every child every chance

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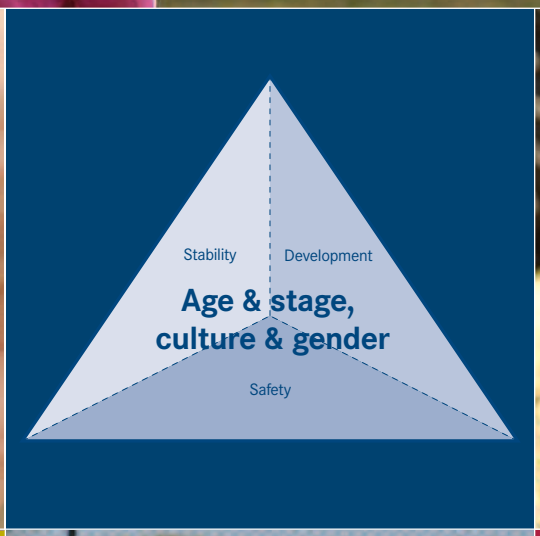
Cumulative harm: a conceptual overview

Best interests series



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Cumulative harm: a conceptual overview

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Introduction

The *Children, Youth and Families Act 2005* (CYFA) creates a strong authorising environment to recognise and address cumulative harm as an integral factor, when considering a child's safety and development. Early identification and response to patterns of cumulative harm to children and young people, and assisting families to receive appropriate supports and services, is a critical part of the legislative and practice reform of the service system. The current reform of the child and family services system in Victoria has been underway since 2002, and has included a comprehensive review and consultation process and the development of new legislation. The CYFA will commence in April 2007. This paper is intended to contribute to practice across the Child Protection, Placement and Support and Family Services sectors.

The Best Interests Principles in s. 10(1) of the CYFA are clear that any decision must always consider the need to protect a child from harm, protect their rights and promote their development. The importance of understanding the effects of cumulative patterns of harm are given prominence in the Best Interests Principles and as such, should be considered in any decision making or actions taken by the Court, Child Protection, or a community service.

This paper defines and discusses cumulative harm and provides a conceptual overview of the issue. The historical context is discussed and the theoretical underpinnings explored and a range of relevant paradigms and research is presented. While this paper presents an academic discussion of the issues, the aim is to engage workers in the field with the experience of children and young people whose lives are dynamic, evolving and vulnerable to cumulative harm, particularly at the hands of those who are meant to care and protect them.

What is cumulative harm?

Cumulative harm refers to the effects of patterns of circumstances and events in a child's life, which diminish a child's sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or 'layers' of neglect. The unremitting daily impact on the child can be profound and exponential, covering multiple dimensions of the child's life.

When considering the literature about cumulative harm, it has been relevant to study theory and research that documents multiple-victimisation, multiple harmful experiences that are interrelated, and maltreatment that is recurrent over prolonged periods. A definition of cumulative harm needs to incorporate all the dimensions.

> *Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.*

Isolated maltreatment might be defined as a single maltreatment or interrelated events or a series of interrelated episodes within a time specified period. Chronic maltreatment might be defined as recurrent incidents of maltreatment over a prolonged period of time (Bromfield & Higgins 2005).

In addition, there is a growing body of evidence to suggest that a maltreatment type does not occur independently and that:

> *a significant proportion of maltreated individuals experience not just repeated episodes of one type of maltreatment, but are likely to be the victim of other forms of abuse or neglect (Higgins 2004, p.51).*

Maltreatment types are also noted to be interrelated, or overlapping (Higgins 2004). As many forms of maltreatment co-occur and could have joint effects, their cumulative impact should not be overlooked (Hamilton & Browne 1999, Rossman & Rosenberg 1998).

The global and complex effects of cumulative harm have been noted within the trauma and psychiatry fields and traditional definitions of trauma have been critiqued as being inadequate in terms of their scope. The National Child Traumatic Stress Network (NCTSN) in the USA used the term 'complex trauma' to describe the experience of multiple, chronic and prolonged developmentally adverse traumatic events. These events are most often of an interpersonal nature and early life onset. This definition was in response to the lack of a definition that could capture the 'multiplicity of exposures over critical developmental periods' (van der Kolk 2005, p.406). These exposures often occur within the child's care-giving system and include physical, emotional and educational neglect and child abuse beginning in early childhood (van der Kolk 2005).

Practice implication:

A major practice implication when considering cumulative harm is that workers are required to assess each notification as bringing new information, which needs to be carefully integrated into the history contained in previous intakes/assessments. Earlier intervention to link vulnerable children to universal services or specialist support services is required to prevent cumulative harm.

A focus on cumulative harm guides those working in the Child Protection, family and placement services system to approach their practice in a different way. It requires that practice is holistic at every phase of the intervention to contribute to the remediation of cumulative harm. Amongst other things, this requires that a range of different services are partnered with when working with vulnerable children and families.

A case example: 'Melanie'

The voice of the child in relation to cumulative harm may be exemplified by Melanie, when she was nine years old. Who was referred to the writer for counselling as she had been suspended from the sixth primary school she had attended and her placement was also at risk of breaking down. Since birth her life had been marked by severe neglect, violence and physical and sexual abuse.

What is striking about the intervention in the early years of Melanie's life is that the impact of the events was not understood holistically from her perspective. There are rich learnings from this case in terms of the importance of understanding cumulative harm from the child's perspective.

Each episode of professional intervention occurred in isolation and did not ground the assessment contextually or historically from Melanie's perspective.

This case highlights the impact of cumulative harm if prevention and assertive and effective engagement with the parents does not occur. The minimalist early interventions to create safety and stability for Melanie, either in her family of origin or in subsequent placements, were lost opportunities to alter her life trajectory. Whilst Melanie's behavioural disturbance could be seen to be more extreme than some other young people, her experience is not uncommon in the Child Protection and Family Services sector.

The focus on **episodic** assessment and **immediate** safety during Melanie's first seven years meant that professionals involved in her life did not fully appreciate the **cumulative** harm she experienced and its devastating impact on her development. The cumulative harm Melanie experienced was a result of acts of omission and commission, which impacted globally on her development; her ability to regulate her emotions, to learn and concentrate at school and to connect with others.

Melanie's early years

Melanie was born chemically dependent to parents with a long history of drug abuse and family violence. They lived in a rooming house at the time of Melanie's birth and had not engaged with antenatal care. Her father was a violent, unpredictable man who had repeatedly assaulted her mother during pregnancy and after Melanie's birth. Her mother was frightened, frightening and overwhelmed. Her behaviour was unpredictable; she had a long history of heroin use and had mostly severed ties with her family of origin who despaired of her lifestyle. Years later, Melanie's mother disclosed that, as a child, she had been repeatedly sexually abused by a trusted uncle and had never been able to tell her parents. After Melanie's birth, her mother appeared to be trapped in a series of crises and despair.

Melanie had been admitted to hospital as a 'failure to thrive baby' at the age of nine months, and her hospital records state that she was irritable and easily startled. There had been three notifications up to this point, however, as the parents were apparently cooperative and willing to attend services, no further action occurred. Prior to this there had been several services attempting to help the family including maternal and child health, drug and alcohol services, and housing. Melanie's mother separated from Melanie's father when she was 14 months old, following a particularly brutal assault where she required hospitalisation, and criminal charges were made. She struggled to manage her heavy substance abuse, violent partners, trauma history (which was never addressed) and transient lifestyle. Melanie was placed for a six-week period and was described as 'difficult' by the carers, resistant to being cuddled and very unsettled at night.

Service responses to Melanie

There had been eight notifications to Child Protection before Melanie was three years old. One resulted in a supervision order. Numerous community service organisations were involved for varying amounts of time and many referrals were made to other services in response to immediate risk. Adult mental health, housing, family violence services, drug and alcohol services, local government family support, acute health services, and homelessness services had all been present in the family's life when Melanie was an infant. Most of the contact was episodic, crisis driven and not focused on the parenting role or capacity.

On another occasion Child Protection issued a Protection Application by safe custody as Melanie was found abandoned in a flat with dirty syringes on the floor. Melanie's mother contested the Protection Application and the court ordered Melanie to be returned home to her care. No service managed to engage Melanie's father.

Various workers engaged with the family and warmed to Melanie's mother, however there was an overly optimistic assessment of her ability or willingness to prioritise Melanie's needs in an **ongoing** way, and an inadequate length of professional involvement and supports to ensure that positive changes were maintained. Services would usually terminate when the issues began to settle, or as a result of the frequent changes of address, or when she had agreed to counselling. However the positive **intent** to attend counselling did not mean that she would actually engage in a change process. Workers struggled to have continuity given the ongoing crises and frequent moves and changes of regions. The moves usually followed a crisis with the rent, fights with the neighbours or a fight or reunion with a partner.

Melanie had been placed several times as child protection and various services tried to support her mother and promote reunification. During this time Melanie was sexually abused by at least three perpetrators (one known to be a partner of Melanie's mother and one being the adult brother of her respite carer), and ultimately was placed on a Guardianship to the Secretary order when she was seven, following the death of her mother in violent circumstances.

Witnessing her mother's partner's violence and directly experiencing their abuse was an intrusive and reoccurring nightmare for Melanie. She had several unsuccessful placements in families who could not manage her increasingly extreme behaviours. Melanie was living in a residential unit when she was suspended from school for kicking and spitting at teachers and for sexualised behaviours towards other children. Her teachers described her as '**hyperactive and feral**' and reported that she was isolated and very angry, particularly when limits were set.

Melanie's words

Initially Melanie described herself as 'feral' to the writer and said she didn't care 'cause she was born that way'. She had no words about the past trauma or her mother's death but as she engaged with drawing in counselling sessions, her early work was frequently of large figures with big hands and eyes, knives and blood. In a counselling session with the writer one day, she responded to the possibility that she 'wasn't feral, but that the bad things that had happened to her were feral'. She hid behind a chair and curled in the foetal position with her back touching the wall: 'cause no-one can get you from behind if you can feel the wall', and struggled to find language to talk for the first time about her past. Like many children who begin to express the terrifying things that had happened to them, she was acutely distressed but initially there were no tears. Her colour changed and her voice was uncharacteristically quiet and tentative.

> *You know, I'd try to pretend I was asleep, cause I couldn't and I was so scared of him…I couldn't… he was so big…I can't get out…and my heart was going bump bump so loud…I can still hear my mum crying and screaming…it's all messed up…I was so scared I couldn't breathe. There's all this stuff in my head…it's like ghosts. All this bad stuff…it's so…it's been like dominos. You know when every thing just crashes down…you know, when you stand dominos up and one topples over the others. You know, boom boom boom and… you know…you don't know which one started and where it will end and that's me!...and I'm scared I might die like her.*

Melanie continued over many months to struggle to find the words to express the unspeakable and to grieve what had happened to her. Her behaviour which had become so difficult to manage and had lead her to be distanced from the nurturing care she so desperately needed, was typical of many children who have been traumatised through cumulative harm. Many children cannot 'say' what has happened to them, they will show you through the language of their behaviour and only when they feel a reasonable sense of control and acceptance will they take the risk to tell.

The engagement with committed, consistent, compassionate and positive adults, who see the good in them, despite the 'bad' behaviour, is crucial to the child's recovery. Parents/carers, teachers and workers who take the time to really help the child to begin to express and make sense of the overwhelming events, are helping the child to process and begin to integrate the trauma. This is of central importance to the recovery process. Traumatic memories are not stored as a narrative or in language as are most memories. Rather, traumatic memories are stored as vivid images and sensations; they are unprocessed, which make sense of the triggers like smells, sights, sounds and sensations that flood the child with the same feelings and terror, as if the abuse was happening in the present time. In Melanie's words: 'they're just like scrambled…yeah like scrambled eggs…you know…all messed into each other'.

Children who have experienced cumulative harm are usually initially unable to connect their current difficulties with their past trauma. This fragmentation and disconnection is typical of the **cumulative** effects of multiple exposures to terrifying events, and inconsistent and inadequate levels of nurture. Melanie's experience of neglect and episodic violence and abuse is common to many children in the Child Protection and out-of-home care systems. Children who have had so many painful things happen and who have not had the comforting healing relationships that all human beings need are particularly at risk of further harm, both at their own hands and at the hands of others (Herman 1992).

Towards recovery

For the past three years Melanie has lived with extraordinary carers who have 'hung in there' through her difficult, violent and self-harming behaviours. They have enabled her to begin to trust that not all adults will betray her. The carers have required consistent support to manage her behaviours and several times she was placed in an inpatient unit. Whilst there have been positive, calm periods, there have been very distressing times. When Melanie was triggered she would act out in a pattern that is typical for many children and young people who have experienced complex trauma, that is, it would be re-enacted.

Over time the carers began to recognise the triggers, which would flood Melanie into a state of overwhelm, when she would act out in classic freeze/fight/flight response. At times, the carers have been punched, scratched, spat on, had rooms trashed, curtains cut, been locked out of their house, witnessed her cutting herself, had to keep knives and medications in locked cupboards, had to respond to her running away, tried to manage her from jumping out of cars, and endured rumours and social humiliations. She has sworn and screamed at them when they say 'no' to the inappropriate item of clothes, or the fast food, or the chat room on the internet, or the cigarettes, or the R rated horror films she was drawn to watching. Like many children who have experienced cumulative harm and are acutely traumatised, Melanie didn't trust anyone. Her carers were tested again and again; Melanie was sure they wouldn't cope with her and she even confided one day that she might as well 'get it over and done with' (that being their rejection of her).

Traumatised children have behavioural impulsivity, hyperarousal and cognitive distortions that have resulted from their earlier traumatic experience. In Melanie's words:

> *I don't know…I didn't mean to hurt her, but she was coming towards me with that face! I just go all hot…it's like she's gonna get me…she's stupid that teacher…before you know it my leg just kicked and kicked her…I didn't kick her five times though…she's lying!*

They spend the majority of time in a low-level state of fear and focus on non-verbal rather than verbal cues. Melanie would act impulsively and hit out at people or objects before she would think about the consequences of her actions. This impacted on her ability to learn, make friendships at school and added to her feeling of sadness and loneliness.

Many carers could not have sustained the commitment that was required to care for Melanie, however many do. The critical difference is often the consistent support, training and specialist services being available when required.

> *A child will adapt to a violent, chaotic environment by becoming hypersensitive to external stimuli, hypervigilant, and being in a persistent stress-response state, or feeling persistently threatened and defensive. This is seen in children who are exposed to neuro-developmental trauma and are frequently diagnosed with Attention Deficit Disorder with Hyperactivity (Perry 1997).*

Van der Kolk (2005) draws attention to the limitations of these descriptions which fail to do justice to the spectrum of problems of traumatised children who have experienced cumulative harm.

> *Because infants and children who experience multiple forms of abuse often experience developmental delays across a broad spectrum, including cognitive, language, motor, and socialization skills, they tend to display very complex disturbances, with a variety of different, often fluctuating presentations (p.405).*
>
> *…multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence, have consistent and predictable consequences that affect many areas of functioning. These experiences engender intense affects, such as rage, betrayal, fear, resignation, defeat, and shame, and efforts to ward off the recurrence of those emotions, including the avoidance of experiences that precipitate them or engaging in behaviours that convey a subjective sense of control in the face of potential threats. These children tend to re-enact their traumas behaviourally, either as perpetrators (eg, aggressive or sexual acting out against other children) or in frozen avoidance reactions (p.406).*

Through skilled, loving and very patient carers, who didn't give up on Melanie; persisted in finding things she was good at; made time for fun; comforted her after her nightmares; accepted support and respite when needed; understood her 'feral' behaviour through the lens of her trauma and attachment disturbance; and most importantly helped her to make sense of it, and connect her feelings with the memories of what had happened to her, Melanie began to recover. The literature refers to this process as the 'integration' or processing of the trauma.

Young people who have been repeatedly victimised can become stuck on the classic triangle of victim, perpetrator, rescuer. It is critical to not view them in fragmented polarised ways, as 'victims' or 'offenders'. They need to be called by their name and we need to understand the unique individual they are. They are resilient and possess enormous strengths and potential and should not be defined by the abuse they have suffered. To heal, interventions need to be thoughtful, purposeful and integrated, rather than reactive, episodic attempts to 'rescue'.

Miller and Dwyer (1997) described the role of parents, carers and workers bearing witness to the child's suffering and the healing that takes place when this occurs.

> *This requires a care-team approach with the child and parents/carers at the centre and Child Protection, family service workers, teachers, therapists and significant others providing consistent support, respite and leadership when needed.*

Whilst working with or caring for young people who have suffered severe cumulative harm is not for the faint-hearted, witnessing and participating in their recovery is deeply rewarding and creative work.

Melanie has begun to catch up on her schoolwork and sometimes she confides to her carers that she feels 'lighter' and that maybe she 'is not bad inside'. She loves her gymnastics and has begun to leave notes for the carers that she loves them. There are still some very hard times but they are lessening in frequency and she now gets invited over to other friends' houses to play. The sexualised behaviours have long ceased and she no longer requires an integration aide at school at play times. She has astounded her teachers with her progress in literacy and she writes long stories. Her carers and teachers, together with her current worker and therapist, have worked through many challenging times. Anniversaries of her mother's death and birthdays are particularly difficult. She still reacts badly to some smells, the sight of blood and unexpected touch. Her adolescence is likely to trigger new issues or the need to rework some of the old wounds.

Children like Melanie who have endured cumulative harm deserve the very best from our service system. If the interventions from different services and sectors had taken a different form, the outcomes for Melanie and her carers may have been very different, as later harms could have been prevented. The importance of purposeful, outcome-focused, child-centred and family sensitive practice and early intervention cannot be overstated.

The CYFA provides an opportunity to improve practice that will strengthen positive outcomes for children. They deserve no less.

What is the change?

The CYFA provides sets of principles that must be regarded by decision makers. For the purposes of the CYFA (s. 8), decision makers are the Court, the Secretary and community services that must have regard to the principles set out in making any decision or taking any action under this Act.

The principles to which decision makers must have regard are: Best Interest Principles (s. 10), Decision Making Principles (s. 11), Additional Decision Making Principles for Aboriginal Children (s. 12), Aboriginal Child Placement Principle (s. 13), Further Principles for placement of Aboriginal child (s. 14).

The CYFA (s. 10) states the best interests must always be paramount when making a decision, or taking action with regard to a child. Included in these principles is s. 10(3)(e) which must consider 'the effects of cumulative patterns of harm on a child's safety and development'.

The grounds for statutory intervention when a child is in need of protection do not change, however they will include accumulated harm, as well as crises or a single serious incident, and focus on the impact of the harm on a child's development (physical, health, cognitive, emotional, psychological, social, environmental, learning, educational, and spiritual) and wellbeing.

- Section 162(2) determines that: 'the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances'.
- Sections 10 and 162 enable earlier intervention and prevention to promote development and safety, and recognition of the cumulative impact of acts, omissions or circumstances that may result in significant harm whereby a child is in need of protection. These acts include:

  162(c) if the child has suffered or is likely to suffer physical injury or harm

  162(d) if the child has suffered or is likely to suffer harm as a result of sexual abuse

  162(e) if the child's emotional or intellectual development is, or is likely to be, significantly damaged and parents have not protected

  162(f) the child's physical development or health has been or is likely to be significantly harmed

These significant legislative changes intend to give greater attention to the cumulative effects of neglect and abuse on children's longer-term wellbeing and development, and shift away from an episodic focus on immediate harm.

The inclusion of the words 'accumulate through a series' in section 162(2) draws attention to the pattern and history of the child's experience, which may have a significant and harmful impact on their development. Specifying acts of 'omission', which may have been considered as low risk if considered episodically, enables a more holistic assessment of the child's lived experience. This calls for policy consideration of the practice changes that will be required to support the legislation.

How does the court currently view cumulative harm?

Whilst the new legislation's additional focus on cumulative harm allows Child Protection greater opportunity to persuade the court to consider the child in an holistic manner, the notion of cumulative harm is a concept already accepted and used by the court. This is reflected in the following often cited passage of Lord Nicholls of Birkenhead in Re H,[1996]2WLR8 at28:

> *The range of facts which may properly be taken into account is infinite. Facts include the history of members of the family, the state of relationships, within a family, proposed changes within the membership of a family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child… And facts which are minor or even trivial if considered in isolation, when taken together may suffice to satisfy the court of the likelihood of future harm. (p.591)*

Practice implication:

Each intake/assessment needs to be historically grounded and mindful of the cumulative impacts of harm, and the exponential impact on the child.

In practice, the challenge for Child Protection when required, is to present evidence to the court that shows the effects of the cumulative nature of harm on children and how it impacts on their development and safety.

An historical perspective

This section outlines the historical context that led to the current reform process in the service system in Victoria. The new policy direction and service development are also outlined so that the theoretical discussion on cumulative harm that follows is grounded in the historical context.

Cumulative harm is not a **new** component of Child Protection practice and is currently being considered in risk assessments and decision making to varying degrees and in different ways. The Victorian Risk Framework, which has been the risk assessment tool used by Child Protection across the state since 1999 has a section labelled 'Pattern and history of harm' which is part of every intake and should inform the analysis and case planning. Indeed, there is good practice currently occurring across the state, which is cognisant of cumulative harm and responsive to the complex needs of children and families. However, many practitioners, researchers and reviewers of practice have critiqued the dominant culture which has evolved as being less engaging of families in assessment and casework and more concerned with a case management focus on immediate risk.

The intention of the previous Act was to respond to vulnerable children and families in respectful, appropriate ways using the minimum intervention required. One of the **unintended** consequences of the practice, which developed from the *Children and Young Persons Act 1989*, is that intake and initial investigations were increasingly based on episodic assessments, which were focused on immediate risk and safety, and less focused on the developmental wellbeing of children, and patterns of abuse and neglect over time.

Protecting children: The child protection outcomes project (2003) also known as The Allen Report, identified the following common assumptions that underpin the CYPA and associated practice frameworks:

- notified problems are easily identifiable
- notified problems are amenable to targeted and time-limited action
- interventions can effect a permanent improvement or change
- the improvements render the appearance of other problems unlikely.

Bromfield, Gillingham and Higgins (2003) have argued that the current CYPA has shaped thinking about a child's wellbeing and safety into a 'cause and effect' model, consequently framing child maltreatment as an isolated event. They have also argued that, in the research domain, definitions of child maltreatment have generally not taken into account the cumulative impact of maltreatment that occurs over an extended period of time via multiple types of maltreatment and by multiple perpetrators. Instead, the focus of research in relation to child maltreatment has been on predicting single incidents of child maltreatment (Bromfield, Gillingham and Higgins 2003).

It can be argued that the practicalities of resource constraints, in the historical context of mandatory reporting, unrelenting demand and the increasing complexity of the families' presentations, have been the major drivers in the evolution of the predominance of episodic assessment. This can be conceptualised as a systemic adaptation that endeavoured to prioritise the most severe cases so that the system would not be overwhelmed by demand and rendered ineffectual. Practitioners have not been ignorant about the importance of prevention and early intervention and

indeed about the notion of cumulative harm, however it has not been privileged as a core issue, given the need to manage critical, extreme cases without 'toppling the system over'.

The research and analysis of statistics in relation to Victorian families in *An Integrated Strategy for Child Protection and Placement Services* in 2002 showed a strong connection between family type and involvement in Child protection. Since 1995-96, parents involved in substantiated cases who have one or more characteristics of vulnerability increased from 41 per cent to 73 per cent in 2000-01. The proportion of parents with two or more characteristics increased from 9 per cent in 1995-96 to 44 per cent in 2000-01. The report encapsulated the issues facing the Victorian workforce when it stated that:

> Analysis of the characteristics of parents involved in substantiated cases of child abuse or neglect indicates complexities and difficulties facing these families...[also] giving important indications of the changes in the client population and, therefore, the challenges facing the child protection system in supporting vulnerable children and families (Department of Human Services 2002).

The Allen Report (2003) found that cumulative harm is widespread, given that 62 per cent of notifications made in 2001-02 had been the subject of a previous notification. This was a striking comparison with 36 per cent having been the subject of a previous notification in 1993-94. In addition, 40 per cent of the substantiations in 2001-02 had been substantiated previously. Also notable is that almost two-thirds of the substantiations in 2001-02 were in relation to emotional harm and neglect.

The Allen Report (2003) went further to state that the high (and increasing) number of renotifications and re-substantiations might reveal opportunity to strengthen Child Protection responses by placing a stronger focus on the cumulative impact of harm rather than understanding 'child abuse and neglect as a point in time event' (Allen Consulting Group 2003, p.71). A good assessment framework will instead consider assessment as a continuing process that is child-centred, rooted in child development and is ecological in approach (Department of Health 2000).

Bromfield and Higgins (2005) observed in their case study of isolated and chronic maltreatment that most maltreatment within families was chronic, and that notifications describing isolated events were frequently inadequate because events were interrelated. This finding emphasised the Allen Report's (2003) research findings. However the paper went further to propose that there is:

> …a need to revise the way in which maltreatment is approached conceptually to better incorporate the on-going nature of maltreatment, as this is the way in which the majority of child victims of abuse and neglect experiences maltreatment (Bromfield & Higgins 2005, p.11).

This was particularly evident in cases where the neglect or abuse issues were viewed as discrete episodes rather than as part of a repeating pattern, which may be having serious consequences on the child's development and wellbeing; or in cases where a developmental lens has not been applied, and the lack of care giving has not been viewed as serious enough to warrant assertive intervention.

For example, when a case has numerous notifications either not investigated or not substantiated, assumptions can be readily made that this case is not one of significant risk. A cumulative risk perspective requires a re-examination of each of these notifications every time a new notification is made in order to assess whether a multitude of low-level risk factors is demonstrating significant cumulative harm (Frederico, Jackson & Jones 2006, p.39)

Interactional patterns of connectedness within the family and strengths need to be understood, along with repeating patterns of harm. The Allen Report (2003) cited a 2002 study in Louisiana, USA where renotifications were more likely to be in relation to other forms of neglect or abuse, than that which was first notified. This suggests that making an assessment based only on the information contained in the report is not an appropriate way to plan an intervention, because new abuse and neglect arises from problems that exist at the time of a preceding report, but are missed or not considered to be related to the presenting child safety issues.

The key characteristics of most families involved in Child Protection are long-term in nature, such as low income, sole parenthood, substance misuse and mental health (The Allen Consulting Group 2003, Bromfield, Gillingham and Higgins 2003). 'Addressing the problems, or at least enabling the families to better cope with the problems, requires sustained support...' (The Allen Consulting Group 2003, p.71). Families who are recognised as vulnerable but who are considered as low risk, usually fall outside the legislative mandate of the (CYPA); therefore, referrals are made to other services. However it has been difficult to ensure that the families have engaged and services are sustained and lead to successful outcomes. The subsequent risk is that the chronicity of the family's problems is unrecognised and that an opportunity has been missed to intervene earlier to prevent major difficulties later on, or the cumulative impact of the difficulties (The Allen Report 2003, Bromfield, Gillingham and Higgins 2003).

Families who experience ongoing concerns about the safety and wellbeing of their children are in repeating 'stuck' patterns, and the helping system, through actions or inactions, can at times become part of the pattern which 'maintains the problem', as an unintended consequence through intermittent and ineffectual intervention. This is particularly relevant when one considers the cases where there have been many previous notifications and the same interventions were repeated without successful outcomes in regard to the children, and their ensuing negative and disturbed behaviours have escalated over time. Melanie's case is a classic example of this phenomena.

Practice implication:

For Child Protection practitioners, when a new notification is received at intake, the fact that previous notifications were not substantiated should not influence the decision making on the current one. Prior notifications may well be indicators of a cumulative pattern of harm.

The current policy in context

Child Protection systems in Western cultures internationally have been critiqued for using a predominantly regulatory approach to child protection and for the increasingly adversarial relationships between parents and protective workers. Regulation refers to the imposition of rules backed by government sanctions, with the intent of modifying or controlling private behaviour (Allen Consulting Group 2003). The reform process in Victoria has recognised the need to have a more ecological perspective, which combines the public health approach with the regulatory approach, in order to address the more chronic and structural underpinnings of child abuse and neglect, and promote a broader community responsibility for child protection. These policy reforms are outlined in the following section.

The document '*Protecting children: ten priorities for children's wellbeing and safety in Victoria*' (Department of Human Services 2004) confirmed the government's particular priority to improving the early intervention and prevention focus of Child Protection and family services system. It refers to a service model that amongst other things will have:

- a stronger focus on avoiding the cumulative effects of harmful behaviours. Child Protection will continue to respond to emergency situations, but will have a greater array of differential responses, which reflect the growing complexity of family problems
- stronger scrutiny of the cumulative effects of harmful behaviours on children, and case planning and consultation support to community service organisations
- to move away from an episodic focus on risk to provide closer scrutiny of renotifications and earlier intervention for multiple referrals.

The accompanying *Protecting children: ten priorities for children's wellbeing and safety in Victoria - Technical options paper* (Department of Human Services 2004a) explores options for practice redesign. The White Paper *Protecting children: the next steps* (Department of Human Services 2005) provides the policy and reform context. It maps out the Victorian Government's vision for an integrated and responsive service system that focuses on early intervention and prevention, incorporates developmental approaches to children's wellbeing and safety, and works together with family services to share responsibility for the protection and wellbeing of children. The White Paper considers the creation of the two distinct pathways into intake services and new provisions for information sharing and consultation between secondary services and Child Protection, as a means to support earlier identification of accumulating harm to children and assist in ensuring that families receive appropriate support and services.

In the past three years, significant service initiatives have been developed and funded to provide a multi-systemic and community-based response to those families and children most in need. The Take Two program which provides therapeutic care to children in the Child Protection system and to their families and/or carers, in partnership with other involved services, and the Innovations Family Support projects have been well received in Victoria.

The Innovations family support program has been fully funded to complete the rollout of local programs across the state. The recently named Child and Family Information Referral and Support Team (Child FIRST) services will begin the community-based intake work in April 2007. This strengthening and integration of the family service sector in Victoria has attracted considerable national and international attention. The focus on early and sustained intervention and support for families where children are vulnerable and a strong partnership between sectors is a significant cultural reform.

Recent data has shown early promising results in stabilizing substantiation rates in Victoria. While the number of notifications received in Victoria rose marginally from 36,956 in 2003-04 to 37,523 in 2004-05, the total number of substantiations stabilised from 7,412 in 2003-04 to 7,398 in 2004-05 (Australian Institute of Health and Welfare 2006).

Culture

Cultural awareness is crucially important to child protection work. It is an essential lens through which we can better understand both the family and the experience of the child. Culture provides a way of defining who we are, how we think, how we communicate, what we value and what is important.

> *Culture constantly evolves and adapts and is always a significant and changing influence on us (Victorian Aboriginal Child Care Agency 2000).*

A child's culture informs all their life experiences, but the impact of culture is especially strong in relation to a child's identity, family and social relationships, health and education. Particular attention to culture is required for Aboriginal children and for children from other culturally and linguistically diverse backgrounds. Together with age and stage of life and gender, culture provides the starting point or lenes for understanding each child's unique circumstances and experience. The role of culture in shaping a child's experience, and culturally competent practice responses will be further developed in the forthcoming *Stability: a conceptual overview* paper.

> *Understanding the cultural landscape of a family is a complicated assignment but necessary if we are to provide helpful interventions in child protection work (Connolly, Crichton-Hill & Ward 2000).*

Hence any intervention should include a thorough assessment of the child, family and cultural group's exposure to potentially traumatic events and secondary life stressors and adversities that pose just as significant a risk to the child's development.

Practice Implication:

Cultural sensitivity and respect is essential in any intervention with families. Workers need to explore the particular meaning events hold within the families cultural traditions.

Section 12 of the CYFA provides guidance on principles for engaging Aboriginal families:

> *(a) in making a decision or taking an action in relation to an Aboriginal child, an opportunity should be given, where relevant, to members of the Aboriginal community to which the child belongs and other respected Aboriginal persons to contribute their views;*

The importance of language is central in understanding the child's experience and behaviour. A good assessment of the child's linguistic ability is important when their first language is not English. **For example, english may become the language of academics and school and the local community playground while the child's first language may serve as the language of feelings** (Canino & Spurlock 2000). This is an important consideration when considering cumulative harm, as memories and feelings of a traumatic event/s are encoded in vivid images and sensations and therefore better processed in her first language.

Practice Implication:

A good assessment of the child and families understanding of language preferences is essential and every effort must be made to enhance their participation.

Section 11 of the CYFA provides guidance on principles for engaging culturally diverse families:

(g) the decision-making process should be conducted in such a way that the persons involved are able to participate in and understand the process, including any meetings that are held and decisions that are made;

(h) persons involved in the decision-making process should be–

(i) provided with sufficient information, in a language and by a method that they can understand, and through an interpreter if necessary, to allow them to participate fully in the process…

(i) if the child has a particular cultural identity, a member of the appropriate cultural community who is chosen or agreed to by the child or by his or her parent should be permitted to attend meetings held as part of the decision-making process.

The impact of cumulative harm on early brain development

Scientific research supports the imperative in policy and practice to address cumulative harm, to give a renewed focus to the critical importance of prevention and early intervention to protect and promote a child's development. Chronic stress sensitises neural pathways and over-develops certain regions of the brain involved in anxiety and fear responses. Meanwhile, other neural pathways and brain regions are under-developed. Children who experience serious and chronic physical or sexual abuse focus their brain's energy on survival and responding to threats in the environment. Children who experience chronic neglect, such as remaining hungry, cold, scared or in pain, focus their brain's resources on survival.

De Bellis, Keshaven, Clark, Caseey, Giedd, Boring, Frustaci, and Ryan (1999) studied 44 children and adolescents who had all been sexually abused between the ages of two and six with some who had experienced physical abuse between ages one and three and who had witnessed domestic violence. The children were school-aged and had been in stable living arrangements for several years. All met criteria for post-traumatic stress disorder (PTSD) and many were also depressed. The brain imaging data showed that, compared with a matched group of physically and mentally healthy children, the maltreated children had smaller brain volumes, fluid-filled cavities in the brain and smaller areas of connection between the left and right sides of the brain. The findings were correlated with the duration of trauma, with children who had been abused longer showing the greatest differences from the controls.

Brain development is characterised by 'sequential development and sensitivity' and a capacity to organise and change in a 'use dependent' way (Perry 1997). Because brain development is sequential, disruptions to normal development in early life will necessarily alter the later development of other areas of the brain, where development depends on signals originating from the lower brain areas. This chain of development suggests that the early life experiences of a child have more relative importance in the organisation of the mature brain. Experiences that can be tolerated for example, by a 12-year-old child, can literally be life altering for an infant (Perry 1997).

Undifferentiated neural systems are critically dependent upon sets of environmental and micro-environmental cues in order for them to appropriately organise from their undifferentiated, immature forms. The cues are dependent upon the nature of the total sensory experiences of the developing child.

Any disruption to the cues contributes to the malorganisation and diminished functional capabilities related to a particular part of the brain, such as with the brain-mediated functions of empathy, attachment and affect regulation. Disruption may occur as a result of either i) a lack of sensory experience, and-or ii) a typical or abnormal patterns of cues as a result of extremes of experience for the child (Perry 1997).

The cortical and sub-cortical areas of the human brain are smaller in individuals who have global environmental neglect. As the brain cortex develops in size and complexity it can be expected to decrease violent behaviour given that the cortex plays a major role in inhibiting, modulating and regulating the functioning of the

lower parts of the central nervous system (Perry 1997). Children who have experienced disruptions to early brain development are likely to be less able to regulate their own behaviour or emotional reactions.

Practice implication:

Consultations with the High Risk Infant Managers and Specialist Infant Protective Workers are a critical component of good practice and must inform the analysis which leads to effective child-centred and family sensitive decision making.

If, during development, the 'stress response apparatus' is required to be persistently active, it will develop in response to constant threat and become hypersensitive and overactive.

In the education system these children might be recognised as bright but unable to learn easily and are sometimes labelled as 'learning disabled'. They might use less mature ways of problem solving, such as violence (Perry 1997). Experienced practitioners have many examples where children have been diagnosed and even medicated for attention deficit disorders when the underlying circumstances of the family violence, abuse or neglect had not been connected with their symptomatic behaviour.

The science of childhood development might be grouped under six main points or practice principles:

i) brain architecture and skills are built in a hierarchical 'bottom up' sequence

ii) social, emotional and cognitive development are highly interrelated

iii) brain plasticity and the ability to change behaviour decreases over time

iv) relationships are the active ingredients of early experience

v) early childhood adversity increases the risk of a range of poor outcomes

vi) stress is harmful to children and inhibits a child's optimal development, particularly when the onset is in the early years (Shonkoff 2006).

The effects of abuse and neglect on the developing brain during children's first few years can result in carious mental health problems, for example:

- Diminished growth in the left hemisphere may increase the risk for depression (Teicher 2000).
- Irritability in the limbic system can set the stage for the emergence of panic disorder and PTSD (Teicher 2000).
- Smaller growth in the hippocampus and limbic abnormalities can increase the risk for dissociative disorders and memory impairments (Teicher 2000).
- Impairment in the connection between the two brain hemispheres has been linked to symptoms of attention-deficit/hyperactivity disorder (ADHD) (Teicher 2000).
- Severely neglected children who have been deprived of sensory stimulation-including touch, movement, and sound-may be at risk for Sensory Integration Disorder (The Parent Network for Post-Institutionalised Child 1999).

- Children who have been raised in environments that totally disregard their needs for comfort, stimulation, and affection may be at risk for Reactive Attachment Disorder (The Parent Network for Post-Institutionalised Child 1999, Child Welfare Information Gateway 2001).

Brain organisation

- The brain is not a single system. It is many interacting and interconnected systems in a hierarchy.
- Different systems (parts) mediate different functions (the cortex mediates thinking; the brain stem mediates arousal).
- Systems are comprised of neurons. Neurons change in response to signals from the environment (sight; sound; smell) or from the body or from other parts of the brain.
- Chemical change in neurons allows information storage (the basis for memory).
- Different parts of the brain store different information (motor area stores information on how to ride a bike; cognitive areas store names and phone numbers).
- The more a system is activated, the more automatic it becomes (playing a piano; memorizing a speech; being afraid).
- In different states of arousal (calm; fear; sleep) different systems are activated.

Source: Perry 2000 (Ernst, Grayson & Webb 2006)

Principles of brain development

- Genes and experience partner to produce brain development.
- There is a dynamic and continuous interaction between biology and experience.
- The brain develops in a sequential fashion from least complex (brainstem) to most complex (cortical areas).
- Disruptions in brain development can lead to life-long deficits or abnormalities.
- Brief stress promotes healthy regulatory abilities. Repeated exposure to overwhelming stress is damaging and can interfere with the child being able to self-regulate.
- The brain must be activated to develop. Caretakers have a critical role in brain activation and must provide nurturing and stable relationships for optimal brain development.
- Some development is time-sensitive but often the child remains vulnerable to risks and open to protective influences throughout the growing years.
- Early intervention is critical as young children are more malleable to experiences.

Sources: Perry 2000, Schokoff & Phillips 2000 (Ernst, Grayson & Webb 2006)

Cumulative harm and childhood trauma

Research indicates that the frequency and severity of abusive and neglectful behaviours experienced by children can be more important in predicting outcomes than the type of maltreatment (Higgins 2004, Levy & Orlans 1998, p.128), and that long-term harm is more likely to result from living in an unfavourable environment or from the emotional damage from abuse rather than physical damage (Department of Health 1995, Cichetti & Toth 2000).

Research has shown that the personal meaning and perception of the child who experiences violence and abuse is weighted by the child much more heavily than an actual injury or degree of force in relation to the severity of psychological distress (Levy and Orlans 1998, p.128).

Practice implication:

The child's subjective experience has to become central to the analysis of the impact of cumulative harm. What meaning has the child or young person made of the trauma they have experienced? What are the particular effects on the child's development?

American psychiatrist Lenore Terr, in her groundbreaking research on childhood trauma in the 1980s, classified trauma into two categories, referred to as the Type I and Type II traumas. Type I trauma refers to the trauma suffered as a result of single, sudden and unexpected events that renders the child or young person temporarily helpless and breaks down their ordinary coping and defences. Type II trauma broadens the concept of trauma to include a child's response to long-standing repeated events where the child experiences 'prolonged and sickening anticipation' (Terr 1991, p.11).

Following a traumatic event or events, children develop characteristics in response to the event. Type II trauma can lead to character changes in the child as a result of the emotions stirred by the trauma, including an absence of feeling, a sense of rage and unremitting sadness alongside the fear of the repeating event. Because repeated events encourage a sense of anticipation and expectation, a different means of coping has to be employed by the child. The behaviours that result might come to be recognised as conduct disorders, attention deficit disorders, depression or dissociative disorders (Terr 1991).

Terr (1991) recognised from her practice and her research that:

> Childhood trauma may be accompanied by as yet unknown biological changes that are stimulated by the external events. The trauma begins with events outside the child. Once the events take place, a number of internal changes occur in the child. These changes last. As in the case of rheumatic fever, the changes stay active for years - often to the detriment of the young victim (p.11).

The evidence base for these effects is now quantifiable, recognisable and well documented in scientific research and literature (Schore 2002, Perry 2001, Shonkoff 2006). Current research in relation to child maltreatment and protective therapeutic interventions reflect an integration of attachment theory, neuroscience, child development, infant mental health, resilience and trauma theory. It is inadequate to consider a child's welfare and development potential without making reference to, or having some knowledge of, how these disciplines are interrelated.

The child's experience of traumatic events is influenced by their individual characteristics, offering an explanation as to why their response to experiences differs between children to apparently similar types of events.

In the pre-verbal child, cumulatively harmful experiences and traumatic experiences, such as abuse, experiencing or witnessing family violence, neglect and unpredictable attachments, are stored in a child's preverbal memory. These memories are intense perceptual experiences and, later in life, often intrude on awareness in the form of hypervigilence, nightmares and hyperarousal. The child may believe his survival depends upon constant alertness. However, in order to maintain a state of alertness, other tasks and development are compromised. Behaviour and feeling is directed by the more primitive brain processes (Perry 2000). Thus, hypervigilant children may show well-developed non-verbal skills -'street smarts' - in comparison to their verbal skills; they may over-read or misinterpret non-verbal cues, perceive eye contact as a threat, and interpret any touch as an antecedent to abuse or seduction.

The cumulative effect on the child of the anticipatory stress and fear of those events reoccurring, and repeating visual memories or 'flashbacks' of those traumatic experiences, as the child attempts to integrate and make sense of them, can re-traumatise the child, consume a child's energies, and lead to cumulatively harmful and pronounced neurobiological changes if sustained over time. If unalleviated or unremediated, or if the child's family environment is not altered, they may lead to stress disorders, anxiety disorders, depression and affective conduct disorders later in life.

Practice implication:

The service system needs to work in a supportive manner with children and their families to better understand the impact of this harm from their perspective and respond to effectively remediate the effect of this.

Osborn and Delfabbro's (2006) study exploring the characteristics of children and young people with 'high support' needs in out-of-home care found that 91.7 per cent of the Victorian sample required psychological assistance in the past six months due to early childhood traumatic experiences of repeated, multiple forms of abuse.

Early maltreatment can have profound and lasting effects on the developing child. One consequence is the development of PTSD. Between one third and one half of all abused children meet criteria for PTSD (Ackerman, Newton, McPherson, Jones & Dykman 1998, McLeer, Deblinger, Henry & Orvaschel 1992, Widom 1999, all cited in Hagele 2005). PTSD is a set of symptoms that can develop following a person's exposure to stress or trauma. The person may have witnessed or experienced an event or events that involved death or serious injury or threat to the physical integrity of self or others. The person's response to the events(s) involved intense fear, helplessness, or horror. For children, the response might be expressed as disorganised or agitated behaviour.

Developmental effects of childhood trauma

The notion of a multiplicity of exposures is a key feature of cumulative harm and the diagnoses of PTSD does not capture the developmental effects of childhood trauma (van der Kolk 2005). Van der Kolk noted the following behaviours as the developmental effects of childhood trauma:

- complex disruptions of affect regulation
- disturbed attachment patterns
- rapid behavioural regressions and shifts in emotional states
- loss of autonomous strivings
- aggressive behaviour against self and others
- loss of bodily regulation in the areas of sleep, food and self-care
- altered schemas of the world
- anticipatory behaviour and traumatic expectations
- multiple somatic problems, from gastrointestinal distress to headaches
- lack of awareness of danger and resulting self endangering behaviours
- self-hatred and self-blame
- chronic feelings of ineffectiveness

The impact of nurture on nature

Genetics do predispose us to act in certain ways. However, in most instances, neither genes alone or early experiences alone determine personality and functioning of the child. **Rather, interplay between 'nature' and 'nurture' determines the landscape of the brain. Genes and early experiences become 'partners in a very complex dance'** (Stein & Kendall 2004, p.2).

Practice implication:

A thorough consideration of the cumulative harm suffered by the child, likelihood of future harm and the supports required to remediate this harm will allow the Child Protection and Family Service systems to redirect their attention to the benefits of intervening earlier.

A study by O'Connor, Rutter, Beckett, Kreppner, Keaveney & the English and Romanian Adoptees Study Team (2000) of children reared in Romanian orphanages highlights these issues. When each child was six years old, researchers assessed what proportion of the adopted children were functioning in the normal range. They found that 69 per cent of those adopted before age six months were functioning normally. That percentage dropped to 43 per cent for children adopted between age seven months and two years, and then to 22 per cent for children adopted between the ages of two and 3.5 years (Child Welfare Information Gateway 2001).

The developmental needs of children are central in the CYFA as is the awareness of the role of the families and service providers in ensuring better outcomes for children. Families can be both the cause of the child's pain and the comfort. As Bowlby (1982) described, attachment serves the function of comforting and helping the child to experience a feeling of security.

Allen (2002) elaborates on the theme of trauma at the hands of an attachment figure as being particularly devastating as the attachment trauma creates a dual liability by creating extreme distress and undermining the development of the biological, emotional and behavioural capacities to regulate that distress.

> Physically abused infants show high levels of negative affect, while neglected infants demonstrate flattened affect (Gaensbauer & Hiatt 1984). There is evidence indicating that neglect may be even more damaging than abuse, and that there is a link between neglect in childhood and antisocial personality disorders in later life (Hildyard & Wolfe 2002). But the 'worst case scenario' is, not infrequently, found in a child who experiences both abuse and neglect (Post & Weiss 1997). There is agreement that severe trauma of interpersonal origin may override any genetic, constitutional, social, or psychological resilience factor (De Bellis 2001). (Schore 2003, p.288-289)

Cumulative harm and neglect

Although chronic neglect and cumulative harm are not interchangeable terms, the high reoccurrence of neglect as an abuse type and its often silent co-existence with other identified abuse types, means that it is frequently a factor in causing cumulative harm to a child's development. Chronic neglect refers to persistent low-level care, or repeated failure to meet a child's needs, or to protect the child from harm. As neglect becomes entrenched, it begins to arrest and impair all aspects of a child's growth and development, as well as a child's desire or ability to relate.

> Neglect occurs when a child's basic needs, such as their developmental, emotional and physical wellbeing and safety, have not been met. Chronic neglect is an entrenched and multi-layered pattern of experience for the child and family. (Frederico, Jackson & Jones 2006)

Although defined commonly and narrowly as 'environmental neglect', neglect takes many forms and usually precedes, underlies, co-exists with, and is masked by, other forms of child abuse.

As more becomes known about the effect of unmet needs on a child's ability to develop and grow, definitions of neglect have become more developmentally focused. It is especially critical for early years development because neglect negatively impacts upon the attachment process between parent and child. It leads quickly to an infant being unable to signal basic needs to a parent, and a parent's inability to read or respond to the child's signals. This is a recursive process where the parent-caregiver reinforces the attachment behaviours of the infant.

Continuity of the presence of neglect in a child's experiences can be used to measure the severity of impact on a child. The more pervasive the neglect the more harmful it is viewed as being (Perry 2006). If an infant's cries do not provoke a helpful, comforting response from an adult, then over a period of time, the baby abandons crying and moves towards dissociation. Perry, Pollard, Blakely, Baker and Vigilante (1995) believe that the younger the child is when maltreatment occurs, and the more helpless, immobile and powerless the child is, the greater the likelihood of triggering a dissociative reaction. He or she begins to disengage from stimuli. Females appear more likely than males to use dissociative processes and the presence of physical injury, pain or torture also increases the likelihood of dissociation. Children who cope this way often show behaviours related to oppositional-defiant disorder (Perry, Pollard, Blakely, Baker & Vigilante 1995).

However, cumulatively harmful experiences, whether or not they are ongoing in a child's life, mean 'maltreated and traumatised children continue to exhibit developmental and learning delays and problems even after the abuse and neglect have ceased and their placements are stable'. (Rycus and Hughes 1998)

A case example: 'David'

David, who is now three years old, was first notified to Child Protection when he was two weeks of age. The concerns reported were held about his mother Karen's capacity to care for him given her mild intellectual disability. Karen was depressed and disengaged from community supports. Karen was struggling with her own unresolved experiences of childhood trauma; she had grown up in a family where family violence was prevalent.

Despite in-home support and enhanced maternal and child health intervention, Karen was struggling to care for David. Karen found it difficult to prepare formula, manage household tasks and had been leaving David unattended in the flat for periods of time. She had no support from David's father who separated from her when she was six months pregnant, and was isolated from her own mother who Karen described as 'always being on her back'. David was often left in the pram with his bottles propped up, the ever present dirty nappy and severe nappy rash. When workers visited the family home they noticed that his head control and development generally was flat and not as responsive as most infants that age. Workers tried to engage Karen, the maternal and child health nurse had assessed David as underweight for his age. Karen was highly resistant to the idea of child care.

Karen would respond to David's needs inconsistently and struggled to connect with him and nurture him. While Karen clearly loved David she struggled to sustain 24 hour care of him and became frustrated when he was demanding and she was sleep deprived. Although there was no sign of physical abuse, all involved were concerned of the potential for this to occur. The Maternal and Child Health Nurse commented that: 'it's as if David knows not to cry…when she gets frustrated she can really yell at him at him and he just gets that heightened startle reflex, and then that wide eye frozen watchfulness'.

Workers generally responded warmly to Karen as she tried to cooperate and was so much in need, however, there was a constant concern regarding the cumulative impact of harm on David. The difficulty was finding the right balance between a compassionate response to the family and David's rights and needs for safety and a stimulating, nurturing environment to promote his development.

Karen was often leaving him with neighbours and he had a number of respite voluntary placements. Workers observed that David was not rolling and hated being on the floor at playgroup, as he was not often given these opportunities at home. David rarely smiled, by the age of nine months he was not showing any preference for his mother and workers reported that he was not vocalising and rarely cried. Fears were held for his development, these concerns escalated after it was reported that Karen had handled him roughly after he had been sick one day. Although the initial protective investigation had been closed when Karen had engaged well with community supports, a second notification occurred after this incident.

The decision was made after several case conferences and reviews for Karen to have regular respite and a plan was developed that targeted David's developmental needs. After a paediatric assessment, specialist parenting education that focused on care giving that engaged secure attachment behaviours, and an early intervention group for David were organised. Karen now has ongoing support from an Innovations Family Support worker and she has engaged with a therapist to support her with her depression and is finding this extremely useful. David's care is currently shared between Karen and a kinship care arrangement with an aunt who was able to support Karen and manage her challenging behaviours.

The cumulative harm that David experienced was unrelenting low level care, which compromised his early development at every level. He has slowly caught up on many of his milestones however his language and gross motor skills are still delayed. He is showing more secure attachment behaviours and will now respond to his mother's cuddles and Karen is very particular about his routine and especially his play and reading before bed. She is a regular now at the toy library. David is attending three year old kinder and despite a very unwilling frightened start, he now loves it. Karen is working on having David home full time.

Practice implication:

Section 10 of the CYFA provides guidance regarding the role of the family in upholding the child's best interests:

3(a) the need to give the widest possible protection and assistance to the parent and child as the fundamental group unit of society and to ensure that intervention into that relationship is limited to that necessary to secure the safety and wellbeing of the child.

The *Child Death Group Analysis: Effective responses to chronic neglect* report

The *Child Death Group Analysis: Effective responses to chronic neglect* report (Frederico, Jackson & Jones 2006), commissioned by the Victorian Child Death Review Committee, and overseen and published by the Office of the Child Safety Commissioner, presented the findings of a group analysis of ten child deaths, which were marked by the presence of chronic neglect. Although neglect issues were present in these cases, neglect was not identified as the cause of death. In addition to neglect, most of the children were exposed to other risk factors, such as other forms of maltreatment, family violence, poverty and exposure to parental substance abuse and parental mental illness.

The ten children in the cohort had a total of 53 notifications. Most of the children experienced other forms of maltreatment or other types of harm, such as physical abuse, exposure to parents' substance abuse and exposure to family violence. Most of the children experienced multiple types of neglect (Frederico, Jackson & Jones 2006, p.18).

Practice implication:

The rational for 'No Further Action' on previous notification(s) needs to be challenged and a different analysis developed based on the new information provided in the current notification.

Apparent in all of the ten cases reviewed was:

> …the level of complexity, whether it was the child's everyday and extraordinary needs, the family systems, the protective history or the ongoing multiple risk factors directly or indirectly associated with the phenomenon of neglect. The challenge in working with highly complex children and families within a complex service system is to understand the child's situation so that clear actions can be taken, whilst guarding against oversimplification. Although it is important to not underestimate the complexities inherent in all forms of maltreatment, abuse that equates to specific events, such as physical and sexual abuse can be easier to assess in terms of harmful consequences compared to neglect (Frederico, Jackson & Jones 2006, p.23).

Shared characteristics of the ten families in the report include:

- Nine of the ten children were notified before nineteen months of age and had substantial child protection histories.
- Eight children experienced more than one form of neglect.
- Most had experienced multiple forms of maltreatment as well as neglect.
- Most of the children had experienced significant developmental, attachment, behavioural and health problems that increased their vulnerability to risk of harm when their needs were not met.
- All of the children's family structures were complex and changing.

- The parents themselves had suffered trauma both as children and as adults resulting in parental inaction, hopelessness and ongoing chaos.
- Families were isolated from the community and there was evidence of poverty as seen by daily problems in paying for food, utilities and child care.

The systemic and practice barriers identified in the report can be summarised as:

- The failure to recognise the complex and entrenched nature of chronic neglect by adopting an episodic approach to assessment and forensic response to intervention.
- The failure to recognise and understand children's developmental needs and the impact of chronic neglect on their development when notified.
- The lack of enhanced support for families.
- Despite being known to the health system there was little collaboration between services and an incorrect assumption of shared responsibility.

As evidenced in these cases, even when neglect was clearly observable, attention was sometimes focused on sexual or physical abuse rather than the neglect. However, in other cases, concerns regarding physical abuse were also not given sufficient weight, perhaps getting lost in a sense of pervasive inadequate care (Frederico, Jackson & Jones 2006, p.23).

The report noted that each incident or series of incidents and each type of neglect could have a compounding impact and therefore needs to be considered in combination, not in isolation of each other. Neglect co-occurring with other forms of maltreatment increases the risk exponentially. An integrated historical analysis is required, where the child's experience is central.

Practice implication:

It is critical that neglect is not considered a lesser problem than other forms of maltreatment given the evidence that its consequences can be damaging. It is also important that the presence of chronic neglect does not obscure other forms of maltreatment (Frederico, Jackson & Jones 2006, p.18).

The cumulative impact of family violence on development

As referred to earlier in this paper, family violence is a common factor in the landscape of lives of children who experience cumulative harm. The presence of violence has a highly detrimental impact on the developing child and a growing body of evidence has documented the particular vulnerability of infants. Alongside the act of physical violence, an additional element of intra-familial toxicity is emotional violence - humiliation, coercion, degradation, and the threat of abandonment or physical assault (Perry 2001).

> Lack of critical early life nurturing, chaotic and cognitively impoverished environments, persisting fear and physical threat and, finally, watching the strongest, most violent in the home get what he wants, and seeing the same aggressive violent use of power idealised on television and at the movies...[t]hese [children] have been incubated in terror…waiting to be the one that controls, the one who takes, the one who hits, the one who can make the fear, not take the fear (Perry 1997, p.10).

Humphries and Stanley (2006) refer to the direct and indirect ways parenting is affected by family violence. These include the high anxiety and depression which undermines a parent's ability to care for their children, and a preoccupation with trying to control the domestic environment so that the perpetrator's needs are prioritised whereby the children's needs for playing, attention and fun are not met, or are intermittently met.

Physical incapacitation as a result of an assault leaves a carer unable to provide physical care, and belittlement and humiliation in front of a child undermines the authority needed to parent confidently. There is also a mismatch between a parent struggling with their survival, and a distressed child demonstrating emotional and behavioural difficulties, who needs more intensive parental involvement. Failing to leave the abusive relationship, or returning to the violent relationship also undermines the parent-child relationship.

> ...[I]t should not be assumed that the removal of the perpetrator is a 'quick fix' which will immediately remedy the problems. The withdrawal of professionals when it is assumed the child is safe sets the woman up to fail just at the time when she may be in a position to more easily avail herself and her children of help and support. Recovery processes entail assistance not just for the individual women and children, but for the relationship between them. This is an essential aspect of domestic violence intervention which has been marginalised through failures to conceptualise domestic violence as not only an attack on the survivor (usually the mother), but also an assault on her relationship with her children (Humphries & Stanley 2006, p.30).

Practice implication:

Where a family has encountered family violence it is necessary to assist parents/carers in non-shaming ways to understand the impact that this has on their children on them as people and on their relationships.

This is not to suggest that every incident of family violence should routinely result in a Child Protection Service response. There is a range of service responses and professionals who may be better positioned to gain meaningful engagement with the non-offending, and offending, parent and children to enable lasting change.

Practice implication:

What do the children or young people say about the risk of future violence? Have they had the opportunity to speak alone? Have we explored their experience?

Early childhood development and cumulative harm

Children require their needs to be met in an ordered and sequential manner if they are to develop and thrive. If early basic needs are not met, neural pathways and brain development becomes compromised, preventing higher order cognitive, emotional and social learning and healthy growth and development from occurring. Development is an ongoing dynamic process occurring throughout life and can be defined as growth and change toward more adaptive capability.

- Development proceeds from the simple to the complex.
- It involves stages or plateaus where new more complex and different capabilities emerge which replace earlier ones.
- Development is cumulative with early developmental tasks providing critical skills or traits that form the foundation of later more complicated tasks. For example, if a child fails to develop trust in the first year of life, without remedial attention the child's development is impeded and the child's social, emotional and cognitive development is impacted upon.

Slee (2002) adds:

- The sequence of development is the same although the rate varies from child to child.
- Development is intimately related to the central nervous system's maturation e.g. a child cannot sit up until the nervous system is mature enough.
- Development proceeds from the head down i.e. head control precedes walking and certain reflexes must disappear before voluntary movement can occur (p.116).

Child development, which is interrupted, can lead to the following problems at various stages. Note this is not an exhaustive list of types of interruptions or the problems that may be caused by interruptions. For a more detailed list please refer to the *Child Development and Trauma Guide* (Department of Human Services 2007).

In the unborn child -

- Pre-natal and post-natal, exposure to psychoactive drugs and alcohol affects the child's brain and body and causes future learning, behavioural, physiological and developmental problems.
- Foetal Alcohol Syndrome causes growth deficits, central nervous system dysfunction, specific facial characteristics and body malformation. Learning and behavioural disorders that result include attention deficit disorder, speech and language disorders, poor short term memory, lack of cause and effect thinking, poor personal boundaries, anger management difficulties, poor judgement and no connection to societal rules (McCreight 1998).
- Cigarette smoking is associated with low birth weight and prematurity.

- Use of narcotics is associated with prematurity, lower head circumference, lower birth weight, and overt withdrawal symptoms of the newborn child.
- Children exposed to drugs in utero were found to have depressed developmental scores at six months, which continued to past 24 months of age. They were less likely to experience care and nurturance from their caregivers or make positive attachments.

In the infant -

- Acute stress produces short-term and reversible deficits; however, repeated, prolonged, chronic stress can be expressed in neuronal structural changes, involving atrophy which can lead to permanent damage (Schore 2002). The most significant consequence of early relationship trauma is the lack of capacity for emotional self-regulation and the loss of ability to regulate the intensity and duration of affects (Schore 2002).
- In the infant brain, states become traits and so the effects of early relational trauma as well as the defences against such trauma are embedded into the core structure of the evolving personality (Schore 2002, p.18).
- A study by Howard (1994) showed that 100 per cent of children who continued to live with their drug using mothers developed attachment problems including avoidance, fear, and anger toward their mothers. The majority of children (64 per cent) of mothers who stopped using drugs after birth displayed secure attachments.
- A study Jaudes and Eckwo (1997) found that one third of substance exposed infants entered out-of-home care placement and were more vulnerable to death in the first few years of life.

In the school-aged child -

Additional stresses are placed on the harmed child by:

- Increased demands for compliant behaviour, high concentration, communication and social interaction levels, which require high levels of psychic energy, internal control, internalised values, and self integration.
- A depleted nervous system, lowered concentration ability and lowered immune system viability through ongoing stress, anxiety and hyperarousal.
- Learning is compromised by lowered visual-perceptual ability caused by overloaded perceptual stimuli response, which leads to compromised balance, reading, visual and ball handling skills.
- Learning is also compromised by lowered auditory processing, which can result from trauma or poor attachment experiences '... the child appears to selectively hear and does only partially hear, due to difficulties with the cognitive and perceptual aspects of auditory processing, especially when background noise is present, as in a classroom situation' (Kier 2003).

- The stresses of not being able to deliver or perform at an age where a child measures achievement by how well they are performing comparative to peers, and trauma flashbacks can lead children to dissociate, act 'spacey' or have blackout periods where 'they are there, but not there'.
- Heightened stress responses and hyperactivity levels in response to perceived comparative failure and/or not having 'a best friend' further fragments a child's self-concept and self-confidence.
- Social relating is compromised by preoccupation and high anxiety particularly in changing situations, which increases the likelihood of aggressive outbursts.
- The emotional and behavioural changes children are forced to adopt in response to an attempt to adapt to, and self protect in, a home environment, that includes abuse and the secret of abuse (Hanks and Stratton 1995, p.90).
- Accommodating ongoing abuse which involves the child in developing behaviours which attempt to ensure safety and decrease pain during victimisation (Briere 1992, p.17).

Broad practice implications

To effectively identify and respond to cumulative harm a message needs to saturate the wider community that child protection is everyone's business and that families and children need to be supported. **This requires an ecological and systemic approach that is strength-based but forensically astute to harm that impacts on vulnerable children.**

It is crucial to adopt a whole of community approach to dealing with cumulative harm and to commit to whole of government approaches to building capacity and strengthening communities.

Interventions need to be cognisant of supporting elders and carers in the community to care for vulnerable members of the community. The importance that the extended kin within diverse cultural groups play in care-giving relationships has been well documented in the international research literature (Garcia Coll 1990, Tolson & Wilson 1990) and in the Australian Indigenous context. The recent 'discovery' of the power of community to shape physical, social, emotional and spiritual health by Western researchers is a belief that has always been a part of the wisdom of Aboriginal peoples (Perry 2006).

Practice and systemic barriers to recognising and responding to cumulative harm:

Bromfield, Gillingham, and Higgins (2003) identified and summarised potential barriers to recognising and responding to cumulative harm, including both practice and systemic barriers. Practice risks include that:

i) an event-oriented approach to Child Protection can result in practitioners failing to observe or be able to act in response to a pattern of maltreatment

ii) information is not carried over from one notification to the next and therefore information is lost over time

iii) assumptions are made that the problems presented in previous notifications are resolved at closure

iv) risk frameworks consider pattern and history with the aim of predicting future behaviour of carers and likelihood of harm rather than establishing the cumulative harm suffered

v) IT systems summarise and categorise previous contact and workloads in Child Protection are demanding therefore the assumption is made that reading case files is neither necessary nor a priority.

Systemic barriers to recognising and responding to cumulative harm:

i) Child Protection being viewed and operated as an emergency service

ii) the system not recognising that families' problems can be ongoing

iii) harm thresholds mean that children considered as 'low risk' fall outside the legislative mandate

iv) a child has to be significantly harmed or at risk of significant harm, and the event is likely to happen again. (Bromfield, Gillingham & Higgins 2003)

Evidence-based studies

Boffa (2006) has drawn attention to a growing evidence base determining which programs are most effective in working with children and families who have experienced cumulative harm. Cameron and Karabanow (2003) have completed a substantial review of the nature and effectiveness of program models for adolescents at risk of entering statutory out-of-home care.

Multi-component programs were reported as obtaining the most sustained outcomes. Components reported as valuable were:

- paid employment and educational supports
- recreational and social activities and summer camps
- health and contraceptive services
- child care
- individual, family and group counselling
- health and social skills education
- drug education programs
- family resource centres.

Reported outcomes include 'much higher secondary school academic performance, increased graduation rates and college attendance, substantially fewer teen pregnancies and less sexual activity, decreased delinquency, fewer out-of-home child welfare placements, and reductions in school bullying (Cameron & Karabanow 2003, p.461).

The value of neighbourhood transformation strategies in areas of high socioeconomic disadvantage was also emphasised:

> …this review found a variety of program models with demonstrated or potential benefits for these youth and families. It identified promising approaches that ameliorate (troubled) parent child relationships, support parents of teenagers, build social competences of youth, and connect teens to peers, adults and communities. Many of the more powerful programs concentrate on several of these areas (Cameron & Karabanow 2003, p.462).

Thomlison's (2003) review of characteristics of evidence-based child maltreatment interventions found that:

> …the strongest evidence base that supports positive outcomes for children and families emerges from home-based services to prevent abuse and neglect, while promoting maternal and child health using social support and instructional interventions at all system levels. Approaches use parent management skills and training cognitive-behavioural strategies to improve parenting practices for physical abuse, neglect and sexual abuse; and techniques for strengthening parent-child interactional and relational skills (p.561).

The article overviews a number of programs with these characteristics, including providing a summary of target populations and settings, intervention duration/formats and outcomes.

Littell and Schuerman's (2002) meta analysis of various program evaluations of intensive family preservation services found no impact of key service components on likelihood of subsequent placement or maltreatment or case closure, including outcomes for different subgroups of families (for example, drug users, housing difficulties, lack of parenting skills and more). Components considered included the duration of in-home services (brief or sustained), intensity of contact with workers, number of concrete services, and provision of specific types of services (Littell & Schuerman 2002, p.672). Consequently, these authors advocate:

- There is no clear advantage of longer or shorter treatments. Intensity should be matched to family characteristics. For example, '(s)ome families may not be able to tolerate intensive services' - willingness to participate may develop slowly, especially when families are involuntary. Workers should offer concrete services early 'to demonstrate they can provide help in meaningful ways' (p.693).
- The relationship between duration of services and outcomes is complicated:

  It is possible that this relationship is curvilinear (that there is some happy medium) and that it is mediated by the severity and intractability of families problems and parents' readiness to change (p.693).

  It may be that the fit between family problems and the types of services provided is what matters, rather than the breadth or array of concrete services (p.693). More attention should be paid to the fit between family problems and the types of services provided in child welfare (p.694).

  ..there is need to develop more detailed information about the services provided to subgroups of families (p.694).

Decision making

Many reviews of practice have noted the tendency of workers to form an over optimistic view of the parenting capacity, (Office of the Child Safety Commissioner 2005, 2006)[1] or, on the other hand, an over-pathologising view of the family, which then limits the potential for engagement. Munro (2002) has an interesting view regarding decision making in Child Protection:

> for the individual, the overwhelming problem with human reasoning is that people do not like changing their beliefs. They go to great lengths to avoid the discomfort of having to revise their judgements. There is no simple antidote to this weakness. Child protection workers can be aware only of how they are likely to err and consciously try to counteract it.
>
> A shift to a more critical approach is equivalent to changing from being a barrister to being a detective. A barrister defends one point of view, offering only information that supports it and trying to deny or discredit any challenges thrown at it by the opposing side. A detective is trying to establish the truth and looks diligently for evidence for and against a point of view. (p.159)

1. (Victorian Child Death Review Committee Report 2005, 2006)

Practice implication:

Practitioners need to have the ability to develop a range of hypotheses and to use pluralist thinking. Good engagement and working with the family over time will enable better solutions and decision to be developed together with the family. Decision making needs to grapple with the complexity of each notification rather than hastily arrive at an overly optimistic or polarised position.

Munro suggests appointing a 'devil's advocate' at case conferences and discussions to minimise group think dynamics that may oversimplify complex issues, requiring sophisticated planning and implementation. If the previous service response was unhelpful then we need to find another intervention or style or process that is more effective and engaging. Statutory intervention may be required if the universal and family services are unable to help change to occur within the family, however without partnership with these sectors it can quickly become a blunt instrument. Clearly the judgement/decision making or case plan needs to be seen as a dynamic, recursive process which is continually evolving as new information comes to light and parents and children change and grow.

Practice implication:

Recording skills need to be supported and workers coached to be focused. Case notes need to reflect the relevant descriptive detail and importantly the analysis and rational that lead to decisions being made.

Hetherington (1998) cited a research study conducted by the Chapin Hall Centre for Children in Chicago that examined decision making in Child Protection. The study concluded that professional decision making in Child Protection is inconsistent and unreliable and that:

> [e]xtreme cases are always easy, the test of a decision making process lies in the middle cases. Such families are subject to the random draw that determines their caseworker…families encountering different workers and experts [are] systematically dealt with differently.

The Victorian Risk Assessment Framework is an extremely useful practice tool to enhance the analysis of strengths, safety and risk factors. It has been incorporated into the Best Interests Case Practice Model to guide practitioners in the complex decisions they are required to make each day.

Careful decision making is particularly important when considering what would be an effective way to engage the family in a change process where the difficulties are ongoing and seemingly entrenched. An unpublished study of renotifications in 1996 by Hetherington (1998) in South Australia revealed that the majority of notifications made were in relation to high-risk, multi-problem families characterised by substance abuse, intermittent family violence, significant instability, and frequent short-term departmental intervention.

Hetherington posed two operational issues facing a statutory Child Protection service that must ensure the safety of children as well as respond to families in need. These are:

- How should the system distinguish between reports needing investigation and the reports requiring support?
- How can the system ensure consistency between the assessments of workers making such distinctions?

With the introduction of Child FIRST consideration has been given to these issues and a paper, *Reporting concerns about children or Young people - a guide for professionals* (Department of Human Services 2006) has been produced to assist with clarifying these complex practice decisions.

Practice implications:

We need to remain curious and reflective about the experience of the children and parents and respond collaboratively to their feedback, always with the vulnerable child at the centre of our consideration rather than traditional agency or system constraints and procedures.

The processes and communication between the parts of the system are critical for the Best Interests Principles regarding cumulative harm to be enacted. This requires that the broader system around the family join to flexibly and creatively engage the family in a solution-focused process that is timely, respectful and culturally appropriate; rather than the family having to struggle to get help in a poorly coordinated service system, or falling through the cracks completely, with dire outcomes for children (Miller in press).

The Best Interests Principles require that we develop effective interventions and then actively monitor the feedback between and within sectors, remaining attuned to the outcomes within the family so that the casework is responsive to the changing circumstances.

Implications of adopting a cumulative harm approach within Child Protection and family services

1. From the point of intake/assessment the Child Protection and Family Services system is obliged to develop a comprehensive awareness of the effects of cumulative harm on a child's safety, stability and development, including multiple forms of harm and the re-occurrence of one form of maltreatment. This should incorporate both the current and past harm suffered by the child. The child's perspective should be heard.
2. The assessment must present the outcomes for the child should their circumstances remain unchanged. This process will identify the probability for future harm to the child, including the impact of harm on their safety, stability and development.
3. A thorough consideration of the harm suffered by the child and the likelihood of future harm will focus the attention of the Child Protection, Family and Placement Service system on the current and future needs of the child. This provides an increased awareness of the supports required to commence the healing process to commence and remediate the impact of trauma. This consideration will direct the assessment of and the recommendations made concerning:
   - parental capability
   - the type of order applied for at the Court
   - the conditions requested on an order.
4. A through consideration of the cumulative harm suffered by the child will direct the way that the Child Protection, family and placement service system plans and works with our partners to remediate the consequences of cumulative harm. Including cases where children remain in their parent's care. These areas include:
   - social opportunities
   - therapeutic interventions
   - other specialist services promoting the child's development and connection to family, school, community and culture (Peak 2006).

Dimensions of assessment

Assessment and decision making in child protection and family services needs to be holistic and well informed. Messages from research inform the following multi-dimensional practice objectives in relation to cumulative harm:

Practice objectives in relation to cumulative harm

i) Early prevention (early in the development of the problem and early in a child's life).

ii) Intervention as early as possible in the development of the problem in order to divert the trajectory of maladaptive development.

iii) Creation of resilience factors and protective factors within a child's environment including family, school and community via connectedness and engagement to mitigate future risk and commence healing.

From a practice perspective this requires the Child Protection workforce to recognise indictors for i) harm suffered and ii) what factors might indicate early indictors of chronic maltreatment or cumulative harm.

Cichetti and Toth (2000) propose that in order to provide a complete account of a child's maltreatment experience, the following features of the maltreatment must be incorporated:

- the severity of the incident
- the frequency and chronicity of the maltreating acts
- information about the perpetrator
- the developmental period of the child during which the maltreatment occurred.

Only then can the qualitative meaning of the experience for the child can be captured.

Further suggestions for conceptualising the experience of cumulative harm via a multi-dimensional approach is to take into account:

- the number of incidents
- the duration of time over which maltreatment took place
- number of maltreatment types
- number of perpetrators
- the child's embeddedness in their family, community and cultural environment
- the child's developmental stage (Bromfield and Higgins 2005).

A more specific typology proposed by Bromfield and Higgins in their case study of isolated and chronic maltreatment (2005) is based upon their reviews of typologies in relation to repeat victimisation, multi-type maltreatment and multiple victimisation. It includes consideration of:

- frequency (number of incidents)
- type (number and classification)
- severity (of adult behaviour and harm to child)
- perpetrators (number of perpetrator and relationship to child)
- duration (period of time over which maltreatment occurred).

Lewis and Ippen Ghosh (2004) report that children exposed to traumas often have caregivers who have been exposed to traumas, and inquiring about their trauma history, symptomatology and reactions is critical in understanding the child's functioning. Somatic complaints, sleep disturbances and eating disorders were common among caregivers immersed in chronic trauma.

Hence a thorough assessment which incorporates a cultural lens as advocated in this legislation would gather information in the following areas:

1. Where did the family come from?
2. How did they get here?
3. What is their environment like now?
4. How does their culture view and cope with the potentially traumatic events they have experienced? (Lewis & Ippen Ghosh 2004, p.30)

Implications for practice in Child Protection and Family Services

Recommended best practice approaches identified in dealing with neglect were: (Frederico, Jackson & Jones 2006)

Best practice principles for preventing neglect and intervening early as determined by the Child death group analysis: effective responses to chronic neglect

- The best interests of the child must always remain central in any assessment, planning and intervention process.
- Focus on safety for the child from all forms of harm.
- Focus on meeting the child's developmental needs and enhancing their wellbeing.
- A family focus, not just parents or child - for both assessment and intervention.
- Effectively engaging the family in the process of change.
- Assessing family's history of use of services and analysing what has worked or not worked over time and therefore what needs to be different.
- Working pro-actively through identified barriers.
- Basing interventions on thorough assessment of the family and the needs and development of the child.
- Use of multi-disciplinary assessments, for example, Maternal and Child Health Nurse, Schools, health services, occupational therapist, physiotherapist, psychologist, psychiatrist.
- Balancing between providing support and validation whilst being able to directly challenge neglectful and other aspects of poor parenting.
- Providing access to practical, concrete assistance to deal directly with concerns related to poverty.
- Setting and monitoring achievable goals and clearly articulated responsibilities.
- Enlisting informal as well as formal support networks that will remain involved after services have ceased.
- Making effective referrals to appropriate and targeted services.
- Coordinating between services and clarifying roles and communication processes, or establishing clear coordination processes before closure.
- Ensuring that those services involved are informed regarding the risk assessment and what would constitute significant harm for this child.
- Understanding both the utility and limitations of legal action to mobilise the parents towards change, and to ensure the child's safety.

Conclusion

Our service system must respond to the painful circumstances in the lives of vulnerable children. It is charged with the responsibility of engaging with families, and having the skills and commitment to respond to cumulative harm. This requires holistic assessments that are cognisant of acts of omission and commission, which impact on the child's development in complex ways. Each report made to services needs to be understood in the context of the family's history and the outcome of previous service attempts. We can only imagine how much less traumatic and painful Melanie's life would have been if earlier assessments and interventions had viewed the information through the lens of cumulative harm. There is no doubt that prevention and early intervention services are crucial in helping vulnerable families and children like Melanie. Her life also demonstrates that committed, consistent, loving care, supported by purposeful, multisystemic intervention can remediate unspeakable trauma.

Outcomes for children will be enhanced if we take the time and remain open to hearing the voice and experience of the child, and engage families in purposeful change-focused interventions. Interventions need to be both engaging of families and forensically astute, that is, knowledgeable about the impact of abuse and neglect. The child's best interests need to be at the centre of all decision making. This will require strong teamwork between all the service providers in the family's life, creative engagement of the parents and frequent communication, and ongoing review of the outcomes. Most importantly, practitioners need to listen to the voice of the child and seek to understand the language of their behaviour.

Cumulative harm in the CYFA calls us to focus on a child's safety and wellbeing, but frames this in developmental terms. This requires us to be child-focused and make every effort to give the widest possible assistance to the family of origin. Service interventions need to thoughtfully harness, in Robbie Gilligan's words, 'life's ordinary plenty' in remediating the hurt child, building resilience and promoting the development of the child's potential. This should include access to those specialist therapies that help any child reach their potential if they are in need. Where a child or young person has become so traumatised that their behaviours are dangerous to themselves or others, specialist services are required to help to engage the young person so that the cumulative harm can begin to be understood and addressed.

Appendix 1

Neurophysiological impact of trauma on a child's developing brain

In their book, Trauma Attachment and Healing, Orlans and Levy (1998) outline the devastating bio-chemical and hormonal impact of harm and trauma in the whole development of the infant and child:

- in the brain the amygdala which evaluates the emotional meaning of incoming stimuli and records it in emotional memory, controlling emotion and aggression, reacts instantaneously, bypassing the rational brain and triggering an alarm reaction
- activating the hypothalamus which secretes corticotrophin-releasing hormone
- stimulating the autonomic nervous system which affects movement
- raising heart rate and blood pressure, slowing breathing
- signalling the locus cerulus in the brainstem to release norepinephrine heightening overall brain reactivity
- releasing dopamine that causes the riveting of attention on the source of fear (Goleman 1999, LeDoux 1992)
- Also releasing the brain stem neurotransmitters or catecholomines which were found to play a major role in post traumatic stress disorder (Perry 1994 in Orlans and Levy, p.77)
- causing dysregulation of the HPA axis(hypothalamic-pituitary-adrenal axis which releases ACTH and cortisol and prepares the body for alarm reaction)
- the immune system, releases twice the normal level of ANA or antinuclear antibody, which leads to impaired immune system functioning
- storing traumatic experiences such as abuse, neglect, and anxious attachment in pre-verbal short-term memory in the hippocampus as intense spatial, temporal and perceptual experiences, which later in life intrude on awareness in the form of hypervigilance, nightmares, hyperarousal and anxiety
- the abnormal persistence of alarm reactions leads to maladaptive brain activities, e.g. redefinition of the baseline level of the central nervous system, leading to persistent hypervigilance and hyperarousal. (Orlans & Levy p.77-78).

The human brain has evolved a highly functional hierarchical organisation, from the lower, more simple portions to the higher more complex cortical regions. The structural organisation of the brain and its functions develop throughout life although the vast majority of the critical structural organisation takes place in childhood.

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Notes

Coordination

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