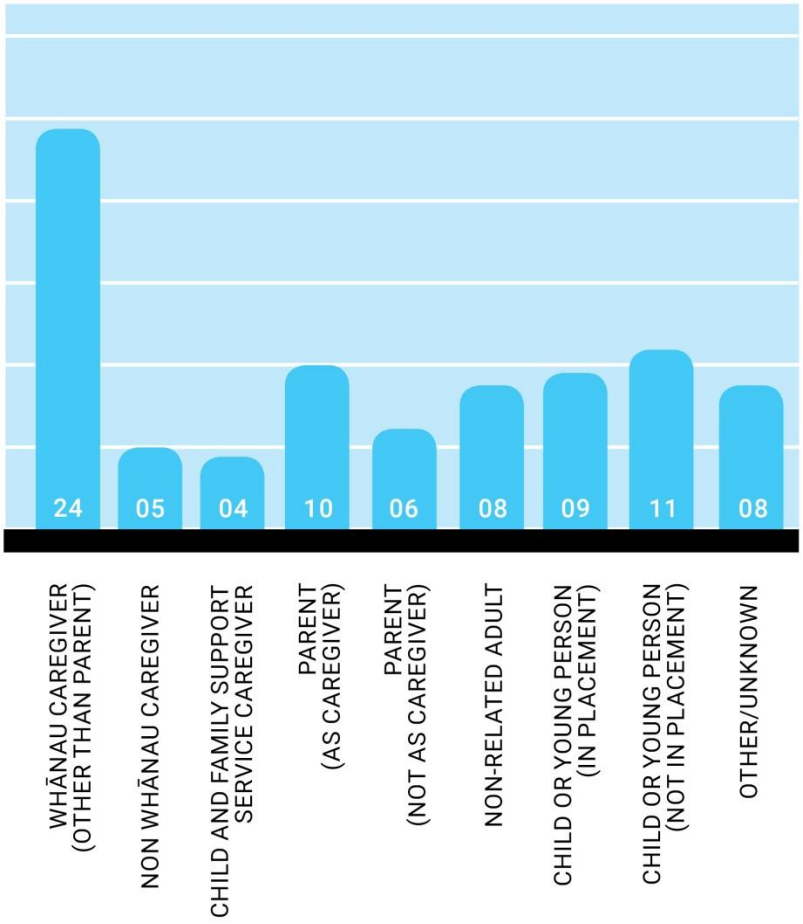
[10] Within this research, it is not possible to identify whether children/young people who are Māori are at a greater risk of harm. Rather, the high proportion of Māori children/young people experiencing harm is likely to be associated with several other factors, e.g. their over-representation within the care population generally or greater exposure to risk factors associated with harm. Māori/non-Māori information was based on all ethnicity associated with the child/young person (including maternal and paternal) and is not limited to primary ethnicity.

Overall nature of harm

Harm was perpetrated by different groups of people

As previously discussed, this review categorised the perpetrators of harm into a number of groups. Figure Three sets out the overall level of harm perpetrated by each group. This figure shows that the largest proportion of harm was perpetrated by whānau caregivers (other than parents). Other children/young people were also commonly the perpetrators of harm, along with parents (as caregivers).

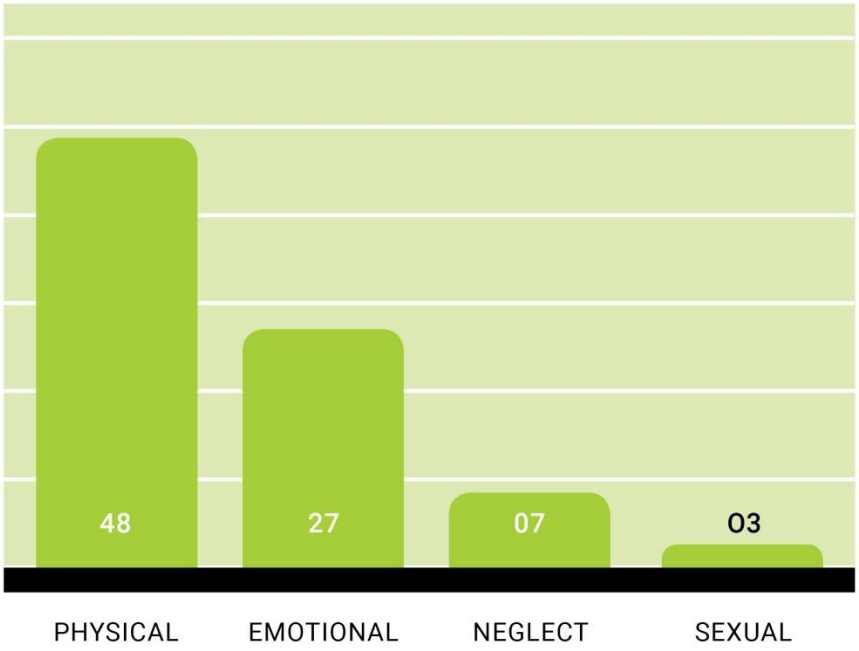
Figure 3: Number of children/young people harmed, by perpetrator type



Children and young people experienced different types of harm

As previously discussed, rather than relying on 'substantiated maltreatment', this review identified any incident of harm that met the CYF practice guidelines or Child Protection Protocol definitions of physical, sexual, and emotional abuse, or neglect. Figure Four sets out the overall level of each type of harm perpetrated. This figure shows that physical harm was most common. The next largest proportion was emotional, followed by neglect, then sexual harm.

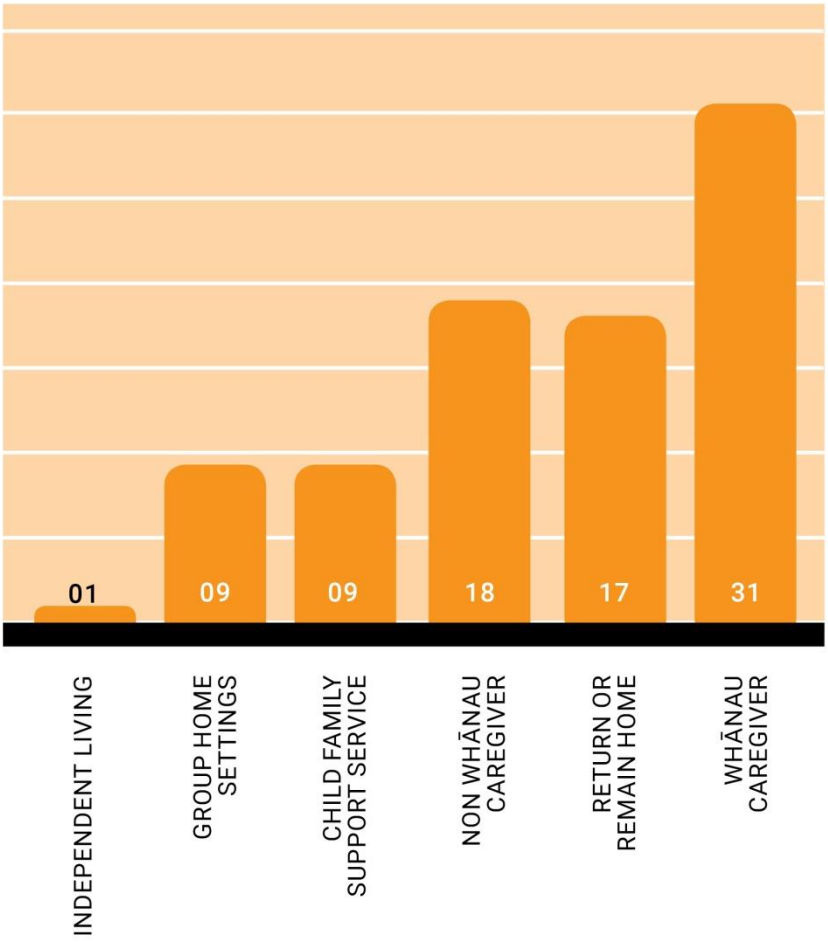
Figure 4: Number of children/young people harmed, by type of harm



Harm occurred in different placement types

Figure Five outlines the number of children/young people who experienced harm within each placement type examined within this review. This figure shows that of those children/young people who experienced harm, the largest proportion were placed with whānau. Levels of harm were also high for children/young people living in return/remain home placements, and non-whānau placements.

Figure 5: Number of children/young people harmed, by placement type



PLACEMENT SPECIFIC FINDINGS

This review does not allow for a comparison of relative safety across placement types

The following section outlines the nature of harm incidents across different placement types. The findings presented outline descriptive information relating to the type, location and perpetrators of harm, and provide an indication of how this picture differs across placement types.

It is important to note that discussion by placement type is limited to the group of 85 children/young people who were found to have experienced harm, and that findings cannot be generalised beyond this group. Further, these findings do not allow for comparisons of relative safety, as harm that occurred within different placements types cannot be usefully compared for the following reasons:

- *This project investigated only the most significant harm incident for each child/ young person.* This approach means that in cases where a child/young person was harmed more than once, only one incident of harm was recorded, limiting the ability to directly compare the extent of harm for each placement type.
- *These findings do not account for the duration of placement types.* It is currently unknown whether different placements types are more risky, or whether higher incidents of harm within specific placements are associated with longer durations.
- *These findings do not allow for comparison against the number of children/young people who spent time within a specific placement type and did not experience harm.* To assess the level of 'risk' within a placement type, it is important to understand the number of children/young people who did and did not experience harm. This information is currently unknown.
- *The sampling approach used within this research does not allow for* statistical *comparisons of relative safety.* The sample used was designed to allow findings relating to the overall extent of harm to be generalised to the full 2015/16 care population. Given this sampling approach, it is not possible to statistically compare harm within different placements types. The sample did not stratify to allow comparisons of relative safety across these placement breakdowns. To enable this would have required a significantly larger sample size.

Within whānau placements, whānau caregivers (other than parents) perpetrated the majority of harm incidents

Thirty-one children and young people experienced a harm incident while placed with a whānau caregiver (other than a parent).

Whānau caregivers were responsible for 74% (23 out of 31) of harm incidents that occurred while in a whānau placement. Of these incidents, 17 were physical harm that occurred within the placement.

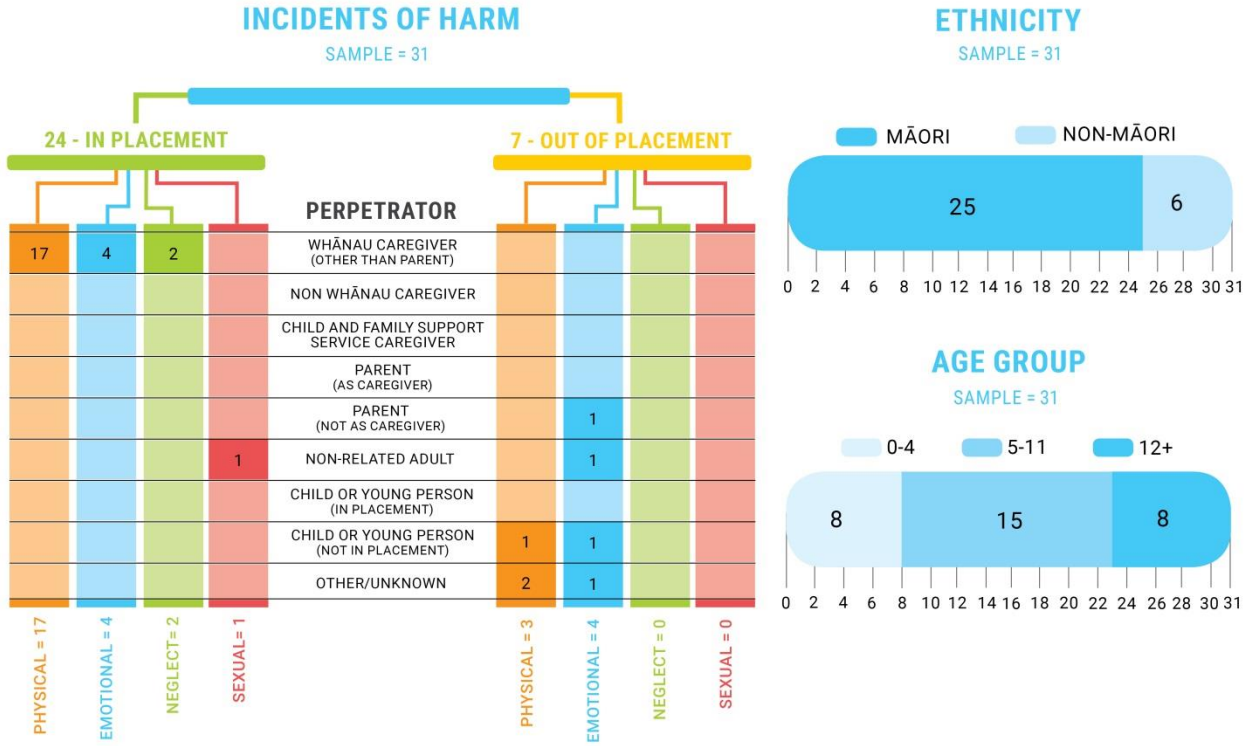
Only two incidents of harm were perpetrated by other children or young people; both of these occurred outside the placement.

One incident of sexual harm was found within a whānau placement. This incident occurred within the placement, but was perpetrated by an unrelated adult rather than a caregiver.

The majority of children/young people who experienced harm within whānau placements were Māori (81%).

Children aged 5-11 comprised the largest proportion of those experiencing harm in whānau placements (48%), followed equally by children aged 0-4 and children/young people aged 12 and over (the proportion of both age ranges was 26%).

Figure 6: Nature and demographics of harm within whānau placements



Within non-whānau placements, non-whānau caregivers and other children/young people were most likely to be the perpetrators of harm

Eighteen children and young people experienced a harm incident while placed with a non-whānau caregiver.

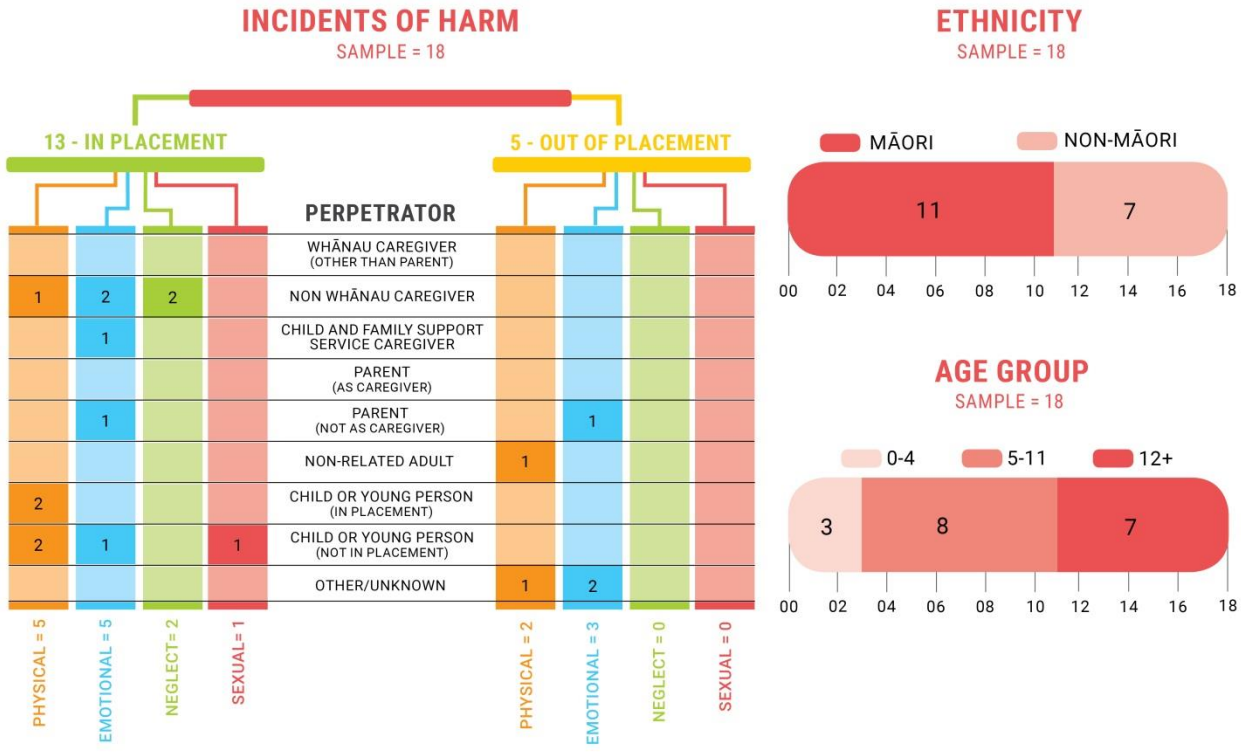
Non-whānau caregivers were responsible for 22% (5 out of 18) of harm incidents experienced by this group. All these harm incidents occurred within placement, and included physical harm, emotional harm, or neglect.

Children/young people not living in the same placement were the next most frequent perpetrator group, accounting for 22% (4 out of 18) of incidents. Types of harm perpetrated by other children/young people were physical, emotional or sexual. These incidents all occurred within the placement.

Sixty-one per cent of those children/young people who experienced harm within non-whānau placements were Māori, while 39% were non-Māori.

Children aged 5-11 comprised the largest proportion of those experiencing harm in non-whānau placements (44%), followed by children/young people aged 12 and over (39%), then children aged 0-4 (17%).

Figure 7: Nature and demographics of harm within non-whānau placements



In return/remain home placements, parents (as caregivers) were responsible for the majority of harm incidents

Seventeen children and young people experienced a harm incident while placed at home, with their natural parents.

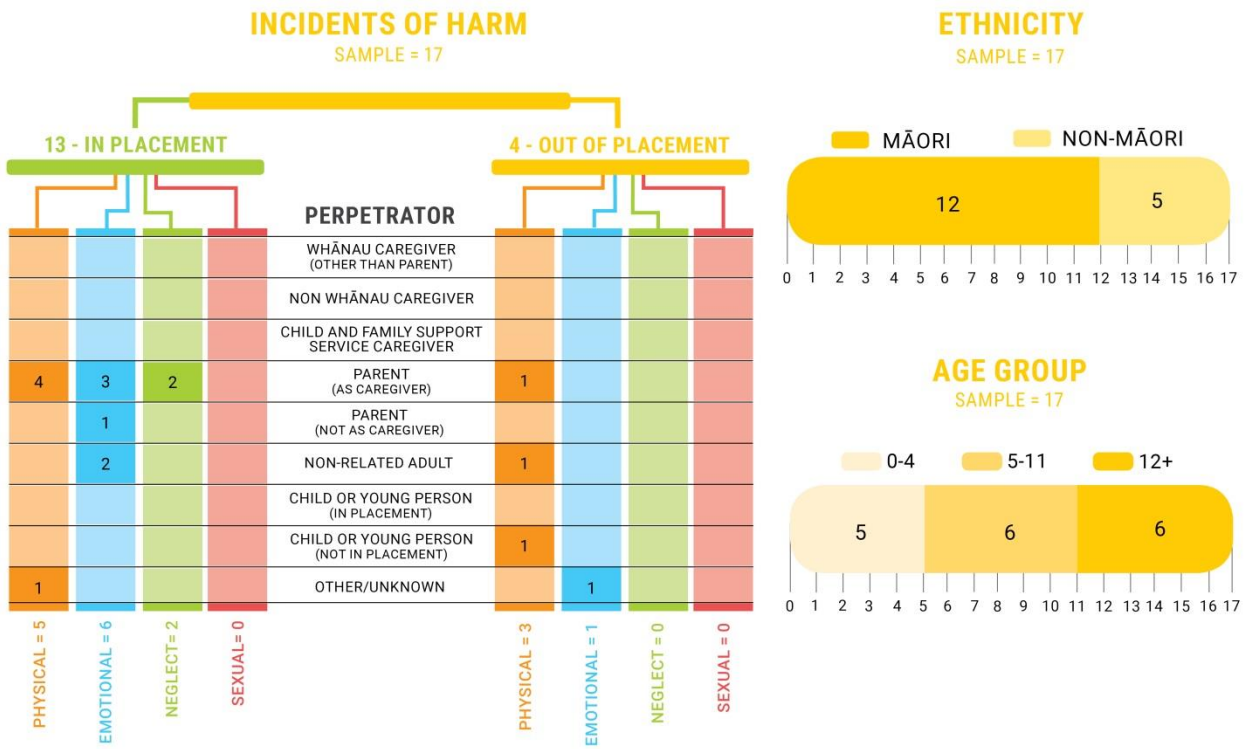
Over three-quarters (13 out of 17) of these incidents occurred within the placement. The most common form of harm was physical (8 out of 17), with the majority of this occurring within the placement. Parents who are caregivers were most often the perpetrator and were responsible for 59% of all incidents (10 out of 17).

Only one incident of harm was perpetrated by another child or young person; this was an incident of physical harm that occurred outside of the placement.

The majority of children/young people who experienced harm within return/remain home placements were Māori (71%).

Children aged 5-11 and children/young people aged 12 and over experienced harm equally within return/remain home placements (the proportion of both age ranges was 35%); children aged 0-4 were the smallest proportion of those experiencing harm (29%).

Figure 8: Nature and demographics of harm within return/remain home placements



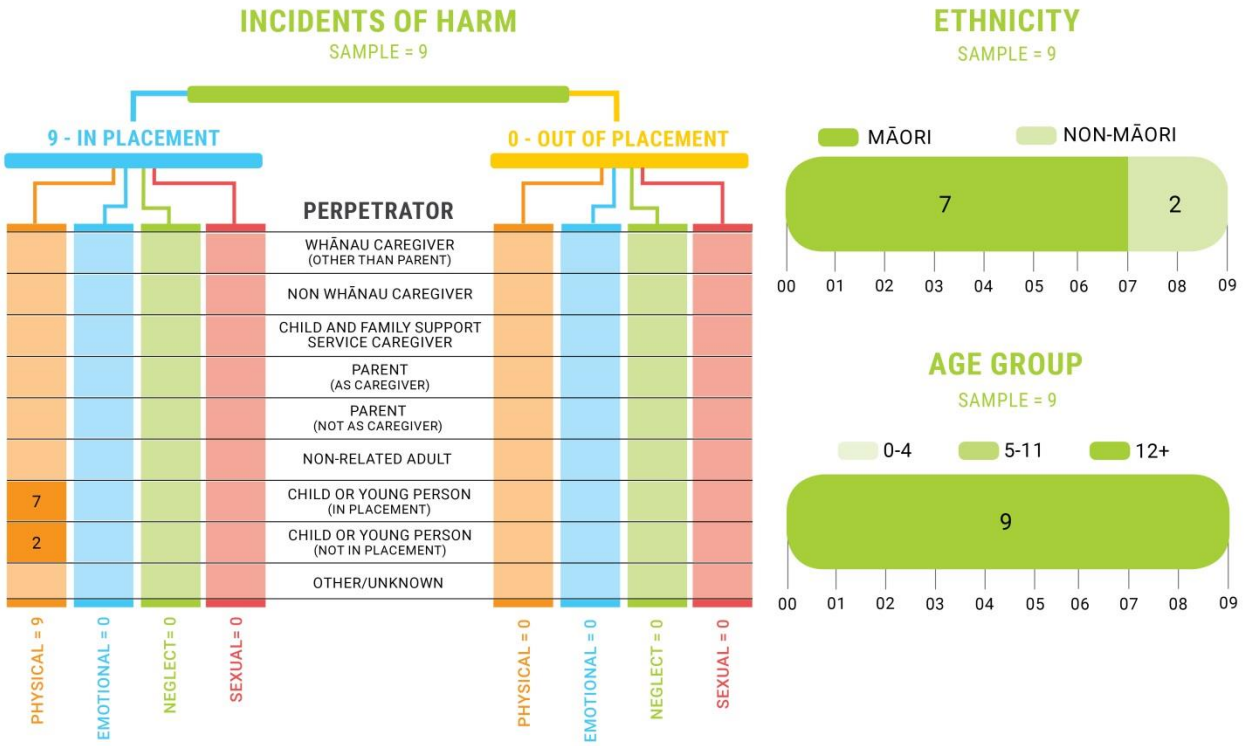
Within group home settings (including Residence and Family Group Homes) all incidents were physical harm perpetrated by other children/young people

Nine children and young people experienced a harm incident while placed in a group home setting. All harm incidents were physical, occurred within placement, and perpetrated by other children/young people. Most harm was perpetrated by children/young people living in the same placement (7 out of 9).

Seventy-eight per cent of those children/young people who experienced harm within group home settings were Māori.

All children/young people experiencing harm within a group home setting were aged 12 and over.

Figure 9: Nature and demographics of harm within group home settings



Within Child Family Support Service placements, incidents were usually emotional harm

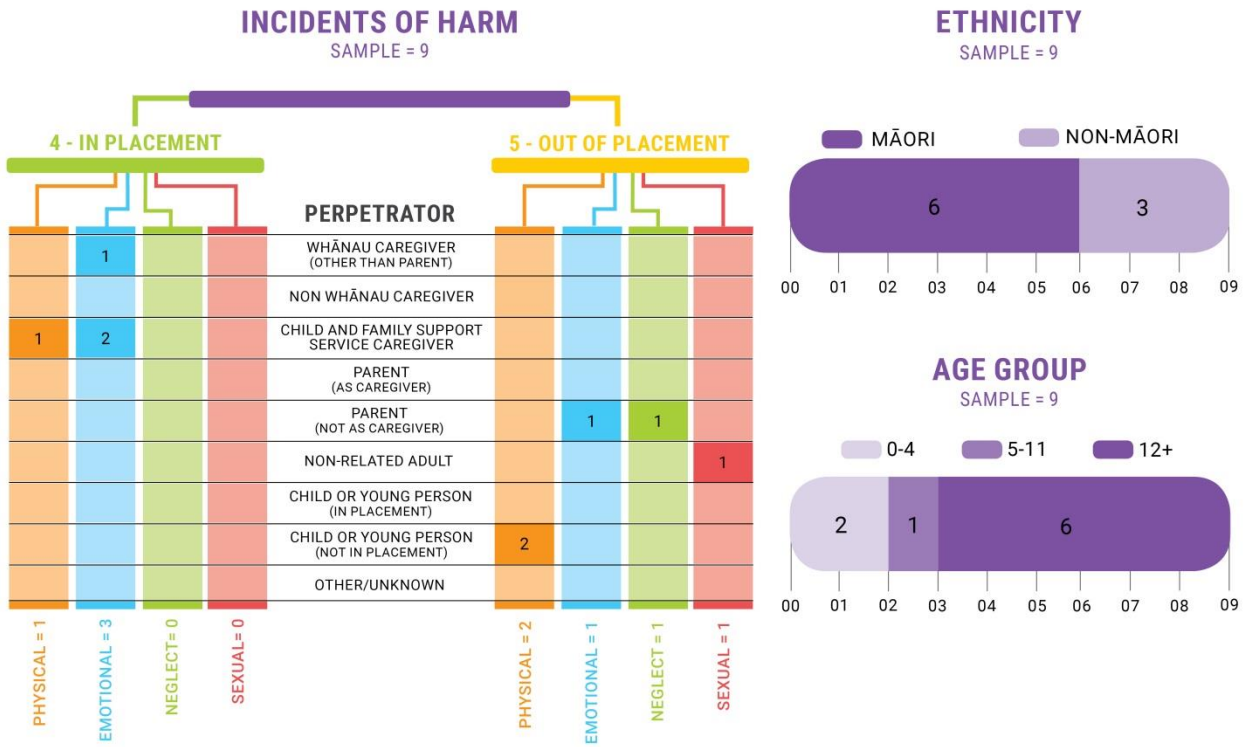
Nine children and young people experienced a harm incident while placed with a Child Family Support Service (CFSS) caregiver.

The most common type of harm seen in this group was emotional, accounting for almost half of all harm (4 out of 9). The majority of harm incidents occurred outside of the placement (5 out of 9). While 7 out of 9 incidents of harm were perpetrated by adults, only 3 out of 9 incidents were perpetrated by CFSS caregivers, with other incidents being perpetrated by whānau caregivers, parents and non-related adults.

The majority of children/young people who experienced harm within CFSS placements were Māori (67%), while 33% were non-Māori.

The largest proportion of children/young people experiencing harm within CFSS placements were aged 12 and over (67%), followed by children aged 0-4 (22%). One child aged 5-11 experienced harm (this equates to 11% of all children/young people experiencing harm within this placement type).

Figure 10: Nature and demographics of harm within CFSS placements



Within independent living placements, only one incident of harm was identified

Only one incident of harm for a child/young person placed in an independent living situation was recorded in this review. It was a case of physical harm perpetrated outside of the placement by a non-related adult. The child/young person involved was Māori and aged 12 years or older.

CONCLUSIONS AND NEXT STEPS

This exploratory research has identified limitations in the current approach for understanding the safety of children/young people in care. As demonstrated by key research findings, past measurement approaches are likely to have under-reported rates of harm, and failed to capture the broad range of harm experienced by children/young people in care. By using a case note approach, and applying a broad definition of harm, it is possible to generate a more accurate and complete understanding of the safety of children/young people in care.

The findings of this research have a number of implications for future reporting. Primarily, these findings suggest that historic approaches cannot be maintained, and that a new measuring and reporting approach is required. For the purposes of future official reporting, Oranga Tamariki will establish an expert group to discuss the findings and implications of this research, and propose a future measurement approach that provides a sustainable and repeatable measure of safety in care.

While this exploratory research used one method of defining and understanding the nature and extent of harm, other approaches may be equally appropriate. As part of its work to propose a future official measurement and reporting approach, the expert group will need to consider a number of key questions, for example, what methodology to use, how to define harm, what placement types to consider, and what perpetrator types to include.

It is important to recognise that the use of a new reporting approach, which defines and measures harm differently than in the past, is likely to identify an increased rate, at least in the short term. An increased rate of harm may also be associated with several aspects of the Oranga Tamariki transformation programme. For example, as recording and practice improves, a greater level of harm is likely to be identified. Further, an increase in the age of statutory care will result in an increased cohort of children/young people at risk of experiencing harm in these settings.

Findings from this research also further highlight the importance of Oranga Tamariki's on-going transformation programme, particularly those initiatives designed to improve the safety of children/young people in care. While this research was not specifically designed to investigate why harm occurs, several factors are identified within existing international research literature[11]. A number of key initiatives included within the transformation programme[12] respond to these drivers of harm, and in the long-term, will act to protect and promote the wellbeing of all children/young people in care.

[11] For example, these factors include caregiver stress, poverty, placements with multiple children, inappropriate placements, placement instability, poor social work engagement, and a range of other general practice issues. For a fuller description of these factors, see Appendix Three.

[12] For example, a focus on child-centred practice, the introduction of the Care Standards, caregiver support and recruitment work, the new Practice Framework, and work to improve the quality and availability of different care placements.

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APPENDIX 1: DETAILED METHODOLOGY

The review involved manually reviewing case records for a representative sample of 698 children/young people in care during financial year 2015/2016. This methodology was chosen because it was thought to be capable of providing a more accurate measure of harm, compared to past approaches that relied on a measure of substantiated maltreatment (which were considered likely to underestimate rates of harm).

The sample was randomised and stratified to enable some generalisations (specifically, the overall extent of harm) to be made to the wider 2015/16 care population. Other findings are descriptive only, and cannot be generalised beyond the group of children/young people identified as experiencing an incident of harm.

Case note review

Rather than relying on substantiated maltreatment findings to measure harm, this review used evidence contained in case notes as the basis of determining harm. Case note review is an established method of child protection research, which enables detection of under-reported harm in records that are not constituted as formal reports of maltreatment (see Huffhines et al., 2016). This approach also enables reviewers to exclude retrospective reporting of harm incidents that happen outside the observation period.

Case note review methodology requires that all relevant electronic case records pertaining to each child/young person in the sample are reviewed by an independent reviewer, and results compared across a team of reviewers. In this review, case notes recorded in CYRAS, pertaining to financial year 2015/2016, were examined on an individual basis for each child/young person sampled.

Children/young people were assumed to be safe in all cases where there was no evidence in any CYRAS record that an incident took place that would meet the CYF practice guidelines or Child Protection Protocol definitions of abuse or neglect.

Case review relies on content analysis of documents where text is coded according to a predetermined coding framework. There are no international protocols for establishing coding frameworks of this nature, although there is one classification system that has been developed alongside the LONGSCAN project. Our team of reviewers chose to develop its own set of codes, which reflected the definitions of statutory care and protection provision in New Zealand. These codes were based on previous case note reviews conducted within CYF.

Guidance on the attribution of harm was developed to supplement existing CYF definitions of harm. These guidelines were refined and stabilised through a cycle of joint and independent review of test cases.

Inter-rater reliability

A team of senior case note reviewers was established for this research, from the iMSD research unit (this team later transitioned to Oranga Tamariki) and the Office of the Chief Social Worker. Each reviewer had extensive experience reviewing CYRAS case notes for the purposes of research, social work quality assurance, and critical incident case reviews.

Inter-rater reliability was established between the four raters through two separate processes.

Firstly, in an initial process, the team tested all variables and values by independently reviewing two groups of ten cases and comparing results. This review was blind, where raters were unaware of the harm rating of the cases, in order to test concurrence in detection of harm amongst reviewers. Through this process, agreement about harm exceeded the 90% level. Variables or values that were

found hard to stabilise were further defined and retested, resulting in some being removed as there was too much variability in ratings. Once all variables and values were finalised, another round of independent rating was conducted, which confirmed that the team of raters agreed in their rating of case material at a level greater than 90%.

In a second and on-going process, all instances of harm ('yes') were moderated by a second reviewer. A sample of cases where the child/young person was assumed to be safe, or where 'no' harm presented, was also included in the moderation process. This moderation was completed on a monthly cycle during the first half of the project, and then again at the conclusion of the project. These results confirmed a high rate of reliability between reviewers, with determinations being changed in less than 5% of cases.

Ethical considerations

This work underwent an internal ethics peer review within Oranga Tamariki. The legal basis for using administrative data for reviewing safety under the Privacy Act 1993 was also confirmed. The review was entirely document-based; there was no contact with children/young people, their social workers, or with anyone else connected with them during the review.

The review team worked within guidelines concerning data handling and storage in order to ensure confidentiality of data. These rules require that no identifying information was reported or released.

A case escalation process was in place should reviewers detect unresolved current safety issues, which placed children/young people at serious risk. This process was not activated. Further work to confirm the safety of those children/young people identified as being at risk of harm has also been undertaken. These checks examined changes in circumstances, and whether continuing perpetrator risk was present. This review did not identify any immediate safety concerns relating to caregivers or children/young people.

Reviewers were experienced social workers, with an extensive background in social work review and audit. Staff members worked as a team to support each other and provide peer review. All reviewers were provided with professional supervision.

Limitations

It is important to note that all social worker judgements about harm are, to an extent, subjective. While reviewers followed existing CYF guidelines relating to physical, emotional, and sexual abuse, and neglect, these definitions are relatively broad, and have not been rigorously tested for inter-rater reliability amongst social workers.

While case note review provides a more accurate and complete measure of the harm experienced by children/young people than past approaches, it is still not possible to capture every incident. For example, it is not possible to measure harm not disclosed by a child/young person, or incidents not recorded within case notes.

As discussed within the body of this report, this research investigated only the most significant harm incident for each children/young person, and so cannot compare the relative safety of different placement types. Further, placement specific findings do not account for the duration of each placement type, or allow for comparison against the rate of children/young people who spent time within a specific placement type and did not experience harm.

Finally, a key methodological limitation associated with case note review is its resource intensive nature. This approach involves manually reviewing all case notes associated with the 698 children/young people sampled. While some children/young people may be in care for a short period, others will be in care significantly longer, and a considerable amount of content may be generated. The research team reviewing these case notes was comprised of four staff working part-time over approximately a 10 month period.

Sampling methodology

This project covers children/young people in the care of the Chief Executive between 1 July 2015 and 30 June 2016. Children/young people in care are those with an active care and protection and/or youth justice custodial order in favour of the Chief Executive, under the Children, Young Persons and Their Families Act of 1989 (CYPF), for the period. It excludes those who were:

- 17 years old or older at the start of the study
- unborn clients subject to a S78 or a S39 order within the period of study but born after the study
- only subject to S141, S1412A, S142A, and S205 of the CYPF Act for the period
- in custody under the Care of the Children Act (COCA) and/or other non-CYPF Act orders.

The population of children/young people in care during financial year 2015/16 involved:

- 4,163 (55%) placed with kin
- 3,467 (45%) placed with non-kin

- 2,351 (26%) under the age of 5 at the start of the study
- 5,279 (74%) 5 years old or older

- 3,430 (45%) girls
- 4,200 (55%) boys

- 4,994 (65%) Maori
- 2,636 (35%) non-Maori

To reflect the complexity of care placements, the sample was stratified by a kin/non-kin placement variable. This variable was based on the client's most actively involved placement. Active involvement was based on the duration of the placement, whether the placement has an approved financial support cost item, or it is the latest placement for the client for the period.

A random sample of clients was selected from the 7,630 children/young people covered in this study, with probability proportional to the size of each stratum. A total of 698 children/young people (352 from kin and 346 from non-kin) were selected to provide a reliable estimate of harm, with 95% confidence at national and stratum level. This approach ensured that:

- the volume of case review work was minimised, and
- the delivery of results within the year could be achieved.

In estimating the size of the sample, a number of previous studies were reviewed, including the results of a pilot study done in November 2015, but none were found that closely resembled the target population for this work. Additionally, reported rates of harm from these studies were quite varied, ranging from less than 5% to about 30%. To estimate a conservative but optimum size for the sample, a 50% rate of harm was initially assumed. This ensured that the sample size was large enough to detect higher rates of harm, but small enough to minimise the cost of the case review.

APPENDIX 2: FULL LIST OF CUSTODY ARRANGEMENTS

Code	Description
25AFPOSW	25 Application for Place of Safety Warrant
26AFWTR	26 Application for warrant to remove
57IDCR	Intellectual Disability (Compulsory Care and Rehab) Act 2003
58MHA	Mental Health (Compulsory Assessment and Treatment) Act 1992
COC027PLC	s27 COCA - Court appointed guardian (placement)
COC031	s31 COCA - Court Ordered Placement CYP Under Guardianship Court (wardship)
COC031PLC	s31 COCA - Application Guardianship of Court(wardship) for Placement
COC077	s77 COCA - Warrant Preventing Removal of Child from NZ
COC117PLC	s117 COCA - Warrant Prevent Concealment (placement)
COC118PLC	s118 COCA - Warrant Prevent removal (placement)
COC119PLC	s119 COCA - Warrant Return of child (placement)
IMM059	s59 Immigration Act - Warrant of care
IMM060	s60 Immigration Act - Warrant of commitment
IMM128	s128(6)(a)(i) Immigration Act 1987
S074	s7(4) Adoption Act
S101	s101 Custody order
S102	s102 Interim custody order
S1102A	s110(2a) Sole guardianship
S139	s139 Temporary care agreement
S140	s140 Extended care agreement
S141	s141 Extend care of disabled
S1412A	s141(2a) Care to an Iwi Social Service

S1412B	s141(2b) Care to a Director of CFSS
S142	s142 Care for moderate disability
S1424B	s142(4B) Criminal Justice Remand
S1425A	S142(5A) Criminal Justice Remand for assessment
S142A	s142(A) Criminal Justice Programme
S205	s205 Prevention of removal of child from NZ
S235	s235 Arrested/custody CE
S235CP	s235 Arrested/custody CE
S235YJ	s235 Arrested/custody CE
S236	s236 Arrested Police (over 24hrs)
S2381C	s238(1)(c) Custody pending hearing to parents or guardians
S2381D	s238(1)(d) Custody pending hearing to the CEO
S2381E	s238(1)(e) Custody pending hearing to the Police
S297B5	s297B(5) Custody to enable a program to be provided
S3074	s307(4) Custody to enable program or activity to be provided
S311S283	s311 & s283(n) Supervision with residence order
S345	s345 Custody pending appeal
S39	s39 Place of Safety warrant
S40	s40 Warrant to Remove
S42	s42 Search without warrant
S45	s45 Extend length of S39 or S40 Warrant
S48	s48 Unaccompanied child or young person
S78	s78 Custody pending determination

APPENDIX 3: FACTORS ASSOCIATED WITH HARM

While this research was not specifically designed to investigate why harm occurs within different placement types, several factors are identified within existing international research literature[13]. This existing evidence highlights some relevant factors that may act as drivers for harm, which intersect and reinforce each other in a variety of ways. These factors include:

- Caregiver stress associated with challenging behaviours and a lack of on-going support.
- Poverty-related caregiver stress, particularly within kin care.
- Placements with multiple children/young people are also associated with increased caregiver stress.
- Supply issues are associated with increased recourse to inappropriate placements.
- Placement instability, resulting from inappropriate placements and a lack of caregiver support.
- Poor social worker engagement is associated with unwillingness by children/young people to disclose harm.
- Harm perpetrated by natural parents is associated with inappropriate return home decisions, or poor supervision of access.
- Incidents of harm within residences, which are often perpetrated by other children/young people, are associated with limited staff capability and inappropriate organisational cultures.
- Poor record keeping, which may result in children/young people being placed with inappropriate caregivers, who have been the subject of previous harm allegations.
- A range of other general practice issues are also identified, including: poor planning decisions, incomplete assessment and completion of care plans, inconsistent case planning, poor screening of carers, limited on-going supervision and assessment of placement safety, and a lack of communication between involved professionals.

[13] See Uliando and Mellor, 2012; Font, 2015; Font, 2015b; Biehal et al., 2014; Hobbes et al., 1999; NSPCC, 2014; Euser et al., 2014; Colton, 2002.