



Cumulative harm

Best interests case practice model
Specialist practice resource

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About specialist practice resources

The Best Interests Case Practice Model provides a foundation for working with children, young people and their families. *Specialist practice resources* provide additional guidance on information gathering, analysis and planning, action, and reviewing outcomes in cases where specific complex problems exist or with particular developmental stages in children's lives.

This *Specialist practice resource* consists of two parts: an overview of cumulative harm and a practice tool to guide you when working with children and young people and their families.

Overview

What is cumulative harm?

Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.

Cumulative harm may be caused by an accumulation of a single recurring adverse circumstance or event (such as unrelenting low-level care); or by multiple circumstances or events (such as persistent verbal abuse and denigration, inconsistent or harsh discipline, and/or exposure to family violence).

This means cumulative harm may be a factor in any protective concern (such as neglect, physical abuse, emotional abuse, sexual abuse or witnessing family violence). Also, because cumulative harm can be caused by a pattern of harmful events, it is unlikely that a child will be reported to child protection explicitly due to concerns about 'cumulative harm'. This means that practitioners need to be alert to the possibility of multiple adverse circumstances and events in all reports, and to consider not just the information presented in the current report but the past history of involvement that may be indicative of cumulative harm. The focus of any assessment and intervention must be to answer two questions: 'Is this child safe?' and 'How is this child developing?'

Cumulative harm and the Children, Youth and Families Act

The *Children, Youth and Families Act 2005* (CYFA) states that the best interests of the child must always be paramount when making a decision or taking action with regard to a child. Included in these principles is:

section 10(3)(e), which must consider 'the effects of cumulative patterns of harm on a child's safety and development'. Section 162(2) determines that: 'harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances'.

The grounds for statutory intervention when a child is in need of protection outlined in section 162 (1) (c)–(f) do not change. Cumulative harm may be a factor in any one ground (such as failure to provide basic care) or a combination of different grounds (such as physical injury and emotional harm) where the prolonged and repeated experience of these circumstances or events have or are likely to cause the child significant harm.

The focus on identifying and responding to cumulative harm is likely to have a greater impact in responses to cases of 'omission' (neglect) that may have previously been considered as low risk when considered episodically.

When considering cumulative harm, practitioners are required to assess each report as bringing new information that needs to be carefully integrated into the history and weighted in a holistic assessment of the cumulative impact on the child, rather than an episodic focus on immediate harm.

Chronic child maltreatment

Bromfield and Higgins (2005) defined chronic child maltreatment as recurrent incidents of maltreatment over a prolonged period of time (that is, multiple adverse circumstances and events) and argued that chronic child maltreatment caused children to experience cumulative harm. Importantly, they found that the majority of children who are abused or neglected experience multiple incidents and multiple types of child maltreatment. This research highlights the critical need to be alert to the possibility that a child is experiencing cumulative harm if they are the subject of repeated referrals to child protection.

Parental and family indicators of cumulative harm

Research has shown that families who experience cumulative harm have:

- multiple inter-linked problems (risk factors) such as mental health problems, substance use and family violence
- an absence of protective factors
- social isolation
- enduring parental problems impacting on their capacity to provide adequate care (such as intellectual disability or substance abuse).

It is important to also have an understanding of how the structural dimensions of disadvantage and social exclusion (such as poverty, homelessness, unemployment, unsafe neighbourhoods and poor access to transport or community facilities) might be compounding the effects of other problems or creating barriers to the parents' ability to deal with their problems. While remaining child focused, we need to give the widest possible assistance to the family. This is clearly articulated in s.10 (3) (a) of the CYFA where the Best Interests Principles state that consideration must be given to:

'the need to give the widest possible protection and assistance to the parent and child as the fundamental 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'.

Remain compassionate to the complexity of families' lives

Effective engagement will require you to build a trusting relationship with all family members. Parents and children's openness to engaging with services may also be affected by their past experiences with formal services and supports. For example, in a recent study McArthur and colleagues (2009) found that some of the barriers and disincentives to parents accessing services were: past experiences of feeling discriminated against or treated unequally due to their situation; feeling humiliated and embarrassed by their circumstances and fearful that their children would be removed; being judged as not needy enough or not meeting set criteria; and that it was up to them to make contact with the right person the first time.

Approach the family non-judgementally and with respect at all times. Reflect on how you approach the family – your warmth, consistency and practical assistance can make a powerful difference to the families' engagement with services and the lives of their children (Miller 2010).

How does cumulative harm impact on children?

The main research and theories that have helped us to understand the way in which cumulative harm impacts on children are on early brain development, trauma, attachment and resilience. This evidence base and knowledge provide different perspectives on the processes and impacts that adverse events have on children.

Early brain development

Disruptions to normal brain development in early life may alter later development of other areas of the brain. Researchers investigating brain development have used the term ‘toxic stress’ to describe prolonged activation of stress management systems in the absence of support. Stress prompts a cascade of neurochemical changes to equip us to survive the stressful circumstance or event. However, if prolonged (such as if a child experiences multiple adverse circumstances or events), stress can disrupt the brain’s architecture and stress management systems leading to hypersensitivity and over activity. Children who have experienced toxic stress or severe disruptions to early brain development may find it difficult to regulate their own behaviour or emotional reactions. Toxic stress may sensitise children to further stress, lead to heightened activity levels and affect future learning and concentration (Shonkoff & Phillips 2001).

Trauma

The term ‘complex trauma’ has been used to describe the experience of multiple, chronic and prolonged traumatic events in childhood (van der Kolk 2003). Whereas single traumatic incidents tend to produce isolated behavioural responses to reminders of trauma, chronic trauma can have long-term pervasive effects on a child’s development (van der Kolk 2003). Exposure to chronic trauma may lead to serious developmental and psychological problems for children and later in their adult lives. These problems include:

- disturbed attachment patterns
- complex disruptions of affect regulation
- rapid behavioural regressions and shifts in emotional states
- loss of autonomous strivings
- aggressive behaviour against self and others
- anticipatory behaviour and traumatic expectations
- lack of awareness of danger and resulting self-endangering behaviours
- self-hatred and self-blame and chronic feelings of ineffectiveness (van der Kolk 2003)

van der Kolk (2005) identified several developmental effects of childhood trauma including:

- disturbances in memory and attention – dissociation, sleep disturbances and intrusive re-experiencing of trauma through flashbacks or nightmares
- disturbances in interpersonal relationships – lessened abilities to trust, re-victimisation, victimising others, lessened ability to cooperate and play and negotiate relationships with others such as caregivers, peers and marital partners

- alterations in systems of meaning – despair and hopelessness, loss of previously sustaining beliefs, suicidal preoccupation, excessive risk taking and difficulty modulating sexual involvement
- alterations of perception – of self and the perpetrator, adopting distorted beliefs
- disturbances in information processing, and meaning of events
- somatisation – digestive system, chronic pain and cardiopulmonary symptoms
- increased anxiety disorders and personality disorders (van der Kolk et al. 2005).

Research has shown that long term harm is more likely to result from living in an unfavourable environment and the emotional damage from abuse rather than physical damage (Cicchetti and Toth 2000). Research has also shown that the personal meaning and perception of the child who experiences violence and abuse is weighted by the child more heavily than an actual injury or degree of force in relation to the severity of psychological distress. (Levy and Orlans 1998 pp. 128)

The child's subjective experience, and the meaning attached by the child to traumatic events is central to the analysis of the impact of cumulative harm. This includes the child's prolonged and sickening anticipation and fear of repeating traumatic events. (Miller 2007)

(See also *Child development and trauma specialist practice resource* for the impact of trauma by age and stage of development.)

Attachment

Human attachment relationships aim to ensure a child feels a secure bond with their caregiver in order to learn and explore the social and physical world (Bacon & Richardson 2001). Babies and young infants exposed to cumulative harm are more likely to experience insecure or disorganised attachment problems with their primary caregiver. For children with a disorganised attachment, the parent/caregiver who should be the primary source of safety and protection, can become a source of danger or harm or be overwhelmed themselves, leaving the child in irresolvable conflict. Attachment difficulties are likely to increase when maltreatment is prolonged. Children's responses will largely mimic those of their parents and therefore the more disorganised and inconsistent the parent, the more disorganised the child (Streeck-Fischer & van der Kolk 2000). Without the security and support from a primary caregiver, babies and infants may find it difficult to trust others when in distress, which may lead to persistent experiences of anxiety and anger (Streeck-Fischer & van der Kolk 2000).

If the source of the harm is also the young person's source of safety (an attachment figure) then the level of trauma is increased (Cook, Spinazzola, Ford, Lanktree, Blaustein, Sprague, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson & van der Kolk 2005).

Resilience

Siblings experiencing difficult family circumstances or abuse can show different levels of resilience due to the complex interaction between their temperament, the impacts of their environment and the parenting they have experienced over the course of their development. For example, all children have aspects of individual vulnerability and resilience. Outside the child are external forces or life events including: risk factors, experiences of trauma and adverse events; and protective factors, positive experiences and potential sources of strength. An individual's experiences of these external forces and response to them can increase or decrease their levels of vulnerability or resilience. Therefore, an individual's level of resilience is not static, rather it is dynamic and evolves and changes over time in relation to the individual's life experiences.

Cumulative harm can overwhelm even the most resilient child and particular attention needs to be given to understanding the complexity of the child's experience. Families in which children are exposed to cumulative harm often lack strong protective factors and are characterised by a range of complex problems that can break down a child's resilience. For this reason, we must be cautious not to focus on resilience to the extent that we ignore the risks for the child. Children who appear to be coping well, but who in fact have internalising symptoms (such as depression, lack of self-worth), are vulnerable to being overlooked (Luthar & Zelazo 2003).

Cumulative harm can overwhelm even the most resilient child. For this reason, we must be cautious not to focus on resilience to the extent that we ignore the risks for the child.

Assisting recovery in children

Research evidence from the Longitudinal Study of Australian Children (LSAC) shows that parental warmth, low parental hostility when disciplining, and parental consistency, reduces the risk of psychological and behavioural problems in children and is linked with more positive child outcomes. Children aged 4–5 years were four times more likely to have conduct problems and twice as likely to have hyperactivity problems when experiencing hostile parenting (Smart et al. 2008). Parental warmth has been shown to increase children's self-esteem (Berk 2009).

In cases where children have experienced cumulative harm the focus of intervention must be on reducing the adversity in the child's life, assisting their recovery and increasing their resilience to future adversity. These children require calm, patient, safe and nurturing parenting in order to recover, and may well require a multisystemic response to engage the required services to assist.

It is important to understand that the brain altered in destructive ways by trauma and neglect can also be altered in reparative, healing ways. Exposing the child, over and over again, to developmentally appropriate experiences is the key. With adequate repetition, this therapeutic healing process will influence those parts of the brain altered by developmental trauma.

(Perry 2005)

The recovery process for children and young people is enhanced by the belief and support of non-offending family members and significant others. They need to be made safe and given opportunities to grieve for the loss and pain they have experienced and to reconnect with their parents and/or carer, school, community and culture (Miller 2007).

Engaging the offending parent to face up to and take responsibility for real change, will also be helpful in the child's recovery process, regardless of whether or not the child remains in their care. Children and young people can carry shame and despair in regard to their parents' behaviour throughout their lives. They may feel burdened with responsibility or become parentified themselves, whilst feeling powerless to change or help their parent/s. As professionals if we can engage the parents in recovery, this will be positive for their child and enhance their healing.

Aboriginal children and their families

Cultural competence, sensitivity and respect are essential in any intervention with families. For Aboriginal and Torres Strait Islander children and families, the impact of historical and ongoing dispossession, marginalisation, racism, colonisation, poverty and the stolen generations have led to high levels of unresolved trauma, depression and grief. (Human Rights and Equal Opportunity Commission 1997). However, do not make assumptions. Many Aboriginal families in Victoria are resilient, thriving and strong within their culture. "They have an enduring and essential connection to country and have survived in the face of this painful history, adapting to include Aboriginal people whose traditional country is elsewhere in Australia and those who have lost or never known their traditional identity". (Department of Education and Early Childhood Development, 2010 (b) pp. 9).

The impacts of the stolen generations have been far reaching and continue today. In the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 7 per cent of Aboriginal people who responded reported being removed from their families and 37.6 per cent had a family member who had been removed. These impacts were even more pronounced in Victorian Aboriginal people living with children, 11.5 per cent of whom reported that they had been removed from their natural family and 47.1 per cent of whom had a relative who had been removed (Department of Education and Early Childhood Development, 2010 (a) pp. 26). Critically, approximately one in five Aboriginal young people aged 12-17 years identify as belonging to the stolen generations (Department of Education and Early Childhood Development, 2010 (a) pp. 28).

Some of the key individual, family and community problems associated with unresolved trauma that have been associated with heightened rates of child abuse and neglect in Aboriginal and Torres Strait Islander communities include: alcohol and drug abuse; family violence; social isolation; and over-crowded and inadequate housing (Berlyn & Bromfield 2010). For example, the vast majority (78.6 per cent) of adults in Victorian Aboriginal families, reported having themselves (or family or friends) experienced one or more major life stresses. (For example, death of a family member or close friend, serious illness or alcohol/drug related problems). This is almost double the rate for non-Aboriginal Victorians. (Department of Education and Early Childhood Development, 2010 (b) pp. 22). In this context Aboriginal and Torres Strait Islander children, or any children living in such circumstances may be more vulnerable to cumulative harm.

Section 12(a) of the CYFA provides guidance on principles for engaging Aboriginal families. Refer to the Aboriginal cultural competence framework and Working with Aboriginal children and families to guide you.

In practice consider:

- holistic family healing approaches that plan to provide for the physical, mental, emotional and spiritual wellbeing of the infant, child, young person and their family
- the healing value of culture, which affirms identity and connection to community as protective factors that encourage resilience
- seek advice from Aboriginal cultural experts. Child protection practitioners must consult with ACSASS.

Culturally and linguistically diverse children and their families

Refugee and migrant communities may be struggling with unresolved trauma, grief and loss after fleeing from war or oppression. Adjusting to a new culture and way of life can also put further stress on families and increase children's vulnerability.

Families who are second generation migrants to Australia may struggle with different social and parenting expectations for young people. Language barriers can become social barriers and place added stress on families.

Section 11(g)–(j) of the CYFA provides guidance on principles for engaging families from other cultures.

Issues of safety and cumulative harm for infants, children and young people should not be minimised. However western cultural expectations can impact unfairly upon parenting assessments when working with Aboriginal families and families from other cultures. Consultation with cultural experts helps us to balance the needs of children and complex family issues. Seek advice and supervision. Refer to the Infants and their families and Adolescents and their families specialist practice resources.

Practice tool

Cumulative harm

The aim of this tool is to provide some additional guidance about specific things you might consider in cases involving cumulative harm. The tool has four parts (information gathering, analysis and planning, action and reviewing outcomes), which reflect the dynamic process of working with families.

Cases involving cumulative harm are complex. You need to access appropriate supervision and engage in critical reflection throughout the process of information gathering, analysis and planning, action and reviewing outcomes. Challenge your initial views and remain open and curious about what you don't know or understand yet. Develop multiple hypotheses.

Information gathering

Information gathering is ongoing throughout the life of a case, and includes gathering information about the child and their family from existing case files, professionals involved with the family and most importantly from children and families themselves. Information also needs to be gathered about previous attempts to resolve the problems within the family by the family themselves, by child protection and by other professionals and agencies involved with the child and family.

Genograms and Eco-maps are very useful to develop early in the response process. They are visual reminders to think and act systemically.

Family meetings and case conferences are an excellent strategy for building your relationships and gathering information. Care team meetings whilst critical, do not replace case conferences, which are particularly important when there is a complex experience of cumulative harm. At a case conference you should be inviting the adult-focused services that may not be directly involved in the care team for the child. The adult-focused services will have invaluable information to inform your work and their role is crucial. Seek a multi-disciplinary perspective.

As you gather information hold the following questions in mind:

- Have you or others been aware of similar issues in the past? If so, have the problems escalated?
- Are there indicators that the child or his/her siblings have experienced other types of harm in addition to those made aware to you?
- Have the alleged circumstances caused, or are they likely to cause, significant harm if repeated over a prolonged period?
- Put the child at the centre of your assessment and analysis of the impact of cumulative harm:
 - How long have the problems in the family been present?
 - How are parental problems and family circumstances impacting on the child?

Indicators of cumulative harm in the case history

The types of reports received and the sources of information may provide indicators that a child is experiencing cumulative harm. When a case has previous reports either not investigated or not substantiated, inaccurate assumptions can be made that this case is not one of significant risk. Well-documented case histories are critical to inform future assessments of the possible presence of cumulative harm. The details matter.

- Read the file.
- Develop a chronology.
- Synthesise the file under the criteria of: type of harm; source of harm; frequency, duration and severity of adult behaviour; and its consequent impact on the child (see Analysis and planning).
- If there is a sibling group, develop a synthesis for each child. Consider the developmental trajectory for other children within the family.
- Consider the past interventions - were they effective?

Indicators of cumulative harm in child protection case history reports might include:

- multiple reports
- previous substantiations
- multiple sources alleging similar problems
- reports from professionals
- evidence of children not meeting developmental milestones
- allegations of inappropriate parenting in public (Bromfield, Gillingham & Higgins 2007).

Talk to parents about their children

Parents' love for their children and motivation for them to be safe and well will usually be the primary reason parents engage with child and family welfare services. Give parents space to talk about their hopes and dreams, worries and fears for their children. You will get rich information about the child and start to build a relationship with the parents around your shared aim of achieving the best outcomes for their child.

Parents are usually experts about their children and their own lives and they will be an important source of information about things such as whether their children are developmentally 'on track' and able to relate, play, concentrate, participate and belong.

- Use the *Child development and trauma resource* with parents to have a conversation about where their child is at developmentally.
- Are there any characteristics of the child or other children in the family making it hard for the parent to meet their child's needs (such as disability, being medically fragile or behavioural problems)?
- Ask parents if there are any characteristics of this child that may strengthen or undermine their resilience.

Effectively engaging families

Research shows that practitioners who engage effectively with families:

- treat family members with respect and courtesy
- focus on building on the family's strengths
- promote positive relationships among parents and children
- develop trust through sensitive and inclusive enquiry about their circumstances
- take an active, caring, whole-of-family approach to their situation
- link up with other relevant services and work together to avoid conflicting requirements and processes
- focus on the children's needs
- maintain a continuous relationship with the family
- establish shared decision making
- provide crisis intervention prior to other intervention aims
- build the quality of relationship between the parent and the service provider
- minimise the practical or structural barriers to accessing services
- chose non-stigmatizing interventions and settings
- remain culturally aware and sensitive

Source: (McArthur et al. 2009, Centre for Community Child Health Royal Children's Hospital, 2010)

Talk with and observe the child

You can get a good sense of what the family environment is like for the child by watching and interacting with them, keeping in mind whether and how their demeanour and presentation may reflect the impact of cumulative harm.

- How does the child present?
- What toys are used in play and how they are used? How does the child interact and play with other children?
- Ask the children about their day. What are their routines? What happens after school?
- Ask about their home and family life. Who lives in their house? Who comes to visit? Who looks after them? What makes them happy? What makes them sad? What is the child saying/not saying? What does this tell us?
- What is the child's relationship with his or her siblings?
- Watch for: developmentally appropriate play, communication and emotional responses; comfort-seeking behaviour when distressed; parent-child interactions; and the child's responses to strangers.

Given most children are scared or ambivalent about disclosure and experience confusion and loyalty even when parents are abusive, what is the best way to build rapport with the child? Be thoughtful, creative and purposeful in your contact with the child and try to help them understand your role and the process. Where possible, give the child choices over the process and timing of events.

Make your observations and interactions with children purposeful. What do your observations and interactions tell you about the child's development, the impact of trauma, attachment and resilience?

Keep in mind that parents and children may behave differently in the contrived and often stressful situation of an assessment and avoid making definitive assessments about parent-child relationships too early. The need for multiple observations in different settings is important for good assessments.

- Is the child meeting developmental milestones?
- Is the child displaying any signs of trauma?
- Are there any indications that the child has attachment difficulties?

Refer to the *Child development and trauma resource* to identify developmental milestones and indicators of trauma at different ages and stages.

Talk to key people in the child's life

Practitioners need to gather information from multiple sources. The parents or carers are usually the starting point for your discussion. However, the extended family and professionals who know the child and their family should be considered as a valuable source of information and often as a partner in decision making and the process of recovery. Think broadly to identify the people who are close to the child or see them routinely to comment on the changes over time. Also think about the specialist practitioners and services that can help you to better interpret the family's circumstances and presentation, and inform your assessment. Don't forget to include the adult focused services.

Family meetings and case conferences will usually inform you more effectively than individual phone calls. Critically, reflect together on the meaning of the information that is being shared from the child/young person's perspective. Leave time to develop clarity about any decisions or plans that need to be made. Remain curious and open rather than defending previous assessments or views that have been formed about the family. Ask your colleagues to challenge your analysis and assumptions. Beware of 'group think' and the pull to polarise and be overly optimistic or overly pathologising. Appoint a 'devil's advocate' at the case conference.

- Have you spoken to the child care practitioner, kindergarten teacher or school teachers who see the child routinely and are a rich source of information?
- Have you spoken to the grandmother, aunts, neighbours and other significant adults in the life of the child or family?
- Have you spoken to the maternity hospital, maternal and child health nurse, family support practitioners, family violence practitioner, housing practitioners, GP, paediatrician, counsellor, speech therapist and other professionals involved with the child and family?
- Have you consulted the supervisor/practice leader or specialist infant protective worker if appropriate? Have you followed through with their recommendations?
- Is the child or young person Aboriginal or a Torres Strait Islander? If so, what is the Aboriginal Child Specialist Advice and Support Service (ACSASS)/Lakidjeka practitioner's (Aboriginal) perspective on this child's safety, stability and development?
- Have you consulted with other cultural services if appropriate?
- Have you liaised with Corrections, Police and obtained the criminal history of the parent or the partner of the parent/s?
- Have you sought advice from the adult mental health service, drug and alcohol service, disability service, and asked specifically how the mental health issues may be impacting on the day-to-day functioning of the parent and on their parenting relationship? Have the adult-focussed professionals realised that there are vulnerable children and concerns about the parenting?

Any professional opinion is of itself limited by the time, role and focus of the practitioner such as a maternal and child health nurse who only sees the infant for brief periods once a fortnight, or the drug and alcohol practitioner who is focused on the adult's recovery not their parenting capacity. When gathering information note exactly how often and the nature of the contact the professional has had with the child.

What problems are being experienced in the family?

What are the primary problems contributing to the parents' current circumstances? Identify the events or behaviours that have brought the family to the notice of your service – what happens and when, how often, who is involved? What are the impacts on the parent as an individual? How does this situation impact their capacity to parent?

- What have the parents' life experiences been?
- What is the repeating or current pattern around the concerning behaviours?
- How is the parents' mental, emotional and physical wellbeing?
- Do they have ongoing issues that may affect their day-to-day functioning and parenting capacity (such as a disability or mental illness)?
- How have the parents' circumstances or problems impacted on their relationship with their child?
- With appropriate support, is the parent likely to be able to provide an adequate level of care to their child?
- What is a good day like for them? What is a bad day like? What makes the difference?

Context of the problem(s)

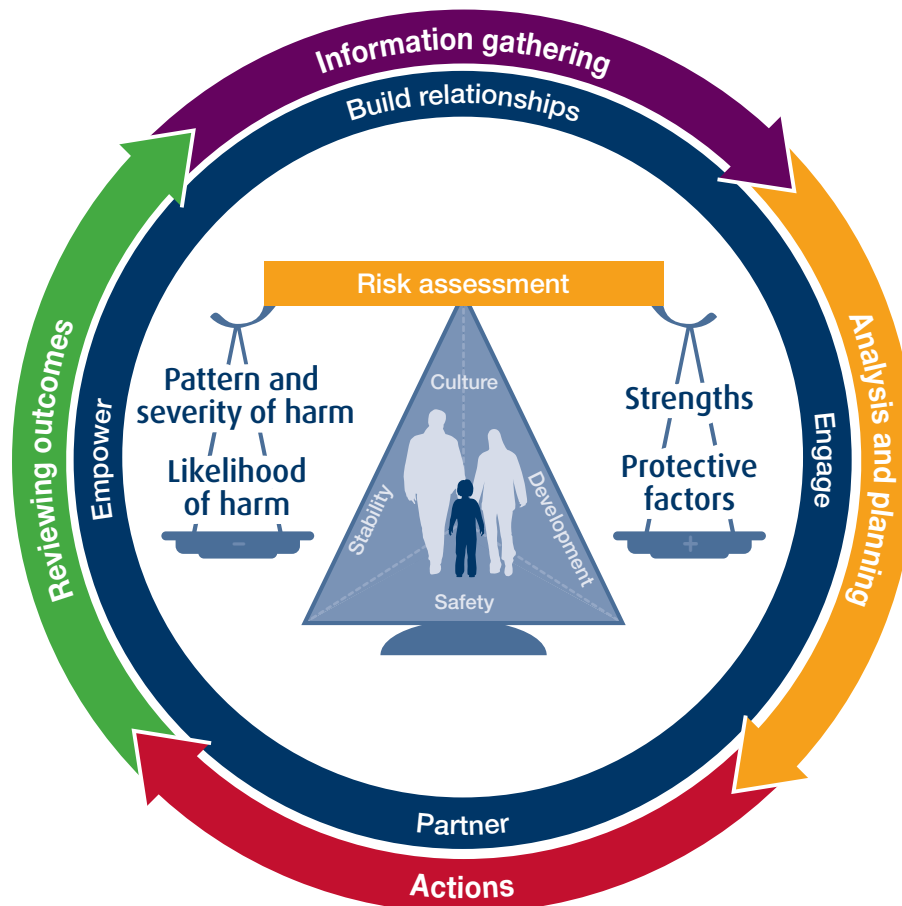
Ask the parent about other aspects of their life. Is this family living within a broader context of poverty, disadvantage and social isolation? If you can assist the family with some of these practical needs, trust will be enhanced and this will assist engagement with the parenting and child-focused concerns.

- Does the family have adequate housing?
- Are the parents in employment?
- Are parents struggling with money problems? Can they pay their bills and buy groceries?
- Does the family have access to transport? Is this affecting their capacity to meet their child's needs?
- Do they feel safe and supported in their neighbourhood or are they socially isolated?
- Do they have any non-professional support?

The following questions might help you to explore the problem from the family's perspective:

- How has the family tried to manage the problems before coming to the attention of child protection?
- What are/were the exceptions to the problem behaviour/s being repeated?
- What was different? What was the context that enabled the family's strengths to be enacted?

Analysis and planning



Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the child's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the child's timeframes for safety and secure attachment relationships. Imagine the young person's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the child.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid et al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.
2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.
3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management
2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change
3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?
Consider the **vulnerability** of the child and the **severity** of the harm:
 - What harm has happened to this child in the past?
 - What is happening to this child now?
2. What is the **likelihood** of the child being harmed in the future if nothing changes?
Hold in mind the **strengths and protective factors** for the child and family.
3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?
4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?
5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?
6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What would there be less of? Who would notice?

The child's subjective experience has to become central to the analysis of the impact of cumulative harm. Put the child at the centre of your assessment. Are there early signs that might indicate that a child is experiencing cumulative harm?

Critically reflect on indicators of cumulative harm in the case history

A cumulative harm perspective requires a re-examination of each of these reports every time a new report is made in order to assess whether a number of low-level risk factors combined are placing the child at risk of significant cumulative harm.

At intake, the rationale for 'no further action' on previous report(s) needs to be challenged and a different analysis developed based on the new information provided in the current report.

- Why was there no further action?
 - Because the alleged event when considered in isolation fell below the threshold for statutory intervention?
 - Because there was insufficient information gathering and analysis?
 - Because the available evidence was not sufficient to enable the allegation to be substantiated?
- What does the information in the new report tell you about the possibility of a pattern of inadequate parenting being present?

Remember: Any previous reports or assessments inform your analysis and decision making, rather than direct it. Previous assessments need to be critiqued in the light of other information and *current* observations held by practitioners. Be aware of the tendency to screen out or minimise information that challenges previous views you have held. Use supervision and ask to be challenged.

Cumulative harm can be very challenging and requires the practitioner to have good observational and analytical skills whilst engaging warmly with families and children. "It requires practitioners to have very acute antennae and a capacity to 'see the wood, not just the trees', ie to put together often disparate aspects and features of a child's life into a deeper understanding of how past events may impact upon a child's current development and future prospects," Naughton, 2010.

What is happening in the child's daily life?

The research of Bromfield and colleagues (2007) demonstrates that it is particularly important to be alert to cumulative harm in cases in which individual incidents (when considered in isolation) do not reach the threshold for intervention. Put together the pieces of information you have gathered and imagine life through the eyes of the child. **What is their daily lived experience?**

- Are the child's basic daily needs being met: sleeping, eating, hygiene?
- How are children spending their time? Are they playing and interacting? Going to school or child care? Spending extended periods without interaction in their pram or in front of TV?
- Do children have a regular routine? Having a routine is important for children because it provides them with consistency, and makes the world more predictable for them. However, having a routine is not the same as having a rigid or inflexible daily schedule.
- Are parents spending time with children, providing them with the nurturance, attention, love and affection they need for positive emotional development?
- Are the children properly supervised? Are there clear boundaries and limits? Is there warmth and constancy?
- What do you think the child might name as the good and bad things about their daily lived experience?

Be alert to chronic neglect

It is particularly relevant to be alert to the possibility of cumulative harm in cases of chronic neglect that are characterised by an unremitting low level of care. The cumulative effects of chronic low-level neglect are easily missed because the term 'abuse' suggests a ring of urgency that 'neglect' does not and the effects of neglect are usually not as obvious. Frederico, Jackson and Jones (2006, p.18) caution:

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.

Refer to the: *Infants and their families specialist practice resource*.

Make your cumulative harm assessment

Draw together all of the information you have collected. To identify whether a child is at significant risk of experiencing cumulative harm it is important to synthesise the information along the following dimensions:

Type – What is the range of adverse circumstances and events that the child has experienced? Make particular note of any types of abuse or neglect that the child may have experienced or be at risk of experiencing.

Source of harm – Who is responsible for the child experiencing these adverse circumstances and events (one person or multiple people)? Does the situation make the child vulnerable to other perpetrators of abuse or neglect (such as extra-familial perpetrators)?

Frequency – How often has the child experienced harm? From your knowledge of the child's history, is there a pattern of these circumstances or events being repeated?

Duration – Over what period of time has the child experienced these adverse circumstances and events? Link this back to the child's age and developmental stage.

Severity – What has been the impact of the circumstances or events on the child's development and wellbeing? What is the likely impact if the adverse circumstances and events are repeated over a prolonged period?

Source: Bromfield 2005

What has been the impact of cumulative harm on each child in the family?

In order to recognise and respond to cumulative harm, the short and long-term effects matter. Your assessment must present the outcomes for the child should their circumstances remain unchanged.

- What has been the impact on the child to date?
- Is the child meeting developmental milestones?
- Are there any signs of trauma?
- What is the quality of parent-child relationship?
- What are the likely impacts on the child's development should their circumstances remain unchanged?

In order to recognise and respond to cumulative harm, the assessment must present the likely 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. Use the Child development and trauma resource to guide your assessment.

Planning needs to be 'with' rather than 'for' the family

The relationship you have built with the family is a powerful determinant of good outcomes. Combine warmth and directness, empathy and clarity about the bottom lines of what needs to change. Always ask the family first about what they want. If they want 'the welfare off their backs', normalise this and show empathy and then clarify what they think would have to change to achieve this. Ask their permission to be 'up front' about the issues for the kids while you empathise with their situation, and how hard it is to be having this conversation. This is both warm and direct, both child focused and family sensitive (Miller 2010).

What interventions might assist the child and family in the short and long term? Note that any action should be based on sound analysis and be purposeful towards engaging the family members in a change process.

Consider the use of multidisciplinary assessments for children and parents. For example, assessments by the paediatrician, maternal and child health nurse, school, health service, occupational therapist, speech pathologist, drug and alcohol service, disability service, GP, physiotherapist, psychologist and/or psychiatrist. Be purposeful about how these will add value to your analysis, and plan to update and review these to assess if the child's outcomes are improving, and that we are on the right track.

Remember: These assessments inform your analysis and decision making, rather than direct it. Assessments need to be critiqued in the light of other information and observations held by Child Protection and Family and Placement services.

If the child is of Aboriginal or Torres Strait Islander descent, remember to consult with the ACSASS/Lakidjeka practitioner when formulating your plan.

Ensure you have considered:

- engaging the absent parent
- engaging violent partners (providing practitioner safety issues have been managed)
- engaging the extended family (be inclusive of grandparents)
- a case conference
- a family group meeting
- an Aboriginal family decision making meeting
- referral to other agency/agencies (such as home visiting, family services, drug and alcohol, mental health, family violence, men's behaviour change, victims of crime assistance services, sexual assault services, CAMHS, family counselling services, refugee services, culturally specific services)

- connections to universal services or community programs/clubs (such as schools, maternal and child health nurse, health services, child care, mentoring programs, sporting clubs, community centres, neighbourhood houses, first mothers' groups, playgroups, parenting groups, toy library)
- respite placement
- a discharge planning meeting
- application for a court order
- making a stability plan with the goal of reunification or engaging intensive family preservation services
- preparing a stability plan within the child's timeframes if reunification cannot occur (refer to the online Child Protection practice manual for guidance). Continue to engage the child's biological family in the planning process. Consider the use of family decision making.
- consulting with the ACSASS/Lakidjeka practitioner if the child is of Aboriginal or Torres Strait Islander descent.

Remember to consider what interventions or services might assist the child towards recovery. Often this will involve adult-focused services to help the parent. Engage the adult-focused service professionals with the child's experience and the parenting issues also. Keep in mind that these services can often offer specialist consultation and advice to the care team, not just a direct service.

Action

Practitioners need to make every effort to engage with families cooperatively to address issues of cumulative harm. Coercive forms of intervention will sometimes be necessary, but this is a last resort. However be aware that the parents' compliance with attending services or accepting your visits does not necessarily mean that the child is safe or that real change has occurred. Engagement is about a change process that has outcomes for children that are positive. Be transparent with the family about what is not negotiable and be clear about timelines and expectations.

A referral to another service will not ensure that the family will engage with that service or that change will occur. You can skillfully help the family to attend and facilitate their engagement. A single service may not be able to assist families to change, and they may require a care team approach. Be careful not to overload the family though, with an overwhelming schedule or an excessive list of services.

Building a partnership with families

It is important that you action your plan with rather than for families. It is critical that professionals develop a strong relationship with the family and child. The strongest determinate of good outcomes in practice with families, aside from the particular characteristics of the family, is the quality of the relationship between the practitioner and the family members. Talk to parents about their wishes and dreams, their worries and concerns, what makes it hard and what might help. Explore their constraints.

What have families tried previously to overcome their problems and how did this work out for them?

Involve children in your intervention and avoid treating them as passive recipients of services designed to 'rescue them'. Bernard (2007) identifies three qualities that characterise individuals who help children resist stress:

- a caring relationship
- high expectations
- opportunities for contribution and participation.

The goals of the intervention need to be developed with the family and extended family and it is critical that they are concrete, behavioural and measurable. The parents need to know when they have been successful and the practitioners need to give feedback to them in meaningful ways that build confidence and realistic hope.

Practice needs to be strengths based and forensically astute, and be respectful and courteous at all times (Miller 2007a). The reason for Family Services/Child Protection involvement must be clearly understood by the family. Clear goals and outcomes need to be established in partnership with the family wherever possible, in relation to what needs to change for the child. Establish clear time lines and expectations with parents, other practitioners and services and extended family.

Working with children and families

It is important to acknowledge that parents may be experiencing trauma symptoms and need ongoing support. Practitioners need to engage parents in managing their responses to their own and their children's trauma. It is normal for parents to feel overwhelmed and suffer shock, anger, severe grief, sleep disturbances and other trauma-related responses.

If the family is initially angry about your involvement, don't take it personally and, in a low-key manner, normalise their response. Listen long and hard about their views and paraphrase, explaining that you want to make sure you've understood and 'got it right'.

If there is a history of family violence or indicators of child sexual abuse, engage the non-offending parent first and make time to meet them separately from their partner. Privilege safety. Inform and work collaboratively with the police and specialist treatment support services.

Engage families in solution-focused thinking. Ask families the miracle question: If you woke up in the morning and a miracle had happened and all your problems were fixed, what would be different? (adapted from De Shazer et al. 1986). What would there be more or less of in your life? How would we know? Who would notice? Alternatively, you could ask families: How will you know when the nightmare is over? What are your dreams for your child? What gets in the way of these becoming real? What would be the first small step in the direction you want for your child? (Miller 2008).

Assist to identify and build non-professional support and help to link the children and family into local community groups eg, sporting teams, local library, new mother's groups etc, which will remain when your intervention has ended.

Working in partnership with other services

Hold case conferences/care team meetings regularly where there are a number of professionals involved. Ensure that agreements are in writing, and that roles and responsibilities and timelines are clearly articulated. It is critical that the professional best placed to engage strongly with the family is identified. This may or may not be the same person who has responsibility for coordinating cross-service responses. The relationship between professionals is of critical importance in achieving good outcomes. You need to build a care team and that means dealing with the process issues and differences as they arise (Miller 2007a).

Remember to coordinate between services and clarify roles and communication processes. Who will do what, for whom, by when? At every stage, have you included parents, carers, teachers, maternal and child health nurses, child care practitioners and any other significant person in the child's life?

When parents can't or won't change

Practitioners must find the balance between providing support and validation while being able to directly challenge neglectful and other aspects of poor parenting (Frederico, Jackson & Jones 2006). Cousins (2005, pp. 5) writes:

... we need to be careful we are not being confused by the illusion of change. Sometimes, in our own hope to see things improve, we can focus on improvements that are not actually about change for the child. This can also be a form of collusion – where the practitioner and the parent know deep down they cannot do it, but no one is prepared to shatter the dream.

Do other professionals' opinions vary? How do these contrast with your own observations? What does this mean for your analysis of risk of harm? The child's subjective experience has to become central to the analysis of the impact of cumulative harm.

As hard as it can be to witness the struggles of some parents attempting to change their situations, ultimately, if a parent won't change, can't change, or it will take too long, then the needs of the most vulnerable family members, the children, have to be prioritised. The short and long-term effects matter, whether there is intent to harm or not. Remember that the desire to change dangerous or neglectful behaviours does not equal capacity to change. Sustaining change is hard work and requires commitment and consistent evidence of changed behaviours.

If family problems that have prevented children from receiving adequate care are overwhelming and intractable, despite 'the widest possible assistance' (s. 10), then the child's rights to safety and stability must be met. A court order and/or placement services may be required.

Placement decisions regarding Aboriginal children

If a child of Aboriginal or Torres Strait Island descent is to be placed in care, we must adhere to the Aboriginal Child Placement Principle and promote a child's connection to their natural family and/or community. This may mean thinking outside administratively defined geographic regions and working collaboratively with other regions to place the child with their family or community.

Consult with ACSASS (LAKIDJEKA) practitioners.

Give consideration to the Additional decision-making principles for Aboriginal children, s 12 CYFA; and regard must be had for the Aboriginal Child Placement Principle s 13 CYFA; and Further principles for placement of Aboriginal child s 14 CYFA.

Preparing matters for court

When child protection is seeking to establish the existence of cumulative harm and the detrimental effect of this harm on children, you must present evidence to the court that supports this assessment and shows the effects of cumulative harm on children.

You need to convey the story of what has happened for the child within the family and your rationale for the course of action you are taking. It is not enough to say a child has experienced cumulative harm. You need to present evidence to the court that shows the effects of the cumulative harm on this child, about the protective concerns, the assistance that has been made available to the family, the outcomes of previous interventions by Child Protection and other services, as well as your acknowledgement of the strengths within the family.

Identifying relevant evidence for any court proceeding requires a great deal of skill. It is highly recommended that workers engage with their solicitor as early as possible to assist in identifying the relevant evidence, and to advise what additional evidence may be required for court proceedings.

Finally, the court needs to be provided with evidence of the likely future 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.

For further guidance in preparing matters for court, Refer to the *Guide to court practice for Child Protection practitioners 2007* in the Child Protection practice manual.

Reviewing outcomes

We need to remain curious about our effectiveness, and constantly review our assessments and planning, in the light of emerging information and the outcomes of our actions (Miller 2008). All families are different and there is not only one solution. Good practice may involve trying several strategies or interventions before reaching the tipping point for change. However, keep in mind that infants and all children, including adolescents are extremely vulnerable and that timelines need to be highly attuned to their needs and safety. It is critical to constantly integrate new information as it comes to light. We need to routinely reassess both the circumstances for the child and family and avoid case drift. Previous service system responses and outcomes of interventions need to be realistically assessed in terms of their ability to assist the child to recover from cumulative harm impacts over the life course of the child:

- What have been your previous responses as a Child Protection practitioner?
- What services and approaches have been most effective? Are there any strategies that are not working well? What needs to change?
- How would the parents and significant others rate themselves in terms of 'where they're at' in relation to where they want to get to?

Have we provided practical and material help? Parents do need to be given a chance to improve their situation, but practitioners need to continually ask the key questions:

- Have parents been provided 'the widest possible assistance'?
- What is their capacity for change?
- Will it be fast enough given the child's age and stage?
- Practitioners also need to give themselves permission to say 'enough is enough' (Cousins 2005, pp. 6).
- Are non-professional supports in place?

Keep in mind the need to assess the responses and outcomes for children:

- What treatment or support have the children received to help them process the overwhelming events?
- What's changed for the child? How do we know?
- Is the child more able to play, concentrate, relate, participate and belong? (Miller 2007).

Refer to the *Best Interests Case Practice Model* for a general case practice guide.

Relevant departmental resources

- Department of Human Services 2007, *Protecting Victoria's children: Child Protection practice manual*, State Government of Victoria, Melbourne.
- Department of Human Services 2007, *Guide to court practice for Child Protection practitioners*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Department of Human Services 2008, *Aboriginal cultural competence framework*, State Government of Victoria, Melbourne.
- Miller, R & Bromfield, L 2010, *Cumulative harm specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R 2010, *Best interests case practice model: summary guide*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R 2007, *The Best interests principles: a conceptual overview*, State Government of Victoria, Melbourne. Online <www.dhs.vic.gov.au>
- Miller, R & Noakes R 2010, *Child development and trauma specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
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