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Referee report on *Predictive Risk Modelling and Child Maltreatment – An Ethical Review*

This is a thoughtful, well-informed, and very comprehensive ethical review of the use of Predictive Risk Modelling (PRM) to protect children from maltreatment. The Review provides a number of important recommendations which are well-supported by the arguments given, and it draws constructively on relevant philosophical and empirical research, along with the risk-stratification methods outlined in the Vulnerable Children report by Vaithianathan et al (2012).

The Review demonstrates well how using PRM to help identify families where children are at risk of maltreatment is likely to improve on current approaches (used in NZ and elsewhere), without replacing certain beneficial aspects of those approaches – such as health professional-initiated referrals, and the use of professional judgement in identifying and responding to the risk of maltreatment. The Review makes clear how the risk-stratification delivered by PRM is crucial for well-targeted and effective interventions, which are particularly important in efforts to redress the relatively high child maltreatment rate in New Zealand. The Review acknowledges that maltreatment of a child often has long-term effects which reverberate through the victim's life, and so can create significant, if not insurmountable, obstacles to their flourishing. (The work of Martha Nussbaum [2006] on the importance of 'central human capabilities', and Daniel Russell [2012] on a contemporary account of welfare, could be drawn on here to help flesh out what a humanly flourishing life plausibly involves, and so what the maltreatment of children threatens to prevent.) Indeed, in extreme cases maltreatment can lead to the victim becoming a perpetrator of child abuse themselves as an adult, and thus a repeating cycle can be created. Further, the maltreatment of children by their designated *parents* (whether biological or social) is particularly egregious, involving a deep betrayal of trust, and often powerful and disturbing feelings of severe betrayal in the victims.

PRM is obviously a sophisticated and powerful tool. It seems likely to identify a significant proportion of children at risk of maltreatment and so casts an impressively wide net. Also, the dynamic nature of PRM, in recalculating the risk on occasions of changing family circumstances, is an important feature, as it provides opportunities for timely engagement with at risk families. The Review helpfully explains that there are good reasons for believing that a targeted program using PRM would be a more cost-effective and overall less intrusive way of reducing child maltreatment than would developing more robust universal programmes, and it shows how PRM would be less likely to compromise professional-family relationships, compared with universal programmes. The Review indicates that predicting the risk of child maltreatment via PRM would be a pioneering use of this tool, but this also provides particular reason to be cautious about adopting it for such purposes. The Review therefore identifies a number of salient ethical concerns about the use of PRM in this context, and provides some excellent suggestions for addressing those concerns.

The accuracy and predictability of PRM seem to be within acceptable boundaries, and evidently compare well with those of, for example, mammograms. Here I thought it would be useful to provide more detail about how child 'neglect' is defined, and about what data the PRM uses in calculating the risk of neglect. (For example, I wondered whether some cases of childhood obesity could count as 'neglect'.) I thought the Review could make more use of hypothetical cases (such as that on p. 46),

particularly to illustrate the sorts of interventions that may be envisaged. Existing research on monitoring for, and responses to, the abuse and neglect of the elderly by their carers, might also be worth investigating, as some parallel issues arise. It would be interesting to consider how certain religious practices (such as the denial by Jehovah's Witness parents of blood transfusions to their children) would fit into the maltreatment categories used, and what responses would be regarded as appropriate in such cases. I notice that a separate report (mentioned on p. 33) is being prepared on cultural influences on child maltreatment – this report will be an important addition to discussions about the ethical implementation of PRM in this context. It seemed to me that it would also be useful to consider the value of parental autonomy or discretion to raise children in particular ways, and whether such autonomy has a kind of 'presumptive priority' (see Robertson 1994, Brighouse & Swift 2006, Overall 2012, and, perhaps, Christos Tsiolkas' novel, *The Slap*, 2008).

The Review raises the important concern that an identification by PRM of a family as 'at risk' can create a presumption that maltreatment will occur (without intervention), when this may not actually eventuate. This is a significant issue, and the Review does well to acknowledge the burdens that can be associated with such a finding. However, it could be argued that, at least the *psychological* burdens that might be experienced by parents/carers due to such a finding are in a sense outweighed by the considerably greater harms to children in other families which are likely to be prevented by the general adoption of PRM for such purposes. (Likewise, where there is regular universal bowel cancer screening for people over 50, as in Australia, those who turn out not to have early signs of bowel cancer are unlikely to regard their anxiety at waiting for their test results as sufficient reason for such screening programs to be abandoned.) The Review also expresses the concern that, "While we might accept that it is proper for an individual to bear costs associated with actual realised wrong doing, it is difficult to justify the imposition of such costs in anticipation of conduct that might never come to pass, merely on the basis of that individual's membership of a high risk group" (p. 23). However, certain sorts of costs due to one's membership of a particular high-risk group are not necessarily regarded by the community as unfair in other sorts of cases, such as where all drivers under 25 are expected to pay higher motor vehicle insurance premiums (including government-imposed compulsory third party insurance), even though a particular driver may not end up being involved in a car accident which they are at fault for.

The discussion of possible protection staff responses to an 'at-risk' identification shows good awareness of the complexity and layering of many child maltreatment problems. The Review presents some reasonably strong arguments (pp. 31-3) against *mandated* engagement in cases of high-risk families, as often being (eg.) counterproductive, and it discusses (eg. p. 22) the importance of *offering* rather than *requiring* engagement by families in such circumstances. Recommendation # 11 that for high-risk families engagement be voluntary, therefore seems to be well-justified. In this context it might be worth considering what published research may reveal about how often families in the top two risk deciles are likely to actually take up such offers of engagement. The Review is also very mindful of the problems of PRM leading to *over*-identification and *under*-identification of maltreatment, and it makes excellent suggestions (p. 22) about how to reduce the negative implications of the inevitable false positives with using PRM. The Review shows admirable sensitivity to the various burdens of stigmatisation that identification as 'at risk' exposes one to, and suggests some sensible and realistic strategies for ameliorating those burdens.

The Review mentions the problem that carers might unexpectedly (eg. via an intervention being offered) learn that a new partner of theirs has characteristics which lead to the child they are now raising with the new partner being considered ‘at risk’ (of maltreatment). In considering the relevant ethical issues in this context it might be useful to draw on discussions of the ethics of sharing familial genetic information, in, for example, presymptomatic testing for bowel cancer. Some have argued that such genetic information is plausibly understood as analogous to a joint bank account (see eg. Parker 2012), where a strong justification is needed for *excluding* another account holder from accessing the account. (Similar arguments also arise in the context of whether to provide donor-conceived children with identifying information about the gamete donors involved in their conception.) For in both the genetic case and the child maltreatment case, it could be argued that privacy or confidentiality protections are not plausibly thought to extend to withholding such information, and that the other party has an overriding right to know such information. The Review also demonstrates clearly how PRM is comparable to more familiar screening programs, and shows how it performs well in relation to principles analogous to the WHO Principles for ethical screening programmes.

The discussion (pp. 45ff) of privacy and confidentiality in this context is useful, though perhaps a more positive characterisation of the concept of privacy could be provided than that given on p. 44. Further, it is not clear how autonomy-based arguments for respecting privacy would apply to young children, though it is, of course, the privacy of the *parents/carers* that it mostly under discussion here. The Review (p. 45) conceptualises the issue about whether family privacy should be breached as a matter of finding a ‘way of understanding’ privacy rights in this context of risk-rated families, which involved respecting the “privacy rights and their limits without abandoning children in high-risk families”. Another way of approaching this issue might be to retain a fairly standard account of privacy, and of the value of/right to privacy, but to distinguish between *restricting* privacy, and *violating* (ie. unjustifiably restricting) privacy. Consider an analogous distinction in the context of the ethical demand to respect patient autonomy in clinical practice. Not every restriction of a patient’s autonomy is plausibly considered a violation of their autonomy – rather, a patient’s autonomy is plausibly thought to be *violated* when it is restricted *unjustifiably*. Thus, the requirement on health professionals to respect patients’ autonomy can be understood as demanding that health professionals do not *unjustifiably* restrict the autonomy of their patients, rather than requiring health professionals to meet whatever informed and voluntary request patients make. Suppose only one of two patients can be given an intensive care bed, and a patient with advanced renal failure is denied admission to intensive care in favour of a patient who stands to benefit far more from treatment in intensive care. The former patient’s autonomy is certainly restricted by being refused admission to intensive care; but if justice requires that the bed be provided to the other patient instead, then the restriction of the first patient’s autonomy in denying him an intensive care bed is justifiable. Similarly, the ethical demand on child protection staff to respect privacy could be viewed as a side-constraint on the pursuit of proper professional goals (eg. protection and/or promotion of a vulnerable child’s important interests). Thus, restricting an at-risk family’s privacy, for the sake of protecting the child from maltreatment, would count as *violating* that family’s privacy only where the restriction itself is ethically unjustifiable.

The Review goes on (pp. 47-8) to provide a sound guiding principle regarding the content of confidential information about risk-rated families that should be provided to child protection officials. The confidentiality issues are handled reasonably well, and to go into them further would require significant additional detail (see Bennett 2007). (It might be worth investigating whether

there are relevant empirical studies about breaching confidentiality in such circumstances which would be useful here.) Some of the data gathered by PRM was not initially collected or revealed by the persons concerned in the context of a confidential professional client relationship, involving a commitment or promise – implicit or explicit – to keep that information confidential. So, it might be worth considering whether or not this weakens the claim of such information to be protected. Also, it might be wondered whether *privacy* becomes a more apt concept than *confidentiality* in addressing certain issues regarding such information.

Overall I think this Review provides an excellent set of recommendations which should be strongly considered if PRM for child treatment is to be implemented in New Zealand.

Thank you for providing me with the opportunity to comments on this Review.

Yours sincerely,



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REFERENCES

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