December 2011

This newsletter focuses solely on the issue of cumulative harm and how the recent Green Paper for Vulnerable Children addresses the issue. SSPA would be very interested in members views on the material presented in the article, please email your views to John Dickson at info@sspa.org.nz

MINIMISING CUMULATIVE HARM FOR VULNERABLE CHILDREN: DOES THE GREEN PAPER REFLECT INTERNATIONAL BEST PRACTICE?

Associate Professor Leah Bromfield

Families have primary responsibility for the care of their children unless they have been judged unfit to provide that care. The role of government is, to the extent possible, to create a society and environment that supports families and child rearing. In the Green Paper the New Zealand government are grappling with the question of when and how the government should support vulnerable children and their families to ensure children thrive, belong and achieve.

Firstly, who and what is vulnerability? The Green Paper states "… vulnerability is the result of an accumulation of factors. While individual factors don't necessarily cause a poor outcome, they can work together to increase the level of vulnerability of children" (p.4). Research literature terms this 'multiple adversity' or 'cumulative risk (Lima, Caughy, Nettles, & O'Campo, 2010; Appleyard, Egeland, van Dulmen, & Sroufe, 2005). Research has shown that multiple adversities such as abuse, neglect, household dysfunction, low socio-economic status and negative social climate have been associated with adverse outcomes for children (Duke, Pettingell, McMorris, & Borowsky, 2010; Lima et al., 2010; Cohen et al., 2006; Chapman et al., 2004). Moreover, the effects or harm caused to children who experience multiple adversities is cumulative and exponential as first concluded by Rutter, 1979 and repeatedly confirmed since that time (e.g., Appleyard et al., 2005; Seery, Holman & Silver, 2010; Chartier, Walker & Naimark, 2010).

"Cumulative harm may be caused by an accumulation of a single adverse circumstance or event (e.g., repeated exposure to domestic violence), or by multiple different circumstances and events (e.g. poverty, household dysfunction, poor parenting). The unremitting daily impact of these experiences on the child can be profound and exponential" (Bromfield & Miller, 2007).

Governments may seek to reduce the risk of children experiencing cumulative harm as a consequence of multiple adversities by implementing strategies designed to reduce the incidence of children who are demographically vulnerable. For example, strategies to reduce tobacco and alcohol consumption during pregnancy to reduce the number of children born with disability; or strategies to reduce teenage pregnancy and early child bearing as this population are known to be more vulnerable to experiencing parenting problems. Long-term primary prevention strategies are important in reducing the population of vulnerable children.

Primary prevention strategies may reduce the population of children who have experienced adversity.

Regardless of how effective these strategies are, they are unlikely to eliminate childhood adversities such as poverty or disability. The population of children and families have varying levels of needs. Parenting is hard and 'adversities' are common, but may not require formal intervention. For example, a single mum receiving income support may be struggling to make ends meet (i.e., she is experiencing 'multiple adversities'). However, she may not require that government intervene, for example, she might be surrounded by supportive family and friends and have the skills and capacity to identify and access education and public health services, libraries, and playgrounds to ensure that her and her children's needs are met (i.e., universal services, supports and infrastructure available to everyone).

When thinking about multiple adversities, and in the context of limited child welfare funding, governments must consider the point at which formal targeted interventions should be offered without assuming the role and responsibility of informal family and community supports in raising children.

Those families that would benefit from formal interventions will also vary in the intensity of their needs. For example, a mother with a learning difficulty may benefit from parenting education and support, particularly during the early years and periods of developmental transition to prevent problems occurring. There is an abundance of research identifying those groups who are vulnerable to future problems developing. Longitudinal research into interventions such as Perry Pre-school have demonstrated a long-term cost-benefit of intervening early with vulnerable populations before problems arise in the order of $17 saved for every $1 spent by the time the child recipients of the intervention reach middle adulthood (Schweinhart, 2004). It is probable that without early intervention a proportion of these families will escalate to become families and children in adversity where children's needs are not being met.

Governments can provide targeted services and supports for vulnerable populations to prevent problems arising (i.e., early intervention).

There will also be a population of children within the community whose parents are not meeting their needs and who are at a very high risk of adverse outcomes if immediate intervention is not provided. For example, a mother struggling with severe depression may also be struggling to maintain routines such as getting children to school or child care, maintaining home hygiene, providing regular means and adequately supervising her children. She may be able to meet her children's needs if she is provided with appropriate services and supports. Without intervention her children will experience multiple adversities and be at high risk of experiencing cumulative harm - compromising their capacity to thrive, belong and achieve.

Where children's needs are not being met (as in the example above) the issue of regulation arises: when does the government use its legal authority to intervene in family life in order to ensure children's safety and wellbeing? Two questions must be answered: One, is the assessment that the parent(s) most likely can meet their child's needs with services and supports? Two, is the parent(s) willing to engage with those services and supports deemed necessary to support them to meet their child's needs? The answer to these questions

will determine whether the parent will be a 'voluntary' client, whether child protection services are necessary to 'require' parents to participate in services or supports, or whether children must be removed into care as this is the only means to secure their safety and wellbeing.

When children's safety and immediate physical needs are not being met, formal services and supports must be available to ensure those needs are met. Child protection and out-of-home care services are necessary when parents are unwilling to engage with formal services and supports or they are unable or unwilling to meet their children's needs or to make the changes necessary to meet those needs within the child's developmental timeframe.

Figure 1 present a visual illustration of the different populations of vulnerable children and their families, and the varying levels and intensity of services required to meet their needs. As stated within the Green paper, situations for families change and they may move in and out of vulnerability, the intensity of their needs may change, as may their capacity to meet the needs of their children.

Children at high risk of experiencing cumulative harm

Children whose needs are not being met as they are experiencing abuse or neglect are at the greatest risk of cumulative harm and serious disruptions to their development such that they are not able to thrive, belong and achieve. Children in imminent risk, such as those experiencing sexual abuse or with injuries as a result of physical abuse, are prioritised by the service system. We respond quickly to address the safety issues within the family or if this cannot be achieved to remove them and place them in care (Price-Robertson & Bromfield, 2011). However, a high proportion of families referred to child protection services are referred due to concerns about child neglect and emotional abuse (Ministry of Social Development, 2009).

In a study of families referred to child protection services in Victoria, Australia it was found that the majority of families were reported to child protection services on more than one occasion. Multiple reports were indicative of chronic child maltreatment, and chronic maltreatment was more likely to be low-to-moderate in severity. Chronic maltreatment was not a series of discrete events, instead it appeared to be symptomatic of enduring parental problems compromising the parent's capacity to provide safe and nurturing care. Neglect was the most frequently occurring maltreatment type among families who were multiply reported to child protection services, but, children experienced multiple maltreatment types, and there may have been more than one person responsible (Bromfield & Higgins, 2005).

In this study, families with isolated and chronic involvement with child protection services were compared. Contrary to expectations, the study did not find significant statistical differences in the types or number of risk factors for families with chronic and isolated involvement. It was theorised that families were socially excluded at the point of first contact with statutory child protection services and that family characteristics were therefore a better predictor of whether maltreatment would occur at all, not of whether it would continue to occur (Bromfield & Higgins, 2005). Family characteristics that did appear important were whether the parental problem that was the underlying determinant of their maltreating behaviours was temporary or enduring, the parent's apparent readiness to change and willingness to seek or accept report, and whether or not there were strong protective factors present, such as a supportive family member who would care for the children or parental employment that connected them to the normative social milieu of the community (Bromfield & Higgins, 2005). However the best means of differentiating families with chronic and isolated involvement with child protection services appeared to be the characteristics of the service they received. The provision of therapeutic or support services reduced the likelihood of re-entry into child protection or extended the time to re-entry. However, most families did not receive a therapeutic response (Bromfield & Higgins, 2005). A procedural approach characterised by assessment, monitoring and information giving was more common.

Data in relation to re-notifications, re-substantiations and re-entry into care, suggest that these issues are not unique to Victoria and have continued to be an issue. In fact, as demand on child protection services has increased the problem appears to have grown. For example, in NSW 58.7% of children involved in reports had a child protection history (Wood, 2008) up from an average of 30% in an international review of studies published between 1999 and 2001 (Bromfield, 2005). Child death reviews and parliamentary inquiries into the function of child protection services continue to identify cases in which children and families were in receipt of services from multiple agencies where children's safety and wellbeing was not secured.

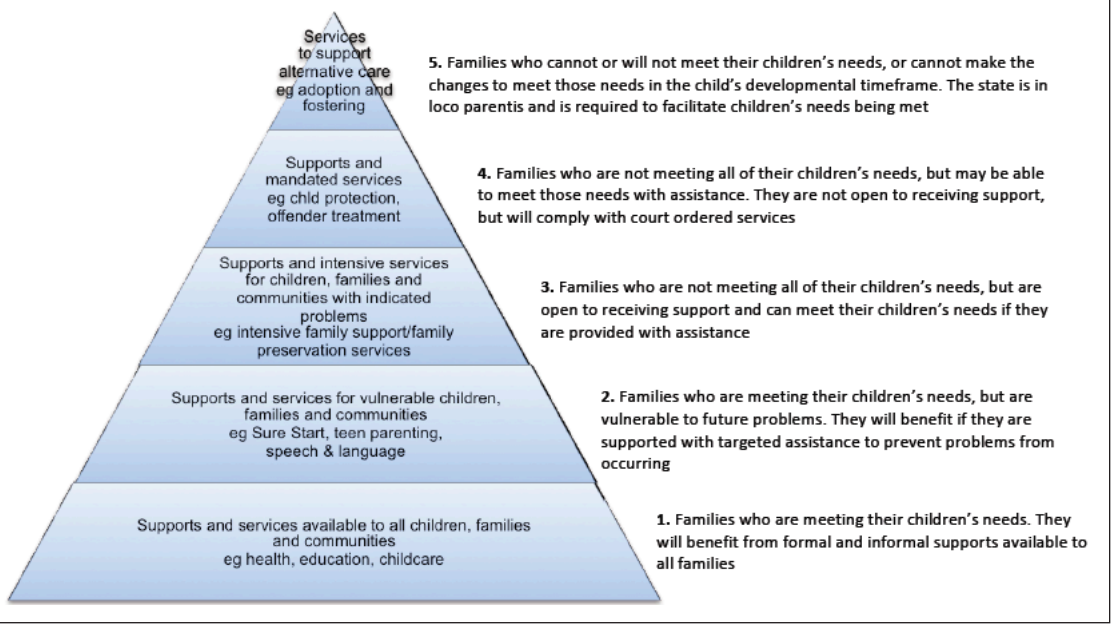
We can conclude that there are a group of children who are well known to multiple services and supports whose needs are not being met; they are likely to experience cumulative harm such that their capacity to thrive, belong and achieve is severely compromised.

An alternative response is needed to better address the needs of children experiencing chronic low-to- moderate severity maltreatment and their families, who tend to be well known to multiple services, to prevent these children experiencing cumulative harm.

Children in care and cumulative harm

There is a cohort of children in care who are also vulnerable to continuing to accumulate adversities that compromise their capacity to thrive, belong and achieve. Research into the outcomes of children in care shows that, on the whole, children in care have poorer outcomes than those in the general community (Bromfield & Osborne, 2007). However, this is likely a consequence of their early abuse histories. Australian research also shows that the majority of children in care improve in their capacity over time (Bromfield & Osborne, 2007). However, there are a significant minority of children whose outcomes continue to deteriorate; they are more likely to experience multiple placement disruptions due to behavioural problems and to have the most extensive and severe histories of abuse and adversity prior to entering care (Bromfield & Osborne, 2007). This group of children have already experienced a degree of cumulative harm and are clearly at risk of further compromises to their development as a result of continuing adversity. There is a need for intensive therapeutic interventions to begin to mitigate these impacts to increase their capacity to thrive, belong and achieve.

Figure 1.
Services and supports matched to different populations of vulnerability



Failure to intervene: A false economy?

The Green paper articulates well the costs to "the individual and society as a whole of not giving children the best start in life", and the "need to focus on those children who are vulnerable" (p.3). For children at high risk of experiencing cumulative harm who are known to services but do not meet the threshold for intervention, we must also consider the costs of assessing that things are not 'bad enough' to intervene. In addition to the risks of cumulative harm for the

individual and society, it is important to weigh up whether the cost of multiple assessments and investigations over the course of a child's development and the opportunity costs in terms of capacity to engage their parents cooperatively in interventions out-weigh the cost of earlier intervention. A re- examination of how services are provided (therapeutic versus assessment and monitoring) may provide some opportunity for cost-shifts in the short-term.

Cumulative harm and the Issues arising in the Green paper

Make child-centred policy changes: Review government spending to get better results for vulnerable children (p.18)

The Green Paper flags the need for 'trade-offs' and 'tough decisions'. It asks whether the government should provide more targeted services to vulnerable children, and if so, where the funding should be taken from to do so.

In a newly completed study of international best practice in child protection, approaches to child protection were compared for England, Australia, Finland, Sweden and Germany. It was found that all five countries were shifting towards a model that comprised a mix of services and supports. Early intervention is important. However, this was balanced with the recognition that there was also a need for more intensive services and supports, including involuntary services (Nett, Spratt, Bromfield, Hietamaki, Kindler & Ponnert, 2011, in press).

'Upstream' earlier interventions such as parenting education can be provided at a lower cost than interventions required for 'downstream' problems such as juvenile justice responses for adolescents with complex behaviour problems. Long-term, the provision of early intervention 'upstream' aims to reduce the number of children with problems 'downstream'. However, the effects of early intervention will take time. Which means that allocating funding to early intervention now, must be balanced with the continued duty of care to the current population of children and young people with high needs.

The message for New Zealand is to avoid an either/or approach. A balanced system will have services of varying intensity matched to the different populations of need (see Figure 1). In the short-term it may require additional funding allocations for early intervention and targeted services.

Pathways into and between services

In preventing cumulative harm, attention needs to be given not only to what services are funded, but to the pathways into and between services. Consider Figure 1, which shows five population groups represented as a pyramid to denote that theoretically the populations will get smaller as need intensifies. Families are responsible for accessing universal services such as general practitioners, schools, childcare, playgrounds, and libraries as needed. Vulnerable and at risk families may be referred to the child protection intake service, which will do an initial assessment and determine whether a child protection investigation is needed or whether the family should be referred to less intensive, voluntary services within the community. This is referred to as 'differential response' and is an important element in a well functioning system. However, problems can arise if child protection intake is the only or the most visible pathway into voluntary services for vulnerable families. The Inquiry into Child Protection Services in NSW (Wood, 2008) found this was the case and that as a result child protection intake services had become overwhelmed by demand and families were not being referred to voluntary services in the community despite these services having capacity to serve more families. It is also worth noting that referral to child protection can be stigmatising and threatening to families, which may adversely impact families' engagement with voluntary services to which they are referred by child protection services. Alternatives include (a) the use of universal services as a platform to identify families with higher needs who can then be referred to additional services without stigmatizing them (e.g. South Australian Sustained Nurse Home Visiting Program); (b) visible centralized referral services for vulnerable families that refer vulnerable children and families directly into voluntary services and supports in their community (e.g., Victorian ChildFIRST services).

The message for New Zealand is to ensure there are multiple pathways into and between services to ensure families with differing levels of vulnerability are matched as early as possible to services that will meet their needs.

Make child-centred practice changes: Better connecting vulnerable children to services

The Green Paper notes that some children and families do not receive essential services that they need. "For example, parents may not know where or how to access services, there may be a lack of appropriate services available, they may not be able to access services, or they may not want to engage with these services" (p.28).

The Green Paper talks about families who are more 'hard to reach', however researchers are now suggesting that this conceptualisation be turned on its head and the question asked as to whether some services are more 'hard to access' for vulnerable families. For example, teenage mums, dads, or refugee parents may not feel comfortable accessing a community parenting program or the local library services due to their feelings of difference. Other issues that can impact service accessibility are opening hours, location, and transport availability (McDonald, 2010). The Australian Government's Communities for Children strategy attempted to address these issues by implementing a strategy targeted at vulnerable and disadvantaged communities, which located services and access points within communities and made them universal services for anyone who lived within those communities. The evaluation of the strategy was favourable with non-stigmatising access points identified as a key factor contributing to its success (Muir et al., 2009).

Are families hard to reach or are services hard to access? Research has shown the importance for vulnerable families in perceiving services as non-stigmatising and welcoming with family-friendly locations and hours.

Make child-centred policy changes: Watching out for vulnerable children (p.23)

The Green Paper proposes that "mechanisms to monitor the needs of children, and their families and whanau, would allow professionals to provide them with the services they need to stay safe and healthy" (p.23)

As described earlier, Bromfield and Higgins (2005) concluded that while therapeutic interventions were helpful, most families did not receive such interventions despite being well known to the service system. Families were more likely to be monitored and assessed. Spratt (2001) in the UK found that identification and assessment of risk had become the foundation of practice with children in need to the extent that family needs were not being identified or met by services. The Green Paper also notes the very valid concern that increased monitoring will lead to "increased identification of unmet needs" (p.23). In preventing cumulative harm it is vital that we not just identify and monitor children and their families living in risk, but that they are provided with a meaningful intervention to support them to make necessary changes as early as possible. Assessing, investigating and monitoring families is not a benign intervention (Scott, 2006) and may damage the families' willingness to trust and engage with services in the future; identifying needs that cannot be met within the current service capacity may harm rather than help vulnerable children.

On a similar theme, the Green Paper raises the concern that there may be unintended consequences when reaching out to vulnerable families by government services is not done well. "For example, increasing the questioning of family and whanau by government services may: increase the waiting time for these services; seem intrusive; discourage more families and whanau from accessing these frontline services when they need them."

These are valid concerns, and will depend on what questions are asked, how they are asked, families' perceptions as to why they are asked, and the service system response. Asking families about their needs, and providing helpful support to see those needs met are likely to be welcomed by families. For example, Ma Mawi Wi Chi Itata an Aboriginal youth drop in centre in Manitoba, Canada has a strict policy that if a young person comes with a specific request (e.g. needing a bus ticket to get home) staff may seek to use the opportunity to learn more about the young person's circumstance and engage the young person in other activities, but the young person's self-identified presenting need must be met.

If questions are asked about needs that cannot be met by NZ Government Services, or if families perceive that they are being asked about their circumstances purely for the purpose of information gathering and monitoring they may indeed view the questions as intrusive and be discouraged from accessing frontline 7 services. However, if this is done well the opposite may well be true and it could be an opportunity to engage families earlier.

Share responsibility (p.9)

The study by Bromfield and Higgins (2005) found that children most at risk of cumulative harm were those known to child protection services, but who were assessed as not needing a child protection response. Child protection services are a last resort, and respond to the symptoms rather than the causes of extreme family dysfunction. They are not a preventative service, but see the consequences when prevention efforts have failed. Preventing cumulative harm requires that other agencies share responsibility for identifying and responding to children and their families who are in need. These include maternal and child health nurses, paediatricians, GPs, child care centres, and schools as well as services that work with adults to respond to many of the

underlying determinants of child maltreatment: mental illness, alcohol and other drug use, domestic violence and homelessness. A learning from the Australian context is that it can be difficult for child protection agencies to convince other portfolios to take on more responsibility for the protection of children, particularly where we are asking agencies to do more than just make a report to child protection services and instead to consider how they might work to differently to support vulnerable children and parents with whom they have contact. The British Government established the Social Exclusion Unit within the Department of Prime Minister and Cabinet to develop policy responses for those groups within the community who were 'deeply excluded' where a cross-portfolio solution was required.

One way in which the New Zealand government could take leadership may be to consider whether there are issues that require a cross-portfolio response, and whether such strategies would have more chance of success if they were led by the Department of Prime Minister and Cabinet rather than a single portfolio.

Make child-centred policy changes: Vulnerable child-first allocation policy (p.21)

Policy that prioritises access to services such as housing, mental health and alcohol and other drug services for parents of vulnerable children is another way of addressing the underlying causes of child maltreatment. The Green Paper raises a question as to what should be "the thresholds for 'vulnerability'" (p.21) when determining priority access to services. Research shows that homelessness, parental mental illness, parental substance addiction and domestic violence by themselves can significantly compromise parenting capacity and children's safety and wellbeing. They are the most common characteristics of parents referred to Australian child protection services (Bromfield, Lamont, Parker & Horsfall, 2010). Any of these issues alone would represent a sufficient risk to children to justify priority access to services for parents with these problems and would be consistent with the NZ Government's adoption of an early intervention approach.

Make child-centred policy and practice changes: Collaboration (p.26), coordination and information sharing (p.24)

The Green Paper recognises that "failures in communication and co-ordination between agencies are frequently cited in inquiry reports, research and policy documents as one of the main reasons for poor outcomes for vulnerable children" (p.26). This is especially true for children experiencing chronic maltreatment who are most at risk of experiencing cumulative harm (e.g. Frederico, Jackson & Jones, 2006). The Green Paper identifies factors identified in research that increase collaboration (p.26) and proposes that the "Government could review the current provisions in legislation to ensure professionals at the frontline, such as teachers, social workers, GPs, nurses, psychologists, police officers and therapists are able to freely share information" (p.24). It also poses the question as to what more could "… be done to improve or promote collaboration between professionals and services?"

The factors identified within the Green Paper that may increase collaboration are primarily suggestions related to the behaviours and obligations of frontline practitioners (e.g., better understanding and respect for each other's roles, improved communication, joint training). In implementing reform we need to ask whether the 8 environment in which practitioners are working is enabling of the practice we would like to see. Collaboration takes time. The evaluation of the Australian Stronger Families and Community Strategy (Muir et al., 2009) found that collaboration increased where collaborative activities were funded. Recent changes to funding agreements within the Australian Government Family Support Program have identified that funding agreements that specified outputs (e.g. targets for client throughput) prevented agencies from working collaboratively and creatively to achieve the desired client outcomes. Agencies with funding under the Family Support Program are now trialling reporting against outcomes achieved rather than outputs. The Northern Territory Inquiry into Child Protection Services (Northern Territory Government (2010). *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children*,) identified a lack of planning and coordination in determining what services would be funded to the extent that there were some communities with hundreds of different service providers. It is not feasible for practitioners in this environment to understand the roles and responsibilities of all of the different providers in their area. Professor Eileen Munro has often cited the need for service systems to be cognisant of the capacity constraints of human cognition when determining expectations of frontline practitioners (Munro, 2011; 1999).

In relation to information sharing, the Green Paper also notes the concern that "some parents and carers may not take their children to professionals such as GPs who may report suspicions" (p.30). As with any policy, implementation matters. Who will be sharing information, with whom? Will information sharing be in a one- way direction in the form of reporting? What will happen with the information? Will it be used for monitoring or to better connect families to services and supports? The South Australian *Information Sharing Guidelines for Promoting the Safety and Wellbeing of Children, Young People and Their Families* – while not yet evaluated – are a promising example of an information sharing protocol guiding the purposeful sharing of information and - critically - sharing information with client consent as the first preference in all cases.

One of the primary goals of collaboration is better service coordination. We want families to be identified early and be matched to the right services to meet their needs, at the right time. We want them not to have to tell their story again and again, or to be bounced from agency to agency because they don't quite fit service eligibility criteria. Where services are engaged we also want this to be coordinated so that we do not overwhelm already struggling families with multiple professionals working unilaterally on separate problems. One of the options suggested within the Green Paper to increase service coordination is "having an appropriate nominated person, such as a lead professional, whanau member or community worker, that coordinates services around the child, and their family and whanau" (p.30). This is a strategy that has been tried within the UK and shows some promise (Children's Workforce Development Council, 2009). Within Australia this currently occurs through case conferences convened by child protection services; a continuing challenge for the Australian context is determining how this role might be extended to other service providers so that the situation for families does not have to get 'bad enough' to warrant a child protection response before service coordination mechanisms are enacted.

Make child-centred policy changes: Working from an evidence-base (p.18)

There is a limited evidence-base that specifically relates effective interventions for families in which children have experienced chronic maltreatment, especially neglect, or been repeatedly referred to child protection services (MacMillan et al, 2008). Those interventions that show promise for this group are intensive and long- term therapeutic interventions, such as intensive family preservation and family reunification services. One of the critical components of evidence-based intensive family preservation services is that they directly – or through active linking to specialist services – address the underlying determinants of family dysfunction and maltreatment e.g. parental addiction, mental illness, homelessness and domestic violence (McLean & Iannos, in development). It may also be worth exploring (and evaluating) creative solutions that may offer more cost- effective and better outcomes for vulnerable children, such as taking a whole family rather than a child into care (BBC News, 2010; Howley, 2009). The proposal put forward in the Green Paper for the ongoing process of research, evaluation and monitoring of programmes and the development of an evidence-base regarding service efficacy in the New Zealand 9 context (see p. 19) is very sound. Critically the Green Paper recognises that "… good ideas are just part of the picture. Better management of the delivery of programmes will also identify and allow us to correct programmes that are poorly delivered or have departed from their original successful format into something less effective" (p. 19). Implementation Science is a field of practice and research that aims to overcome the "… paradox of non-evidence-based implementation of evidence-based programs" (Fixsen, Naoom, Blasé, Friedman & Wallace, 2005). In their landmark review and synthesis of implementation research, Fixsen and colleagues (2005) from the US-based National Implementation Research Network define implementation as "a specified set of activities designed to put into practice an activity or program of known dimensions" (p. 5). Implementation science provides great promise for informing the effective implementation of evidence-based strategies and programs.

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The Australian Centre for Child Protection is funded by the Australian Government through the Department of Innovation, Industry, Science and Research. The views expressed in this publication do not necessarily reflect the views of the Department of Innovation, Industry, Science and Research.

References available on request from SSPA.