Neglect in Infancy and Early Childhood: Towards a Definition of the Problem

by

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ABSTRACT

Child neglect is the most commonly referred and re-referred form of maltreatment reported to child protection services in Australia, with the number of notifications continuing to grow despite the implementation of new legislation, policies and systems for protecting children over the last decade. Infants and toddlers under four years of age are the most vulnerable and most likely to suffer the devastating consequences of neglect. The early years are a critical period in terms of neuronal development in the brain, and the stage-salient processes involved in children's immediate and ongoing psychological and physical development. It is also the period during which they are at increased risk of serious injury and fatality. Yet the unique nature of neglect in this age group continues to be inadequately responded to both in practice and in research.

This thesis draws attention to the urgent need for a broad and concise, child-centred and needs-based definition of neglect that focuses specifically on this highly vulnerable age group. Improved understandings of and responses to child neglect have been held back by the lack of agreement about what constitutes neglect, and how best to define and measure it. While some progress has been made towards a conceptual definition of neglect in early childhood, research is needed to advance the development of a definition that is both conceptually sound and operational.

The primary and concomitant aims of the research were to gain a better understanding of the nature of neglect in infancy and early childhood and to further the development of a conceptual and operational definition of the problem. The second aim of the project was to establish reliable statistical data relating to the notification rate and the pattern of referral for infants (<48 months) in an Australian context. The research involved two distinct studies – 1) an investigation of notified cases of neglect and abuse relating to children under 48 months of age in two rural and urban regions in Tasmania, and 2) an in-depth exploration of the nature of neglect in a child protection sample of infants (< 48 months) from one group of families in which a subject infant had died, and (19) infants from another group of families in which a subject child had suffered various forms of neglect-related harm.

The main contribution of this research has been the development of a system for identifying and measuring the sub-types of neglect that are unique to infancy and early childhood. The classification system provides a unified, child-centred operational definition, with each sub-type founded on empirically based constructs of need. The need constructs served to both identify the particular sub-type of neglect and/or unmet need being notified and provide more useful and appropriate frequency measures, which are aggregated to measure levels of severity and chronicity, and or to assess levels of (accumulated) risk. The research has also helped to clarify the nature of the neglect experience for this age group; particularly in cases in which a death or serious harm has occurred. It has demonstrated the need for broad and concise operational definitions of early childhood neglect which can readily identify the unmet needs of vulnerable children in practice and classify and measure the different sub-types of neglect for research.

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CHAPTER ONE

Introduction

> Child neglect is a pattern of behaviour or a social context that has a hole in the middle where we should find the meeting of basic developmental needs. Infancy provides the easiest context in which to observe this because the needs of infants exist within a much narrower range than those of older children and adolescents.

Although the true prevalence of child neglect is unknown, it is generally acknowledged to be the most pervasive, commonly reported and rapidly growing form of child maltreatment in the Western world (Burgess, Daniel, Scott, Mulley, Derbyshire & Downie 2012; De Panfilis 2006; Watson 2005). Recent child protection statistics in Australia show that neglect and emotional 'abuse'[1] continue to be the most commonly referred and substantiated forms of maltreatment, and that these referral rates are increasing [Australian Institute of Health and Welfare (AIHW) 2012]. Despite the mounting body of evidence showing higher incidence rates and more profound effects than abuse, neglect continues to suffer from inattention in research, policy and in multi-disciplinary practice, while physical and sexual abuse continue to evoke a much greater response from the public and professionals alike (Connell-Carrick 2003; Garbarino & Collins 1999; Gaudin 1999).

Infants and toddlers less than four years of age are more likely to suffer from neglect than any other form of maltreatment, are the most vulnerable and suffer the most devastating consequences; yet they continue to receive little attention in the literature on neglect in general and in the definitional literature in particular (e.g. English, Graham, Litrownik, Everson & Bangdiwala 2005; Erickson & Egeland 2002; Gaudin 1999; Jordan & Sketchley 2009; Scannapieco & Connell-Carrick 2002). Exploring age-specific indicators of neglect is seen as an issue of the utmost importance (US DHHS 2002, cited in English, Thompson, Graham & Briggs 2005). The research presented in the following thesis argues for and responds to the need identified in the literature for research to work towards better understandings and definitions of the problem (Black &

[1] Exposure to family violence is considered to be a form of neglect in the research being presented here, but it is currently considered to be a form of emotional abuse in child protection in Australia. The mandatory reporting by police of all family violence incidents to which children have been exposed has led to emotional abuse being the most commonly reported concern in some states, including Tasmania.

Dubowitz 1999; De Bellis 2005; Dubowitz & Poole 2012), particularly in the context of infant and early childhood development (e.g. Connell-Carrick & Scannapieco 2006; English, Thompson et al. 2005; Garbarino & Collins 1999). This chapter provides an introduction to the main issues, concepts and debates that provide the groundwork for the research, which is followed by an outline of the main aims and objectives, and a brief description of the structure of the thesis.

Background: Issues and Debates

Child neglect and child development

The development of children is generally regarded as being the result of a complex set of interacting factors operating at the level of the individual, the family and the community, in line with the ecological approach to child maltreatment described by Garbarino (1977) and Belsky (1993). Garbarino and Collins (1999) argue that if the physical and psychological development of children is to proceed effectively, there are certain basic needs that must be met – the failure to meet those basic needs is considered to be the essence of child neglect. How these needs are defined is partially dependent on the particular society and culture, and while it is generally recognised that children require minimum, constantly evolving, community standards of care, there is little or no agreement so far about what those standards might be. Consequently, child neglect is most commonly legally defined in terms of parental failures or omissions of care – which may or may not include emotional and/or psychological aspects care – which result in harm or risk of harm.

For infants and toddlers in particular, the development of a secure attachment relationship between 'mother' and child is vital to healthy physical, psychological and emotional development, which points to the importance of embracing developmental theoretical approaches to better understand and explore the problem of neglect in this age group (Belsky 1984; Bowlby 1969/82; Cicchetti & Toth 1995; De Bellis 2005; Perry 2002). The early years are a critical period in terms of the neuronal development of the brain and the stage-salient processes involved in the children's immediate and ongoing psychological development (Belsky 1984, 1993; De Bellis 2005; Erickson & Egeland 2002; Perry 2002). While children of all ages suffer both ongoing and

immediately harmful effects of neglect, it is during the prenatal and early stages of development that it has the most serious and long-lasting physical and psychological consequences (Crittenden 1999; Egeland, Sroufe & Erickson 1983; Hildyard & Wolfe 2002).

The consequences of neglect

Although much of the research on child development has been informed by the study of child maltreatment, discussion of the research findings on the impact of neglect on child development is complicated by the lack of conceptual and definitional issues that surround the problem (Besharov 1981; Cicchetti 1989; Giovannoni 1989; Perry 2002). Most of the research on the causes and consequences of neglect has been carried out in the United States where the early studies were primarily conceptualised in terms of abuse or maltreatment in general (e.g. Cicchetti & Carlson 1989), and most of the more recent research still fails either to adequately distinguish between abuse and neglect – particularly between emotional/psychological abuse and emotional/psychological neglect – or to distinguish between and/or include the different subtypes of neglect, particularly the all-important emotional and/or psychological neglect sub-types (De Bellis 2005; Gaudin 1999; Zuravin 1999).

Nevertheless, the negative developmental effects of physical and psycho-emotional neglect in the critical early childhood period have been found to be more severe than those associated with physical trauma (e.g. Egeland & Sroufe 1981b; Garbarino & Collins 1999; Hildyard &Wolfe 2002). The longitudinal study of infants in the Minnesota Mother-Child Project provided substantial evidence concerning the detrimental impact of physical neglect and emotionally unavailable mothering on the cognitive development and impulse control of the children (Egeland & Sroufe 1981a). A particularly important outcome was the cumulative nature of the harmful effects that emotionally unavailable mothering had on the all-important attachment relationship (Egeland & Sroufe 1981a, 1981b). The consequences of neglect in this age group are wide-ranging; they include cognitive deficits, poor motor and language development, retarded growth, non-organic failure to thrive, behavioural and psychological problems,

physical injuries and fatality (Connell-Carrick & Scannapieco 2006; Iwaniec 1997; Scannapieco & Connell-Carrick 2002; Sullivan 2002;).[2]

Neuro-scientific research is now able to demonstrate the critical importance of sensory stimulation and experience, and deprivation thereof, on brain growth particularly during the very early stages of child development, and during prenatal development (e.g. De Bellis 2005; Glaser 2000; Perry 2002; Strathearn, Gray, O'Callaghan & Wood 2001). Perry (2001a) observes that conceptual approaches to human behaviour (and development) have been tainted by the nature versus nurture debate. He argues that there is now physical evidence to show that while children do have certain genetic potential, if their sensory and socio-emotional experiential needs are not met, there are severe long-term consequences for brain function. Developmental problems such as language and motor delays, impulsivity and hyperactivity and so on, are caused by abnormalities that are visible in the brain. The effects of exposure to traumatic events such as family violence can also be seen in the developing brain (Perry 1997).

Infants who are subjected to prenatal neglect through exposure to alcohol and/or drugs are not only at risk of neuro-developmental deficiencies, low birth weight, prematurity and neo-natal abstinence syndrome (NAS), they also have an increased risk of suffering harm as a result of further abuse and neglect (Chasnoff & Lowder 1999). Infants and toddlers are the age group at greatest risk of fatality due to maltreatment in general; reports of death in this age group due to neglect in the US range from 32% to 48% of all reported child death cases (Scannapieco & Connell-Carrick 2002). Although problematic conceptual and definitional issues have resulted in a lack of reliable data about the exact causes of child deaths in Australia and the UK, 31% of the suspicious deaths in the state of NSW between 2009 and 2010 were found to be due to (physical) neglect, and in England, there was evidence of neglect in at least 40% of all maltreatment fatalities (Lamont 2010; Sidebotham, Bailey, Belderson & Brandon 2011).

Child death case reviews in the states of Victoria and Western Australia have highlighted the role of chronic neglect in cases in which very young children known to

[2] Accurate data relating to the number of children who have died from abuse or neglect in Australia is difficult to obtain due to the lack of information currently collected (AIHW in Lamont 2010).

child protection have died [NSW Department of Community Services (DoCS) 2006; Frances, Hutchins, Saggers & Gray 2008). The findings of the reviews provided the impetus for two separate reports aimed at better understanding the issue off chronic neglect in child protection practice in those states (DoCS 2006; Frances et al. 2008).

The first year of life is generally regarded as the most precarious and the period when infants are at greatest risk of death, with the infant mortality rate commonly seen as an indicator of the health and well being of the society as a whole. Sudden or unexpected deaths account for the majority of deaths of infants between 1 month and one year of age in Australia and the US (Queensland Health 2008). Although the campaign to reduce SIDS in the early 1990s succeeded in dramatically reducing the number of unexplained deaths in the general population in Australia, the number of cases in the child protection population has not decreased over time [Victorian Child Death Review Team (VCDRC) 2000]. Concerns have been raised about the changing and preventable nature of some unexpected or unexplained deaths in infancy in families involved in child protection; especially the environmental and family risk factors that are evident in many of the cases [Department of Health and Human Services (DHHS) 2007a, 2008a; Hobbs, Wynne & Gelletlie 1995]. In Tasmania at the time this research was being conducted, the Council of Obstetric and Paediatric Mortality and Morbidity expressed their concern about the high number of SIDS cases in families who are known to child protection and the problem of exposure to drug and alcohol mis-use both prenatally and in the infants' environment at the time (DHHS 2007a, 2008a).

The neglect of neglect

> Whether or not a condition receives attention as a social problem – and the way it is defined – tends to be only weakly related to the significance of the problem to society as a whole, to how people are affected by the condition, to the number of people affected, to the severity of the effect, and to the causes of the condition. (Wolock & Horowitz 1984, p. 530)[3]

The 'neglect of neglect' is a refrain that has become embedded in the literature since it was first raised by Wolock and Horowitz (1984) almost thirty years ago. While the phrase may well have suffered an inevitable loss of meaning as a result of its over-use, the failure to address this increasing and increasingly complex problem persists. The

[3] The source of this version of M.P. Martin's (1978) original quotation was not able to be located.

problem of child neglect has been said to exemplify the tensions that exist in the development of systems, policies and practices aimed at striking a balance between excessive intervention and the protection of children whose care and protection needs are not being met (Parton 1995; Parton, Thorpe, & Wattam 1997; see also Munro & Calder 2005, Platt 2006). The neglect of neglect has been described as a failure, or even a "stubborn refusal", to come to grips with the centrality of neglect in child protection policy and practice and in the problem of child maltreatment itself (Wilson & Horner 2005, p. 471; Wolock & Horowitz 1984; see also Erickson & Egeland 2002; Flaherty & Goddard 2008; McSherry 2007; Parton 1995). It is also seen as the failure to close the gap between the nature of the problem and the way it is conceptualised and defined in research, child protection legislation and policy, and in multi-disciplinary practice (e.g. Barnett, Manly & Cicchetti 1993; Besharov, 1981; Cicchetti & Manly 2001; Dubowitz, Black, Starr & Zuravin 1993; Wolock & Horowitz 1984; Zuravin 2001).

Definitional neglect

While research in the field has made some progress in more recent years, knowledge about causes and consequences, how prevalent it is, or even how best to intervene and treat the problem continue to be negatively affected by the ongoing failure to arrive at a clear definition of what constitutes neglect or a reliable method of measuring and assessing this inherently complex problem (e.g. Dubowitz, Pitts et al. 2005; Zuravin 1999). Legal definitions are vague and differ widely, nationally and internationally; policy and practice definitions vary from agency to agency, and from one professional to another; research definitions are neither standard nor universal, and often depend upon child protection classifications (Zuravin 1999). Yet, as Martin (1979) pointed out more than thirty years ago,

> The issue of defining abuse and neglect is one of central importance and logically precedes a discussion of incidence, etiology, (sequelae), and treatment. The vagueness and ambiguities that surround the definition of this particular problem touch every aspect of the field—reporting system, treatment program, research, and policy planning. (Martin 1979, p. 56, cited in Zuravin 1999)

The main body of definitional research on neglect has come from the United States, and, for the most part, is reliant on the child protection services designations of abuse and neglect, which usually refer simply to the presence or absence of the four major types of

physical abuse, sexual abuse, emotional maltreatment and neglect (Dubowitz Pitts et al. 2005). Other studies fail to make any distinction between abuse and neglect and refer simply to 'maltreatment' in general (Taylor, Daniel & Scott 2012). Where studies do take the different sub-types of neglect into account, they usually refer to the physical forms of neglect only, despite the fact that it is the psychological and/or emotional aspects of neglect that are so vital in early childhood development (Belsky 1993). In most of the definitional (US) research, the psychological and emotional aspects of neglect are currently conceptualised as belonging to the separate category of emotional/ psychological maltreatment or emotional abuse. Yet many of the legal and child protection definitions – in Australia and in parts of Great Britain, at least – refer to the meeting of children's developmental needs or causing developmental harm (Holzer & Bromfield 2007; Minty 2005). Consequently, the ever-increasing number of different types of abuse and neglect in Australia are serving to increase the already wide gap between how the problem is defined in research, policy and practice and the nature of the neglect experience itself.

The definition debate

Arriving at a standardised operational definition of neglect in the US has been impeded by definitional debates concerned with numerous issues such as whether or not definitions should be:

- broad and general or narrow and precise;
- based on instances of actual harm or potential harm;
- based on statutory definitions, or developed independently for a particular purpose;
- inclusive of incidents of emotional harm (also referred to as psychological harm);
- encompassing of all acts that jeopardise the development of children;
- focused on harm to the child, or parental behaviour, or a combination of the two;
- concerned with parental intent. (Zuravin 1999)

There are two major issues in the continuing debate. The first concerns what specifically lies within the scope of neglect, and whether neglect should include potential harm or only actual harm (Dubowitz, Pitts et al. 2005). The nature of neglect means that it is often not possible to classify it in terms of 'risk' or 'harm', which poses a problem when

it comes to matters of classification and substantiation of neglect cases; especially in Tasmania where, under the *Children, Young Persons and Their Families Act 1997*, abuse and neglect are defined in terms of actual harm and 'risk' of harm, as well as parental acts and omissions of care. Furthermore, the type of harm that occurs as a result of neglect, or inadequate parental care, is usually neither imminent nor observable (English, Thompson et al. 2005). Dubowitz and others (1993, 2005) see a second major issue in the conceptual debate to be whether or not neglect should be viewed in terms of the child's basic needs not being met from the perspective of the child. This can also be seen as an attempt to address the fundamental problem of attending to neglected children's needs, which are often not attended to within a risk assessment approach to child protection (see e.g. Parton 1998).

Australian systems for protecting children have tended to follow the lead of the United States in its conceptual approach to defining the ever increasing number of types of 'child maltreatment', to the extent that neglect is considered as a form of abuse in many policy documents throughout the country and conceptualised and defined in terms that are interchangeable with abuse in a number of jurisdictions. Although definitions of abuse and neglect and the legal grounds for intervention in child protection legislation vary among Australian states and territories, in general they focus on parental actions or omissions of care and include references to risk and harm to development (see e.g. Holzer & Bromfield 2010). The debate is still at a very early stage in Australia, but the central elements of the concept of child neglect include the following: acts of omission or commission, and the issue of parental intent; standards of care; severity of consequences and type of harm; potential and/or actual harm; and chronic or episodic neglect (Lawrence & Irvine 2004; see also Jack 1997, 2004).

Dubowitz and his colleagues (1993) have been at the forefront of research aimed at developing a definition of neglect based on children's basic developmental and care needs, rather than the prevalent method of defining neglect based on the presence or absence of particular parental behaviours (Dubowitz, Black, Starr & Zuravin 1993, Dubowitz, Newton et al. 2005). The ecological and developmental approaches being taken with this model means that instead of the 'perpetrator-victim' framework pervading child protection, it focuses on the development, health and wellbeing of the child, while simultaneously acknowledging the multiple interacting factors of the

individual, family, community and societal factors that contribute to neglect (Dubowitz et al. 1993).

Neglect chronicity

Chronic neglect is generally understood to be characterised by an unremitting low-level care for children, and an accompanying pervasive ingrained sense of hopelessness within the family (Tanner & Turney 2003). Some common interacting factors associated with chronic neglect are entrenched poverty, substance abuse, psychological impairment, high levels of family violence, and depression (Wilson & Horner 2005). Child neglect is more chronic and intractable to intervention than other forms of child maltreatment – as measured by referral rates, the percentage of cases with multiple substantiations, reduced re-unification rates, and higher rates of re-entry into out-of-home care (DePanfilis & Zuravin 1999; Wilson & Horner 2005). Farmer and Lutman (2010), for example, found that almost three quarters (73%) of the children who had been removed and then returned to their parents' care were subsequently re-referred to social services, and 59% of the children were found to have been abused or neglected within the three years after re-unification.

According to Wilson and Horner (2005), chronic neglect combined with substance abuse "is a tough therapeutic nut to crack", with continued neglect and re-entry into care rates approaching 30% within three years (p. 475). However, it is the heterogeneity of chronic neglect and its inter-relatedness with other forms of abuse, such as lack of protection from physical, emotional or sexual abuse, which further highlights its pervasiveness (Dubowitz, Newton et al. 2005; Kaufman Kantor & Little 2003). Most of the neglected children (84%) in the Farmer and Lutman (2010) study had experienced some form of abuse as well.

Just as there is a general lack of agreement about how to define abuse and neglect, there is little agreement about how best to conceptualise and define 'chronicity'; despite its importance as a means of measuring and assessing the severity of the problem in research and practice. The chronicity of neglect is regarded as being central to understandings of the way in which it causes developmental harm (English, Graham et al. 2005). Chronicity is generally defined as "a persisting situation of abuse and neglect"

(Ethier et al 2004, p. 1267). Chronic child neglect is said to refer to "the ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs by a parent or caregiver" (Kaplan et al., 2009, p. 1). However, for De Bellis (2005), any or all neglect in infancy and toddler-hood is perceived as a "chronic condition or stressor", regardless of whether it is a continuous form or a single episode or incident (p. 154).

The dimension of chronicity is tied to, and inter-related with, other dimensions such as frequency, duration, sub-type, and developmental timing (English, Graham et al. 2005; Manly et al. 2001). The lack of distinction between the different dimensions, and the fact that both chronicity and severity are commonly defined and measured in the same terms is an important issue that needs to be addressed in research. The issues of chronicity and severity are particularly problematic in relation to neglect and child development because of the potential nature of the risk and the harm to the child.

Neglect in child protection policy and practice

Legislative and system changes introduced during the last decade across Australia resulted in a vast increase in the number of child protection referrals which left child protection systems struggling to cope. A string of inquiries and reports across the various states and territories resulted in a shift towards a 'prevention and support' approach to child protection, similar to the refocusing initiative that had already occurred in England – which has been the subject of similar but limited criticism from some specialists and researchers in the field (see, e.g., Goddard & Tucci 2008; Liddell et. al. 2006; Munro & Calder 2010; Platt 2006a; Sammut & O'Brien 2009). Both the Gateway style of the system approach itself and the shift in focus has led to concerns that some children who are at risk of harm are falling into that gap between the nature of the problem and the way it is conceptualised, defined and assessed (see e.g. Barton & Welbourne 2005; Broadhurst et al. 2010; Flaherty & Goddard 2008; Horwath 2011; Munro 2010; Platt 2006; Sammut & O'Brien 2009).

The rationale behind the changes in Australia that child abuse and neglect are being over-reported, on the grounds that only a small percentage of cases end up being substantiated, and, therefore, the threshold for what is considered to be a child

protection concern needs to be raised (Goddard 2009, Sammut & O'Brien 2009). As Goddard (2009) points out, there is little or no data to suggest that over-reporting is occurring – on the contrary, research suggests that the incidence of neglect is higher than the statistics indicate (e.g. Erickson & Egeland 2002). The data upon which system and policy changes are based are of poor quality and unreliable to say the least, and they in turn are based on a wide range of legal and policy definitions that are "inconsistently and partially defined" and inconsistently and variously applied (Goddard & Tucci 2008, p. 6). Consequently, the substantiation rates tend to be similarly and substantially different from one jurisdiction to the next. It could also be argued that low substantiation rates are just as likely to reflect the higher entry thresholds and lower investigation rates which occur in under-resourced and overloaded systems (see, e.g., Jacob & Fanning 2006; Department of Health and Human Services 2011). A review of the literature by Daniel, Taylor and Scott (2009, 2010) confirms that professionals have higher thresholds for what constitutes neglect than the general public and that operational definitions can affect the number of services provided.

Furthermore, findings show that neglect – as the most common type of maltreatment referred – is the least likely to be investigated, and is notoriously difficult to assess and substantiate, as well as being the most likely to be minimised (e.g. Farmer & Lutman 2010; Horwath 2007; Jones & Gupta 1998; Minty & Pattinson 1994; Stone 1998). It would appear that social workers are either "'overwhelmed' by the enormous and impervious problems presented by neglectful families or 'underwhelmed' to the point where practitioners 'normalise' neglect" (Buckley 2002, cited in Horwath 2005b, p. 100). Workload pressures, resources and local systems have all been found to influence how the assessment process is interpreted in practice (Horwath 2005a; Horwath 2007).

The aim of the support service or gateway style of approach is to take the pressure off departments by filtering out the so-called 'less serious' concerns at the earliest stage of the child protection process, and to provide (that is, offer) early intervention and support to those children identified as being most vulnerable. It raises the question of which concerns are considered less serious and which children are considered to be most vulnerable. Studies have found that cases were more likely to be filtered out at both the initial and investigative stages, without service or protection, if the allegations concerned neglect rather than physical or sexual abuse (Horwath 2005a; Gibbons,

Conroy & Bell 1995, cited in Parton, Thorpe & Wattam 1997). Analyses of cases of child death and serious injury carried out in England identified that, in cases of long-term neglect, thresholds for child protection services were rarely met (Brandon et al. 2008). Brandon and her colleagues (2008) also point out that pressures on resources further raise the thresholds for services for children, noting that "most children who die from abuse or neglect are not at the child protection end of the safeguarding continuum at the time of the incident" (p. 314).

Some researchers and writers in the UK continue to question the transformation of child protection services towards prevention and away from the protection of children (Munro & Calder 2010; Platt 2006a, 2006b). Not only are there problems associated with the 'reactive' incident-based approach to current methods of assessing risk in cases of neglect, the English experience appears to be that the particular emphasis, or singular focus, on 'children in need and their families' has now resulted in a move away from identifying children at risk of harm (Munro 2010; Munro & Calder 2010). Munro (2010) argues that those children, like Victoria Climbié, who the Framework[4] was supposed to protect are the ones being left at risk of harm in this situation. Research on practitioners' use of the Framework has identified the need for more rigorous assessments and the need to explore ways of assessing neglect that use more professional expertise, are more child-centred and are able to identify and respond to the needs of the child (Brandon et al. 2005; Horwath 2005b, 2011). As Daniel (2005) points out, neglected children in particular are both in need and 'at risk', which leaves them somewhere in the middle of the two options of the 'Framework' guidelines, and increases the difficulties that workers are known to face in assessing cases of neglect (e.g. Buckley 2000; Horwath 2005b).

There appears to be some agreement among researchers in Australia and the UK that it is not just the single focus of the welfare paradigm that is the problem, it is also the failure to base the policy on strong foundations in research (Munro 2010; Goddard & Tucci 2008). Goddard and Tucci (2008) argue that the fundamental problem with the approach being taken in the Federal Government's new national framework for protecting children, outlined in *Australia's children: Safe and well*, is that it is too

[4] The Framework for the Assessment of Children in Need and their Families (Department of Health 2000)

narrow in its focus, and that the welfare paradigm being used "provides only a partial understanding of the causes of child abuse and neglect" and that its capacity to explain chronic neglect and psychological neglect and abuse is limited (p. 7). In his submission to the Victorian Government's enquiry into the protection of children, Goddard (2011) argues that a shift in the policy paradigm is needed which places children's needs at the centre of the decision-making process.

Neglect and risk assessment

While new theoretical frameworks and systems for protecting children have been implemented, there have been very few changes in the way allegations of neglect and abuse are assessed in this country. For various reasons, including the high staff turnover and a lack of appropriately qualified and experienced workers, child protection services have continued to rely on an approach to assessment that is based purely on establishing the level and immediacy of risk (and/or safety). The (sole) use of risk-based approaches to assessment have been found to result in an incident-based approach to assessment and decision-making that is at odds with the concept of neglect and its central role in child maltreatment and child protection in general (see e.g. Gillingham 2006; Goddard and Tucci 2008; Wilson & Horner 2005). Risk assessment instruments are also believed to lead to a focus on the actions of the parents and the determination of blame – rather than what the child is experiencing – and that it is this focus on parents that not only determines the assessment of harm to the child but also whether the harm or the child's care and protection needs will be assessed (Elliot 1998, Gillingham & Bromfield 2008; Houston & Grifffiths 1999).

Critics argue that there are dangers and shortcomings in an approach to child protection that is based on the medical/disease model of abuse and heavily focused on individual (parental) pathology (Broadhurst 2003; Goddard, Saunders, Stanley & Tucci 1999; Jack 1997; Masterson & Owen 2006; McConnell & Llewellyn 2005; Murphy & McDonald 2004; Parton 1998). They claim that such approaches focus on the assessment and management of risk when assessments should be aimed at identifying and meeting the needs of children or responding to child maltreatment (Goddard et al. 1999; Jack 1997, 2000; Parton 1998). Gillingham (2006) argues that risk assessment – and the part it

plays in the neglect of neglect – is "implicated in any problems that children's protective services face" (Gillingham 2006, p. 86; see also, Goddard et al. 1999).

Nonetheless, from a child protection perspective, the problem of neglect in infancy and early childhood is essentially a combination of unmet basic needs and risk of accumulated and potential harm. If there is anything to be gleaned from the experience of other countries described above, it is the fact that it is unlikely that any one approach, method of assessment, or intervention is going to adequately deal with such a complex problem. The foregoing also implies that there is good reason to hope that a more child-centred approach to defining and assessing the problem would put the focus back onto the child's developmental, care and protection needs and away from questions of parental pathology, intentionality and blame.

Neglected research

A review of the trends in child maltreatment literature over a 22-year period found that the vast majority of articles were on physical and sexual abuse, with neglect and emotional abuse making up only a small minority and remaining consistently low over the time period (Behl, Conyngham & May 2003). It is not surprising to find that neglect also receives much less definitional attention than other types of maltreatment (Connell-Carrick 2003; Dubowitz 1999; Dubowitz, Pitts et al. 2005; Dunn et al. 2002; English, Thompson et al. 2005;Watson 2005; Zuravin 1999).

Despite its devastating consequences, and its pervasiveness, the lack of neglect research in general continues and research focusing on neglect in this vital early childhood period is sparse indeed (English et al. 2005; Perry 2001, 2002; Scannapieco & Connell-Carrick 2005). The literature identifies a particular need for research that is aimed at gaining a better understanding of the nature of the actual neglect experience of the child, disentangling neglect from other forms of abuse, and defining it in terms that will improve understandings of the problem and the quality of practice and research (e.g. Belsky 1993; Dubowitz et al. 2005a, 2005b; Gaudin 1999; Higgins 2004; Taylor et al. 2012; Watson 2005).

The existing child neglect research base relies heavily on the United States and, more recently, the United Kingdom; apart from a number of government and institutional reports and papers, there is very little, if any, independent Australian research that deals specifically with child neglect (DoCS 2006; Tanner & Turney 2003; Watson 2005). The "complete lack of reliable data" on either abuse or neglect in Australia – in particular, the lack of reliable prevalence data – the inconsistent, imprecise and incomplete definitions of abuse and neglect, and the lack of independent research into child protection in general have all been cited as issues that need urgent attention (Goddard & Tucci 2008, p. 9).

Summary

The care and protection needs of a significant number of children are clearly not being met, directly or indirectly, by parents and caregivers, child protection and welfare systems and multi-professional practitioners alike (e.g. Daniel 2004; Gillingham 2006; Goddard & Tucci 2008; McSherry 2007; Parton 1995; Spencer & Baldwin 2005; Wotherspoon et al. 2010). The current difficulties facing researchers and professionals in the fields of child neglect and child protection have arisen out of a need for better understandings of the nature of the problem as well as better ways of defining, measuring and assessing it. Conceptual and operational definitions of neglect are needed for research, policy and practice which take into account the multi-factorial aspects of the problem, are more child-centred and more accurately reflect the experience of the child. Researchers and statisticians need to be able to more accurately and reliably describe and measure the problem and compare their findings. Professional practitioners in the various disciplines need to be able to identify the unmet care and protection needs of infants *and* to assess the immediate and potential risk of harm, in keeping with the unique nature of neglect in this age group and the cumulative and serious nature of its developmental and other harmful effects.

This thesis presents an argument for and a response to the need to further the development of a child-centred definition of neglect that takes into account the developmental and care needs of infants and very young children (less than 48 months of age). It is argued that conceptual and operational definitions of neglect are needed that more accurately reflect the nature of the neglect experience for this vulnerable age

group both prenatally and in early childhood, in order to narrow the ever-widening gap that exists between the nature of the problem and the way it is understood and defined in research, policy and multi-disciplinary practice.

Research aims and objectives

The primary and concomitant aims of the research were to gain a better understanding of the nature of the neglect experience in infancy and early childhood to inform and further the development of needs-based conceptual and operational definitions of the problem into a system for classifying and measuring neglect in this vulnerable age group. A second aim of the research was to establish reliable statistical data relating to the notification rate and the pattern of referral of neglect and abuse for infants (<48 months) in an Australian context.

The thesis is structured around two separate studies. The first study is an investigation of notifications of neglect and abuse made to child protection in relation to children under 48 months of age in two rural and urban regions in Tasmania. This study will be referred to henceforth as Study One. The second study is an in-depth exploration of the nature of neglect in a child protection sample of infants (< 48 months) from one group of families in which a subject child had died, and infants from another group of families in which a subject child had suffered some form of neglect-related harm. This study will be referred to from here onwards as Study Two. The main objectives of the research were:

1. to investigate (a) the notification rate of abuse and neglect for all infants (< 48 months) notified to the Department in the 2005 calendar year in two child protection regions in Tasmania; and (b) the general pattern of referral and response for infants notified during the 2005 calendar year; and (c) the pattern of referral for the infants and their sibling family groups over a period of four years;
2. to develop a classification and measurement system for the research, which provides conceptually sound operational definitions of neglect in infancy and early childhood that can be applied across the domains of research, practice and policy; and

3. explore the nature of the neglect experience in the early developmental period from before birth through infancy and early childhood (< 48 months of age) – in terms of unmet basic care and developmental needs – and identify any specific unmet needs relating to cases in which infants or young children have died;
4. to clarify the definitional issues that are currently impeding effective research, policy and practice, including the nature of the relationship between abuse and neglect.

Thesis Overview

Chapter Two provides an overview of the child protection system in Tasmania at the time and the changes that were being implemented in Australia and Tasmania during the period covered by the research. It also includes an historical account of the development of child welfare and protection in this state, beginning with the early days of settlement, and then following the legislative and definitional changes that have led to the welfare and protection services that are now in place.

Chapter Three provides a description of the methods – such as Ethical and Departmental Approval processes, the source of the data and the data collection processes and procedures – that were common to both studies, as well as those that were used to meet the specific aims and objectives of Study One. The chapter includes some discussion of the unique challenges that were presented by the issues relating to the data itself and the state of the system at that time generally.

Chapter Four presents the results of Study One. The chapter provides a statistical picture of the pattern of referral and response for notified cases of abuse and neglect for the subject infants, and within the broader family setting, over the four-year study period in two rural and urban regions including approximately half of the total population of Tasmania. Data relating to the notification rate, course and characteristics of neglect and abuse in this age group is established.

Chapter Five begins with a brief account of the growing level of concern regarding the role of neglect in preventable deaths of infants and very young children. A critical analysis of current approaches to defining neglect and emotional maltreatment/abuse is

presented in order to highlight the various issues and debates and to further the argument that new and more conceptually sound and precise methods of defining neglect and 'emotional maltreatment' are required. The main objective of this chapter is to describe the development of a set of operational definitions of neglect that are able to take into account the unique care and protection needs of infants and very young children – to form the basis of the system for classifying and measuring neglect to be applied in Study Two.

In Chapter Six, the approaches to the problem of neglect measurement are considered in light of findings relating to its multi-dimensional aspect and the methods currently being used for measuring and assessing neglect and child maltreatment in general. A new method of measurement is proposed which has been built into the classification system developed for the research. The findings of Study Two are then presented and summarised according to each of the eight neglect sub-types.

Chapter Seven provides a discussion of the findings relating to its occurrence and the pattern of referral for this age group, and the contributions of the thesis relating the nature of neglect and how best to define the problem in light of the findings and in light of the cases in which a child has died or has suffered serious neglect-related harm.

CHAPTER 2

The Evolution of Child Protection in Tasmania

The previous chapter provided a brief outline of the main issues and debates taking place in the literature in the field of child neglect generally and in the early period of childhood development in particular – its increasing incidence, the serious nature of its wide range of effects, and most importantly, the neglect of the problem in theory, research and professional practice. The main purpose of this chapter is to describe the system (or systems) in place for protecting children in Tasmania during the period covered by the research described in the following chapters.

The introduction provides a brief overview of the constantly evolving systems for protecting children and the main issues and debates under discussion in Australia during this period. The chapter then gives an historical account of the development of child welfare and protection in Tasmania, which begins with the fundamentally important forcible removal of Indigenous children during the early settlement of Tasmania, and then follows the legislative and definitional changes that have led to the welfare and protection services that are now in place. Finally, the Tasmanian child protection system(s) in place or in the process of being implemented during the period covered by this study is described, together with the legislative and policy changes that were also being introduced at that time.

Introduction: The State of the Nation

Each state and territory in Australia is responsible for its own health and welfare issues, with each having a unique set of legislation to provide for the care and protection of children. This means that the ever-changing systems for achieving that purpose, and the fundamental concepts and definitions underpinning policy and practice, also vary among the different jurisdictional regions. The resultant lack of comparability of national child protection data and research, though not a uniquely Australian problem, continues to be a source of concern for professionals in the field who have been calling for national standards, legislation, definitions and policies for protecting children for a number of years (e.g. Goddard & Tucci 2008; Liddell, Donegan, Goddard & Tucci

2006). Notably, the greatest disparity between jurisdictions is in the initial notification and assessment phase (Bromfield & Higgins 2005), which is the main focus of the following study.

The growing number of referrals to child protection services throughout Australia since the mid-1990s has been accompanied by an ongoing search for alternative methods of managing the problem. The recommendations of the influential *Messages from Research* (Dartington Social Research Unit, 1995) in the UK and the development of structured risk assessment tools in the US, which eventually filtered their way down to Australia, together with a study carried out on the Western Australian system by the British researcher David Thorpe (1994) provided the basis for new models of child protection and family support that were being established or trialled by the various state and territory government departments by 2001 (Tomison & Stanley, 2001). Some major changes, supported by the enactment of new legislation in some jurisdictions, were implemented to varying degrees at this time:

- There was a move away from narrowly defined investigative approaches to include an assessment of the broader context of the child and the family, which focused on their wider needs, strengths and resources, and their formal and informal supports. While the aim was to engage with community professionals in an attempt to prevent maltreatment by addressing family problems in a holistic approach, it led to the problem of having to differentiate child protection issues from social welfare issues.
- Influenced by the more positivist approach in the US, most services were using some form of risk assessment guide or structured risk assessment tool.
- Services were attempting to tailor the response to the reported concern via some form of differentiated response system or streaming of reports based on an initial assessment of whether the report required a child protection assessment. (Tomison & Stanley, 2001, pp. 1–3)
- Definitions of child maltreatment and/or risk have become narrower and focus on harm, which more effectively screen out a large proportion of the cases that may be hard to define and difficult to service. (McCallum & Eades 2001, pp. 270-271)

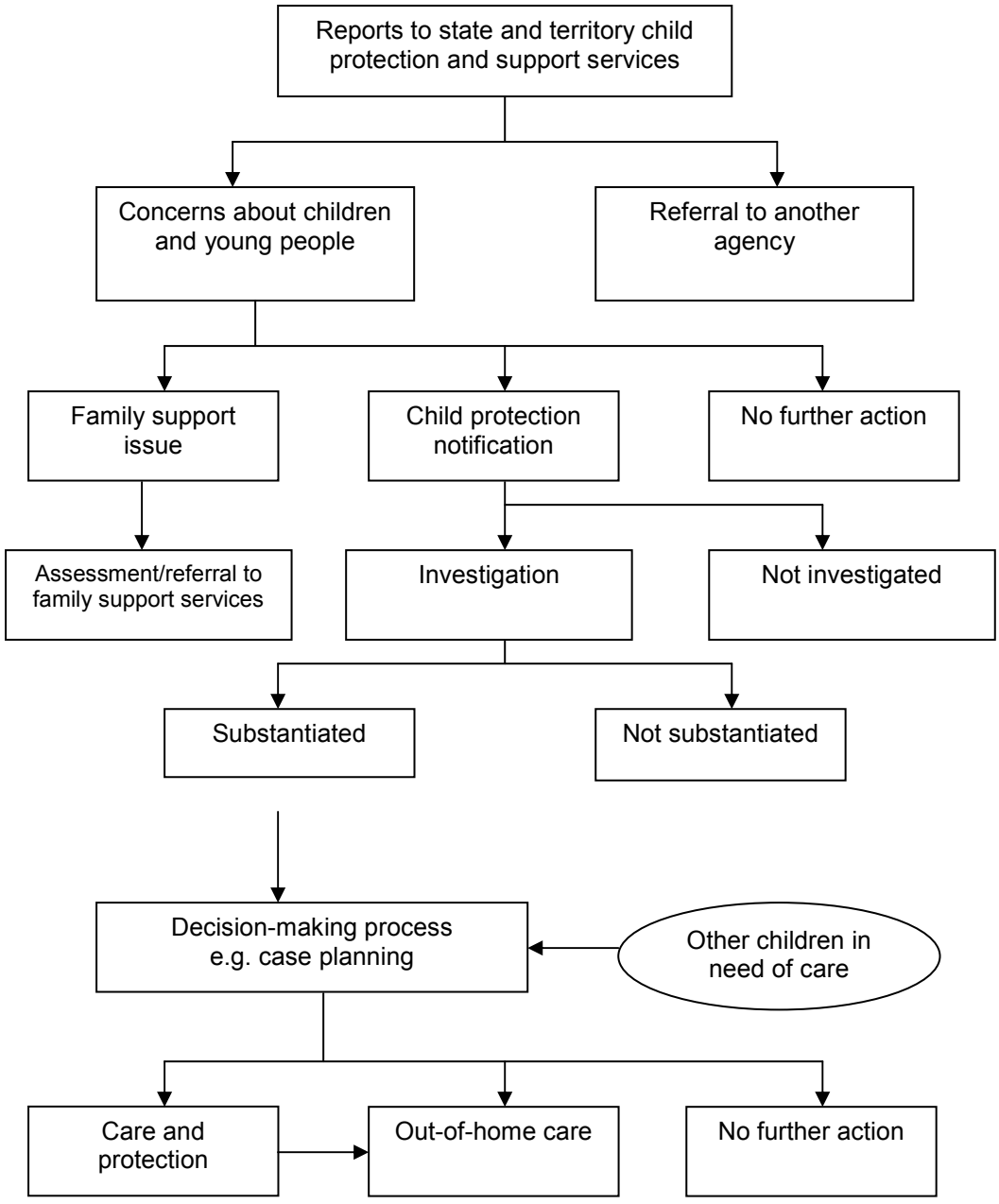
However, with the legislative and system changes made early in the decade, such as new mandatory reporting requirements and new methods of classifying notifications, the number of reports to child protection services continued to rise. The increasingly high notification rate, the seriousness and complexity of the issues being reported, and the inability of child protection systems to cope had reached a crisis point in Australia. State and territory governments have responded to the crisis in recent years with a series of inquiries that have led to, or have proposed, major restructuring and reorganisation of their protection systems, which are based the Victorian model. This model is founded

on the premise that the problem is due to the large numbers of 'less serious' child protection concerns blocking up the system; its solution to the problem is to provide dual pathways into the system, whereby the 'less serious' cases can be streamed off to intervention and family support-services so that the 'more serious' cases can be attended to in a more timely manner.

At the national level, the revelations of the Northern Territory Government's '*Little Children are Sacred'* report (Wild & Anderson 2007), the Federal Liberal Government's subsequent intervention in the Northern Territory, the continuing rise in the number of notifications, and the highly publicised deaths of children brought the seriousness of the situation to public attention. The incoming Labor Government responded to calls for change and a more uniform approach to the problem (Liddell et al. 2006), with an initial consultation process and the subsequent development of a national framework for protecting children. It was described as a "a 12-year overarching strategic framework for reform (2009-2012), supported by rolling three-year action plans identifying specific actions, responsibilities and timeframes for implementation" (Commonwealth of Australia 2009, p. 35).

Although some fundamental concerns have been raised in response to the proposed framework, about the intervention and support approach this is the system that the "National Framework for Protecting Children" is being developed and structured to support. It is yet to be seen whether or not the national strategy for reform answers calls for a more uniform approach to the problem and eventually succeeds in bringing the states and territories in line with each other, rather than simply ensuring the provision of support services and financial assistance (or punishment) for 'families in need' (see e.g. Goddard & Tucci 2008; Liddell et al. 2006).

Despite the systemic and legislative differences and the changes that are continually taking place among the states and territories, child protection processes in general maintain many features in common and tend to follow a similar course of events. The relevant pieces of legislation for each jurisdiction lay the foundations for the provision of services and provide the grounds for intervention, with definitions of 'abuse and neglect' and what constitutes 'a child in need of care and protection', together with a set of guiding principles (see Appendix A, Box A2.2).



(Note: Family support services can be provided at any point in the process)

Figure 2.1. A simplified model of the child protection process [from the Australian Institute of Health and Welfare (2009), *Child protection Australia 2007–08*, p. 3]

Historical Background

The separation of Aboriginal children from their families

The history of the forcible removal and separation of Indigenous children from their families is central to the development of the principles upon which current child protection policy and practices in Tasmania are founded. Aboriginal children were forcibly removed during two periods of Tasmania's history; in the first fifty years of colonisation and again from the 1930s onwards.[5] When Van Diemen's Land[6] was first occupied in 1803, conflict between the European and Indigenous inhabitants erupted and continued for the next thirty years or so. Aboriginal people were shot and killed in such large numbers that by 1818 the Indigenous population had fallen from an estimated 4,000 to less than 2,000 (Ryan 1981, cited in HREOC[7] 1997).

Kidnapping Aboriginal children or otherwise taking them from their families for domestic or farm labour had become common practice in the early settlement years. Despite Governor Davey's proclamation of "utter disgust and abhorrence", issued in relation to the kidnappings in 1814, nothing was done to improve the situation; in fact, it continued to become even more widespread (quoted in Reynolds 1995, p. 90, cited in HREOC 1997, p. 2/8). Finally, in 1819, Governor Sorrell commissioned a report that included a list of "all the children and youths held by 'Settlers or Stock-keepers, stating from whom, and in what manner, they were obtained'" – those found to have been taken without the consent of their parents were sent to Hobart to be educated and maintained 'at Government expense' (Rowley 1970, p. 44, in HREOC 1997, p. 2/8).

By the late 1820s, with the influx of new settlers taking up more of the land, conflict between the Indigenous and non-Indigenous populations had escalated into what became known as the 'Black War'. After a failed attempt to drive the Aboriginal

[5] This brief account of the removal of Aboriginal children draws on the report of the Human Rights and Equal Opportunity Commission (HREOC), *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Chapter 6. Canberra: Stirling Press, April 1997. Electronic copy retrieved on 3/02/2010 from: http://www.hreoc.gov.au/social_justice/bth_report/

[6] Tasmania was called Van Diemen's Land from the time it was colonised in 1803 until 1856.

[7] (HREOC) Human Rights and Equal Opportunity Commission

inhabitants down to two peninsulas in the South-East, an officially sanctioned plan to move them onto Flinders Island – where they were to be provided with protection, food, clothing, and shelter – was negotiated and carried out with George Robinson acting as both negotiator and protector. More than 200 Aboriginal people had been removed to the Flinders Island settlement by 1835. The fourteen Aboriginal children who were between the ages of six and fifteen years were sent to live with the storekeeper and the catechist soon after they arrived. Disease, loss of freedom, inadequate (and presumably non-traditional) food rations and shelter had devastated three quarters of the Aboriginal population within eight years, with approximately fifty people surviving in 1843. The 48 members of the community who were still alive in 1847 were moved again, to another reserve on Oyster Cove. The children were taken from their families and sent to the Orphan School in Hobart "to 'adjust' to non-Indigenous society" (HREOC 1997, Ch. 6, p. 2/8).

There was another small Indigenous community, made up of the descendants of Aboriginal women and about twelve non-Indigenous sealers, who had been living on Flinders Island before the establishment of the reserve. Although the community had resisted attempts by Robinson to remove them earlier, by the end of the 1870s they had all moved to Cape Barren Island. The Government established a formal reserve on Cape Barren in 1881, and a missionary school teacher was appointed in 1890, who visited the island regularly along with other visiting missionaries. By 1908, the Indigenous population on the island amounted to 250 people, and the term 'Cape Barren Islander' became synonymous with 'half-caste', regardless of where the person came from. Every effort was made to control the lifestyle of the community through the provisions of the *Cape Barren Island Reserve Act 1912* – though with very little success – which attempted to force the islanders to construct dwellings and fence off and cultivate the land in order to become self-sufficient agricultural farmers.

The Tasmanian Government, unlike the other state governments, did not formally adopt a policy of removing Aboriginal children – mainly because of the severe decline in the Indigenous population since they were removed to Flinders and Cape Barren Islands, and since the colonisation of Australia more generally. Government reports during the late 1920s, nonetheless, contained proposals to remove children from their families, which would have been able to be achieved with the Welfare laws relating to neglected

children which were already in place. After concerns expressed in a 1929 report about the poor living conditions and the number of children who were suffering from sickness and malnutrition, the Government appointed the head teacher on the island as a Special Constable. From 1928 until 1980, the head teacher had the powers and responsibilities of a police constable, which included the power to remove a child for reasons of neglect under the child welfare legislation. The refusal of Indigenous families to adopt the agricultural lifestyle specified in the *Cape Barren Island Reserve Act (1912, 1945)* together with the ensuing problems of poverty and alcohol abuse – and the surveillance of their lifestyle specified within the Act – meant that they were constantly at risk and in great fear of losing their children. Cultural differences relating to the care of children by community members added to the risk of children being removed during this period, which led some families to return to mainland Tasmania.

An inquiry into the future of Cape Barren Island in 1944 revealed that the Aboriginal population had fallen to 106, and the health of the Islanders was continuing to deteriorate – which was thought to be mainly due to their dependence on external food supplies. The ensuing *Cape Barren Island Reserve Act 1945* imposed more rigorous conditions on the lessees in return for the free land grant than the 1912 Act; its stated intention being to enforce self-sufficiency by 1950. But other reports at the time suggest that a different objective was the "gradual but eventual total absorption of the half-castes into the white population" (Tasmanian Government Final Submission, p. A-16, cited in HREOC 1997, Ch 6, 4/8). In the 1944 census anyone less than 'octoroon',[8] had not been recognised as Aboriginal, which meant that, officially at least, Tasmania had no Aboriginal population left:

> If they were not Aboriginal then there was no need for a special Reserve. The Cape Barren Islanders had been defined as white people, after having been defined as non-white for the previous 70 years. (Tasmanian Government Final Submission, p. A-16, cited in HREOC 1997, Ch 6, 4/8)

The official designation did nothing to prevent the Aboriginal families on Cape Barren and nearby islands from being known and targeted for their 'lifestyle'. From the 1950s the welfare laws were increasingly being used to remove children on the grounds of neglect and take them to the mainland. Housing was inadequate, and documentation

[8] In classifications employed at the time, 'octoroon' is used to denote the offspring of a 'quadroon' and a white person, or a person who has one-eighth Aboriginal blood.

shows that families, particularly single mothers, sometimes experienced difficulty obtaining relief payments, which placed them under increased threat. But the main cause of the continuing deterioration in the health of the Islanders was the lack of fresh food supplies, especially fresh milk and other perishables, which had to be brought by boat to the Island. Eventually, after health surveys carried out in 1956 and 1960, children were provided with food supplements through the health and education departments and the Save the Children Fund.

Parents were often unable to challenge decisions due to the island's remoteness from the mainland; they could also be charged with the criminal offence of child neglect and sentenced to imprisonment, thereby facilitating the removal of any siblings or other children living in the house at the time. Children who were removed were often separated from their siblings – despite government policy that they should maintain contact with their family – and either fostered out to non-Indigenous families or placed in state homes with mostly non-Indigenous children. From the sixties through to the seventies and eighties, some initiatives were put in place to help keep families together, and to provide study grants for secondary education on the mainland, in recognition of the traumatic effects that colonisation has had on the Indigenous population.

The Aboriginal Information Service (AIS) was established in 1973 to provide legal representation for Indigenous children and parents who were involved in child welfare and juvenile justice matters, which helped to reduce the number of children who were being removed through the legal system. The AIS has since been incorporated into the Tasmanian Aboriginal Centre (TAC), which continues to offer a range of supports and services to Aboriginal families and to be involved in child protection processes and decisions involving Aboriginal children. The Tasmanian Government joined with the other jurisdictions in accepting the new policy guidelines relating to the fostering and adoption of Aboriginal children and the principle of Aboriginal participation in the planning and delivery of welfare services, at the Australian Aboriginal Affairs Council Meeting of Ministers held in Hobart in 1980. The Aboriginal Child Placement Principle, which states that an Indigenous family must be the preferred placement for a child in need of alternative care, was eventually formally adopted by the Tasmanian Government in 1984 and incorporated into social welfare practice (HREOC 1997). This

Principle has since been embedded in the *Children, Young Persons and Their Families Act 1997*.

The Development of Child Welfare and Protection

The early years[9]

The development of child protection in Tasmania was greatly influenced by its settlement as a penal colony. Welfare services for children were initiated in the early days of colonisation to provide for the care of children whose parents were convicts and to deal with the serious problem of orphaned, abandoned and neglected children, and the illegitimate children of female convicts:

> The women are occasionally let into the town, and have free communication with their associates. When they bring forth illegitimate children they are received into a nursery, where they live on the same abundant fare, and with nothing to do but nurse their infants; as soon as the children are of proper age, they are sent to the Orphan School, which should be called the school for illegitimate children of the convicts, and the mothers are dismissed to repeat the same expensive course of conduct. (Rev. H. P. Fry, *A System of Penal Discipline*, p. 192, cited in Clark 1950, "Treatment of female convicts in Van Diemen's Land 1830-50 c.", pp. 119-20)

The first State institution for children to be established in the settlement was the King's Orphan Schools in Hobart in 1828 – later known as the Queen's Orphan Asylum – which by 1865 housed as many as five hundred children (Daniels 2006). According to Pearce (2006), the orphan schools were seen as part of the convict system, with the same "regimentation, discipline, punishment and control" and religion and education were perceived as means of transforming the children into respectable and industrious adults (p. 1/1). Accusations of child abuse and lack of proper care, were a constant cause of concern for the authorities, with Lt-Governor Denison bemoaning the "lack of parental character" in the schools in 1848 (Daniels 2006, p. 1/3). Philanthropic and religious groups played an important role in raising matters of social concern and caring for the most vulnerable members of the community. The prevalence of "delinquency and waywardness" among young children and the growing number of street children gave rise to anxiety for the future generations upon which the colony's success would

[9] This account of the early development of social welfare in Tasmania is primarily based on Daniels' (2006) brief historical overview of social welfare and Rimon's (2006) overview of the history children's homes in Alison Alexander's (2006) *Companion to Tasmanian History*.

depend (Daniels 2006, p. 1/3; Rimon 2006). Philanthropic organisations were not always prepared to provide care for criminal children, but there was some acknowledgement that they were "victims of a penal system" and deserved a chance to become good citizens (Daniels 2006).

Although care of the indigent population was perceived by the British Government to be the role of private philanthropy, church groups were too small in the colony's early years and the penal nature of the settlement were said to create an attitude of 'self-righteous indifference' towards the poor, who were mainly ex-convicts. While a few charitable individuals, families and philanthropic groups provided some assistance, the Government was obliged to take most of the responsibility for the relief of poverty in the early years. A formalised outdoor relief system started in 1862 and provided assistance to people outside institutions, such as the aged poor and abandoned children who were waiting to be admitted. After self-government in 1856, while it retained the main responsibility for social welfare, the Government sought greater involvement from the voluntary sector (Daniels 2006; Rimon 2006).

Voluntary boards were set up to establish the Hobart Girls Industrial School in 1864 and, following the passage of the *Industrial Schools Act 1867*, the Boys Home and Industrial School in 1869, followed by the Girls' Industrial School in Launceston in 1877, and a Catholic institution, St Joseph's Industrial School and Orphanage, in 1879. The purpose of the *Industrial Schools Act 1867*, which was modelled on the *English Industrial Schools Act 1857*, was to provide "for the education and training of Vagrant and unprotected Children and Youthful Offenders" (31 Victoria, No. 37, the Act, 1867). The accompanying *Training Schools Act (1867)* enabled the segregation of so-called 'delinquent' boys and girls from the children who were classed as destitute, with the establishment of the Hobart Boys' Training School in 1869, later known as Ashley Detention Centre, and 12 years later the Hobart Girls' Training School (1881–1905) opened in the Old Gaol Building at Anglesea Barracks. All of the Industrial homes provided some religious and formal education, but the emphasis was on industrial training, such as domestic work for girls and rural or farm work for boys. In the Training Schools for 'delinquent' children, much harder work was expected: boys had to perform manual and agricultural labour for seven hours a day, followed by attendance

at night school, while the 15-18-year-old girls were trained as domestic servants and were locked in their cells each night (Rimon 2006).

With the Industrial Schools legislation, child welfare was positioned within the framework of the criminal justice system, through which children were committed to institutions. The Act defines an unprotected or vagrant child within the classes of children to be detained in certified Industrial Schools as "any child apparently under the age of fourteen years that comes within any of the following descriptions; namely:

- That is found begging or receiving alms ... or being in any street or public place for the purpose of so begging or receiving alms
- That is found wandering and not having any home or settled place of abode, or proper guardianship, or visible means of subsistence;
- That is found destitute either being an orphan or having a surviving parent who is undergoing Penal Servitude or Imprisonment;
- That frequents the company of reputed thieves. (*Industrial Schools Act 1867*, 31 Victoria, No. 37, Section V)

Further provisions include any child under the age of twelve years who has been charged with a punishable offence, any child under the age of fourteen who is deemed by a parent to be uncontrollable, or whose parents are unable to care for the child due to the father's drunkenness, absence, or having committed a felony (*Industrial Schools Act 1867*, Sections VI–VIII). The concept of 'an unprotected child' – which, in the legislation at least, relates to the lack of parental control, education, training and moral guidance of the child – is quite different from later notions of 'a child in need of protection'. The concern of the Government was more about the threat such children posed to social stability than it was about the children as victims of abandonment and neglect by their parents (Scott & Swain 2002, p.4). Children in need of protection were seen at this time as both victims of the system, or their parentage, and as a threat to social order and the future of the colony.

Social welfare as a state departmental responsibility began with the Office of the Administrator of Social Relief in 1873. The Charitable Grants Department had legislative responsibility for the care of destitute children and the inspection and supervision of institutions such as children's homes, asylums and training schools, which continued to be run by religious groups and philanthropic individuals or organisations. With the first Administrator of Charitable Grants, W. Tarleton (1873-80),

we see changing and more enlightened attitudes towards children, particularly in relation to the state's duty, which he saw as "promoting the happiness and well being of the children in its care" (Daniels 2006, p. 1 of 3). A boarding-out system was introduced in 1871 to replace the mass institutionalisation of children; any children who could not be boarded out by the time the asylum was closed in 1879 were sent to the industrial schools.

The Department for Neglected Children was created by the *Youthful Offenders, Destitute and Neglected Children Act 1896,* which also instigated visiting committees to carry out inspections of foster homes and institutions and made provision for complete responsibility for the Boarding-Out Scheme for neglected children, previously administered jointly with the charitable organisations. Although some attempt was made to keep siblings together, separating children from their parents was considered to be central to the reformatory process. With the efforts of three departmental administrators in particular, provisions for the welfare of children were brought up to a standard that was equal to most of the other states. Nonetheless, the deficiencies of Australian Neglected Children's Departments were being recognised at the time by child rescuers, who noted the Departments' failure to actively seek out children at risk, the low standards of care, and the emphasis on deterrence (Scott & Swain 2002).

The campaign for the vote by the Woman's Christian Temperance Union in the 1890s had succeeded in raising public awareness of the importance of motherhood and the need for nurture and moral training and protection (Evans 2006a). Their moral purity campaign in 1895 had retained a focus on the importance of morality and good citizenship and had led to the inclusion of 'uncontrollability' and 'living with a prostitute' to the categories of 'a neglected child' in the *Youthful Offenders, Destitute and Neglected Children Act 1896* (Evans 2006b). The idea of children being 'in need of protection' because of physical ill-treatment and neglect was introduced with the creation of the *Prevention of Cruelty to, and Protection of, Children Act 1895*.

While the issues of physical abuse (or 'cruel treatment') and neglect of children were certainly addressed by the Act, the provisions were directed squarely at the behaviour of parents and guardians rather than specifically focusing on the wellbeing of the child. The idea of parental/guardian intent is also introduced in the Act's provisions for the

prosecution of any person having custody, control, or charge of a child under the age of fifteen years who "*wilfuly* ill-treats, neglects, abandons, or exposes" the child "in a manner likely to cause such child unnecessary suffering or injury to its health" [author's emphasis, Section 2(I) of the Act 1895]. The Act also places restrictions on the employment of children on the street or in establishments that sell liquor for purposes such as begging or public entertainment [Section 3(I-III) of the Act 1895].

With the population scare in the early twentieth century, and an unacceptably high death rate among illegitimate infants in Tasmania in the mid-1900s, an increased interest in the health of infants emerged (Evans 2006a; Evans 2002). According to Evans (2002), the *Infant Life Protection Act 1907* was passed "in an attempt to curb infanticide" with the new provisions for the inspection of nursing homes. However, "most historians of the subject agree that poverty, inadequate feeding, and gastric flu caused such deaths, with infanticides being committed by the babies' own mothers" par. 14).

Amongst its provisions, the Act sought to tighten up regulations surrounding the registration of births and deaths of infants, especially illegitimate infants, and to improve by various means the standards of health, hygiene and care for infants in nursing homes (the Act 1907). While many of the foster mothers in the system were conscientious and loyal, there were ongoing problems of inadequate care and suspicions of abuse, and in 1918 the *Children of the State Act* (the Children's Charter) created the new State Department, bringing with it much tighter controls and tougher provisions (Evans 2002, par. 53).

The 1918 Children's Charter provided the most detailed definition of a 'neglected child' up to that time, which does not fundamentally change until the passage of the *Children, Young Persons and Their Families Act 1997*. Interestingly, physical ill-treatment is included in the definition of a 'neglected child' for the first time, which is still very much focused on the circumstances of the child but does refer to some parental behaviours which may lead to those circumstances. The Charter, nonetheless, retains the government focus on control and the reformation of the unprotected child within its stated aim of "better provision for the protection, control, maintenance, and reformation of neglected and destitute children" (The Act 1918). The definition of a 'neglected child' is set out in terms that are wide ranging and relate to specific situations – which

allows some insight into the social context that gave rise to the legislation and the prioritisation of social and moral issues – as "a child –

I. Who is found in a house of ill-fame, or who is known to associate with or be in the company of a person known to the police or the department to be or reasonably suspected of being a prostitute, whether such person is the mother of the child or not; or

II. Who is found stealing in a public place, or who associates or dwells with any person known to the police or the Department, to be a thief, drunkard, or with any person who has no apparent lawful means of support; or

III. Who has no visible means of support, or has no fixed place of abode; or

IV. Who begs in any public place, or habitually wanders about public places, being in no ostensible occupation, or sleeps at night in the open air in any public place; or

V. Who is not provided with the necessary food, nursing, clothing, medical aid or lodging, or who is neglected, ill-treated, or exposed by his parent, and such neglect, ill-treatment or exposure has resulted, or appears likely to result, in any permanent or serious injury to the child; or

VI. Who, being of the compulsory school age, is an habitual truant from day school, or whose parent has been convicted at least twice of neglecting to cause such child to attend school; or

VII. Who, by reason of neglect, or drunkenness, or other vice, of its parents, or either of them, is growing up without salutary parental control and education, or in circumstances exposing such child to an idle or dissolute life; or

VIII. Who is illegitimate, and whose mother is dead, or is unable to maintain or take charge of such child; or

IX. Who takes part in any public exhibition or performance whereby the life or limb of such child is endangered; or

X. Who is deserted by its parents; or

XI. Whose parents or only parent are or is undergoing imprisonment for an indictable offence; or

XII. Who, being a female, solicits men, or otherwise behaves in an indecent, or improper, or disorderly manner, or habitually wanders at night without sufficient cause in a public place;

XIII. Who, being under the age of Fourteen years, is engaged in street-trading, in a public place, or in any other place than the child's home; or

XIV. Who is found by a children's court to be an uncontrollable child; or

XV. Who, by reason of ill-treatment, continual personal injury, or grave misconduct, or habitual intemperance of its parents, or either of them, is in peril of loss of life, health, or morality; or

XVI. Whose home, by reason of neglect, cruelty, or depravity, is an unfit place for such child. (Section 4, The Children's Charter 1918)

The "unduly benevolent" Children's Charter, together with the *Infants' Welfare Act 1935,* brought major changes, including the "closer supervision of children in poor

circumstances, a probation system for young offenders and the removal of imprisonment for children under fourteen" (Daniels 2006, p. 2 of 3).

1935–1970

Although both the *Infants' Welfare Act 1935* and the subsequent *Child Welfare Act 1960* focused on the issue of neglect as grounds for placing children in the care of the State, the wellbeing of children during this period was assessed in terms of their physical health and development only. Psychiatric or psychological assessments were made for the purpose of ascertaining a child's level of mental functioning only – which often resulted in the child being labelled mentally deficient – although reports did mention emotional impairment in relation to the behaviour of parents and between family members (Tasmanian Ombudsman 2004, p. 59). Many of Tasmania's current policies and practices are directly attributable to the repercussions of this period of child welfare history, which includes the second period of removal of Aboriginal children from their families and communities.

The *Infants' Welfare Act 1935* was introduced "to consolidate and amend the Law relating to the Welfare of Children and the Protection of Infant Life" (the Act, January 1936). A 'neglected child' is defined under this Act in basically the same terms as the 1918 Children's Charter, with additional circumstances relating to children's exposure to drug use and infectious diseases (see Box A2.1 in Appendix A). The 1935 Act repealed the 1895 and 1896 Acts and provided the Governor with the power to establish or abolish institutions for the care and maintenance of children of the State. It also provided for the licensing of foster mothers – who had to be of good character, able to nurse and provide for infants in their care or charge, and in good health and free of any constitutional disease or physical or mental disability. Sections of the Act related to the care of all children under the age of five, and included the inspection and registration functions pertaining to nursery- or day-care for infants.

The *Child Welfare Act 1960* makes further provision for the care of neglected and 'delinquent' or wayward children, and the conditions under which a child can be made a ward of the State. It contained the revolutionary principle that "the erring child should be treated not as a criminal but as a child who is or may have been misguided or

misdirected and that the care, custody and discipline of each ward of the state must approximate as nearly as may be to that which should be given to it by its parents" (Tasmanian Ombudsman 2004, p. 60). A child who was found guilty of a criminal offence could now be either released on orders or made a ward of the state. While neglected and delinquent children theoretically had the same entitlements under the Act, non-government agencies had the care of neglected children while the Department provided institutional care for delinquent children, as well as a fostering service.

The concept of a child in need of care and protection is introduced with the 1960 Act, which results in a greater emphasis on the notion of parental actions or omissions of care, with a child "being in need of care and protection because the parent or guardian was unfit or not exercising proper care":

> ... proper care and guardianship shall be deemed not to be exercised in respect of a child if he is not provided with necessary food, lodging, clothing, medical aid, or nursing, or if he is neglected, ill-treated, or exposed by his parent or guardian." (*Child Welfare Act 1960*, Section 31.2)

The concept of "proper care and guardianship" adds a new dimension to the definition, which leaves greater room for interpretation and a greater need for professional judgement. The following part of the definition of a 'neglected child' is basically a more concise version of the 1935 one: "a child –

a) who, having no parent or guardian, or having a parent or guardian unfit to exercise care and guardianship or not exercising proper care and guardianship, is in need of care and protection, to secure that they are properly cared for or that they are prevented from falling into bad associations or from being exposed to moral danger;
b) who is beyond the control of the parents or guardians with whom they are living;
c) who associates with a person who is, or is reputed to be, an habitual thief, or a drunkard, or a prostitute or with a person who has no apparent lawful means of support;
d) who is found wandering without any settled place of abode, or without visible means of subsistence, or begging or receiving alms, or loitering for the purpose f so begging or receiving alms;
e) who is found in a brothel or a place reputed to be used as a brothel or in a place where opium or any preparation thereof is smoked;
f) who, being female, solicits, importunes, or accosts any person for immoral purposes;
g) who, being a child who has not attained the age of 16 years in respect of whom there have been at least two convictions under Section 9 of the *Education Act 1932* does not, without lawful excuse, attend school regularly;
h) who dwells with, or in the same house as, a person suffering from venereal disease or from tuberculosis in conditions that are dangerous to their health. (cited in AIHW 2001, p. 60)

While child welfare continued to focus on care, control, discipline and training during the early sixties, attitudes and policies were continuing to develop with changing notions of childhood and improved and more widespread knowledge about child development (DHHS 2009). The 1960 *Adoption Act*, for example, emphasised the best interests of the child, and by 1966 departmental policy was stressing the importance of the emotional relationship between parent and child, stating that it was to be disturbed only as a last resort. The Child Welfare Division of the new Department of Social Welfare began to provide additional services for families such as childcare and developmental and preventive services in parallel with de-institutionalisation (Daniels 2006, p. 2/3).

Despite these advances in thinking, it has been acknowledged that child welfare services "emphasised child rescue rather than child protection" throughout this period, under the belief that any care – even the mass dormitory-type accommodation of institutionalised care – was an improvement on the existing circumstances of the children who were 'rescued' (DHHS 2009, p. 17). It has been recognised in hindsight that the basic and individual needs of children were not being met under these conditions, and this has resulted in significant problems being encountered by many of them as adults, which in turn have affected their capacity to parent their own children (DHHS 2009, p. 17). The HREOC Inquiry found that children removed from their families are more likely to suffer from low self esteem, depression and mental illness; more likely to come to the attention of police; more vulnerable to other types of abuse; and more likely to have suffered the loss of their Aboriginal culture (HREOC 1997). In his *Review of Claims of Abuse*, the Tasmanian Ombudsman (2004) makes the point that general issues of neglect and systemic abuse were raised by all claimants in the process of telling their stories; however,

> Such concepts are normally defined in terms of a failure or an omission by the State to provide adequately for basic and special needs of children in care, as distinct from the perpetration of overt actions of abuse on a child" (Tasmanian Ombudsman 2004, p. 9).

Whether or not the failure to provide for the needs of children is an 'overt act of abuse', it raises the question of why it was only an enquiry into abuse in the first place. The issue serves to highlight the length of time it takes for new policies and ways of thinking to filter through and take effect in actual practice. Even under the legislation at the time, these children were not receiving 'proper care and guardianship' as prescribed

by the Act. The continuing history confirms that reactionary policy and system change, which is most often how changes in child protection come about, inevitably results in the new issues being attended to at the expense of others and children increasingly being doubly victimised through systemic neglect.

Recent child protection history

From the 1960s through to the 1970s the international focus on the 'battered child syndrome', first identified by the American paediatrician Henry Kempe and his colleagues (see Kempe, Silverman, Steele, Droegemueller & Silver 1962), marked the beginning of a new phase in child protection history and led to a rapid growth in child protection services. In Australia, two more papers of significance were published in the *Medical Journal of Australia* in 1966: one raising concerns about the health and development of neglected infants brought into a child welfare reception centre (Bialestock 1966) and the other discussing non-accidental injuries observed in the Royal Children's Hospital in Melbourne (Birrell & Birrell 1966). Once the highly respected medical profession started to voice claims that child abuse was a serious problem, and had evidence to back up their claims, child protection started to shift away from the moral charity model towards a medical model requiring the expertise of the medical profession (Scott & Swain 2002).

Out of this shift came the *Child Protection Act 1974* which was created "to provide further and better protection for children of tender years who have suffered from beatings or other cruel treatment" (the Act, 1974). The Child Protection Assessment Board was established to enact the legislation, which was to consist of no more than five members, including a paediatrician, medical practitioner and social worker, with a legal practitioner as Chairman. Systems were put in place for the receipt of notifications of maltreatment by any concerned individual and mandatory reporting requirements for certain professionals (to be specified) were instigated. Regional Child protection units were set up – which were responsible to the Child Protection Assessment Board, later to become the Child Protection Board – to respond to the 'Miscellaneous Complaints' that were received in relation to maltreatment concerns about children and young people under the age of twelve years (DHHS 2009).

Under Section 8 of the 1974 Act –

> (1) Any person who suspects upon reasonable grounds that a child who has not apparently attained the age of 12 years has suffered injury through cruel treatment is entitled to report the fact to an authorised officer, and the report may be made orally or in writing. (*Child Protection Act 1974*)

The definition of 'cruel treatment' under the Act includes the concepts of injury, parental intent and omissions of care, as follows:

> (2) References in this Act to injury shall be construed as including references to disease or any other morbid condition.
>
> (3) For the purposes of this Act, a child may be regarded as having suffered cruel treatment notwithstanding that the treatment was not intended to be cruel or was not intended to result in injury to the child; and the neglect, or failure to perform any act required for the welfare, of the child may constitute cruel treatment of that child. (*Child Protection Act 1974*)

A number of major conceptual changes take place with this new legislation. There is a complete shift of focus away from neglect towards the resultant physical harm: a child in need of protection is no longer defined in terms of 'a neglected child' but as a child who 'has suffered injury through cruel treatment'. A complete inversion of the way neglect and cruel treatment are defined takes place, in that 'a neglected child' previously included a child who suffered cruel treatment, now the concept of cruel treatment includes 'neglect'. The definition refers to actions and omissions that have occurred in the past and have already caused the injury or harm – evidence of which is to be supplied by a medical practitioner. The definition of a child in need of protection moves away from the notion of proper care and guardianship with its focus on the (neglected) child, towards the concept of evidence of harm and parental actions and omissions. While the definition of a 'neglected child' was very specific, the definition of 'cruel treatment' is more open to interpretation, but restricted by the provision of evident harm. Last, but not least, the idea of cruel treatment as independent of parental intent, or the cause of ill-treatment, is introduced in this Act.

Changes such as these can have a considerable effect on the way child protection systems work, in that they require more subjective judgement and interpretation on the part of the professionals involved and lead to the creation of a more forensic approach within child protection policy and practice. Professional and public awareness of child abuse continued to grow, and concerns were (and continue to be) raised about the medical establishment's "pre-occupation with physical abuse at the expense of the more fundamental problem of child neglect" (Scott & Swain 2002, p.127).

The change of focus from neglect to abuse had come at a time when social policy on a national level was attempting to take the pressure off disadvantaged families. Better family relief and social security services and educational opportunities were introduced by the Federal Government during the Whitlam era (1972-75). This greater emphasis on social policy in general went hand in hand with a more therapeutic model of child protection aimed at providing disadvantaged families with greater educational and other opportunities which would improve family functioning and outcomes for children. Greater awareness of children's developmental needs and the inadequacies of institutional care for children led to a move in the 1970s towards foster care and family group home placements for children. By the mid-eighties, all of the institutions in Tasmania had been closed except for one Government-run training facility. The number of wards of the State dropped from 976 in 1975 to less than 300 by the 1990s.

Whether or not it was the sexual liberalisation taking place nationally and internationally that may have led to sexual abuse eventually receiving the attention it deserved in the eighties is a matter of debate. But there were definite signs that this previously repressed issue was coming into the open, with 24 allegations of sexual abuse made to the Child Protection Assessment Board in 1980. The resultant *Child Protection Amendment Act 1986* is very much directed at this highly sensitive and recently acknowledged problem. The Act introduces the new category of sexual abuse as well as the concept of emotional harm within its definition of an abused child. The notion of a child being 'likely to suffer' some future harm as a result of neglect is also introduced in this new definition. On the other hand, the legislation reverts to the 1895 approach – seen in the *Prevention of Cruelty to, and Protection of, Children Act* – defining abuse and neglect in terms of parental actions or omissions and outcomes of harm or injury to the child, as follows: "A child is taken to suffer abuse if:

a) whether by act or omission, intentionally or by default, any person:
    i) inflicts on the child a physical injury causing temporary or permanent disfigurement or serious pain; or by any means subjects the child to an impairment, either temporary or permanent, of a bodily function or of the normal reserve or flexibility of a bodily function (for example, administering drugs or alcohol); or
    ii) neglects, or interferes with the physical, nutritional, mental or emotional wellbeing of the child to such an extent that the child suffers, or is likely to suffer, psychological damage or impairment; or the emotional or intellectual

development of the child is, or is likely to be, endangered; or the child fails to grow at a rate that would otherwise be regarded as normal for that child;

b) any person causes the child to engage in, or be subjected to, sexual activity; or

c) the child is, with or without the consent of the child or of the parent, guardian or other person having the custody, care or control of the child, engaged in, or subjected to, sexual activity that is solely or principally for the sexual gratification of any other person; or is in whole or in part the subject of, or included among the matters portrayed in, any printed matter, photograph, recording, film, video tape, exhibition, or entertainment; or is in any other manner exploited. (AIHW 2001)

Child sexual abuse came to be seen as the most serious form of abuse after physical abuse and to dominate child protection practice and research, especially in the US – even though researchers were again warning against a pre-occupation with sexual and physical abuse, arguing that neglect and emotional maltreatment can cause more serious and long-term harm to children (Dubowitz 1999; Scott & Swain 2002).

Child protection services during the following period have embraced the best interests of the child as a founding principle of their decision-making and practice, which is guided by four themes relating to the essential needs of all children – protection, continuity, care and connection. In this approach, the whole community is perceived to share a responsibility to create "an environment for children and young people which is safe, nurturing and supportive" (DHHS 2006, p. 31). There is a strong emphasis on building resilience of children within families and communities by ensuring the provision of certain protective factors; including, bonding to a primary caregiver, positive relationship with at least one adult, connectedness to school and community, and a sense of hope for the future (DHHS 2006, p. 32.)

A System in Progress

Child protection services in Tasmania are provided by Children and Family Services (CAFS), which is part of Disability, Child, Youth and Family Services (DCYFS) in the Department of Health and Human Services (DHHS). The primary legislation governing the care, protection and wellbeing of children is the *Children, Young Persons and Their Families Act 1997* (CYPFA, or the Act), and the *Family Violence Act 2004* (the FVA). The 1997 Act commenced on the 1 July 2000, replacing the *Child Welfare Act 1960*, the *Child Protection Act 1974* and the 1986 Amendment Act. The principles that form the foundations of the new legislation are based on the United Nations Convention on the

Rights of the Child. This legislation, in conjunction with the Tasmanian Risk Framework, lays the foundations of child protection policy and practice in Tasmania currently and throughout the period covered by this investigation.

Child protection has undergone substantial systemic, structural and policy changes since the Act was proclaimed in 2000, in a series of attempts to put mechanisms in place to deal with the increasing demands being placed upon the system as discussed above. It is important to bear in mind that such radical changes have significant unavoidable consequences, particularly in the initial implementation phase. In addition to the wide-ranging effects on the system itself, it takes time for practitioners to become familiar with new policies and practice regimes, and the likelihood of judgement and communication errors occurring during this time also increases. The high turnover of child protection staff compounds the problem, with the consequential lack of experience being brought to the important professional judgement and decision-making tasks. The ongoing systemic problems and enquiries and resultant reforms outlined below have profoundly affected who will be protected in the system, for what reasons and how they are to be protected, and increasingly importantly, the timeframe within which any intervention or protection might occur protection.

Child protection reforms since the implementation of the Act

2000–2003

Although the 1997 Act was not proclaimed until 2000, changes to the child protection system were set in motion in 1997 with the introduction of new regional intake and assessment teams in the North, North-West and South of the state. The new assessment teams were aimed at providing a greater level of scrutiny of allegations of abuse and neglect in decision-making about whether cases should proceed through the statutory system or not. An initial differentiated response system was implemented, based on that originally developed in Western Australia as part of their *New Directions* for child protection services there, in which reports of abuse and neglect were classified by Child Protection Workers as either 'Child Harm/Maltreatment allegations' ('notifications' requiring further investigation) or 'Child and Family Concerns' (consultations) (DHHS 2006; Tomasin & Poole 2000).

The result of this counting system was a (theoretical) reduction in the number of notifications – substantially dropping from 2,993 in 1995-96 to 1016 in 1997-98 and then even further to 422 in 1999-2000 – which continued to fall "as staff became familiar with the new system" (DHHS 2006, p. 30). It is worth noting that all of the states except for Western Australia and Tasmania were experiencing increased numbers of notifications throughout the same period. In reality, though, the expanded mandatory reporting requirements in the new legislation, and greater community awareness, had created an increase in the number of reported cases of abuse and neglect in Tasmania which, because of the new classification system, were not reflected in the national child protection data. It is even more concerning that the number of substantiations – and the number of cases that received further investigation – which resulted from the new classification system during the same period dropped dramatically as well from 244 in 1996-97 to 97 in 1999-2000: a substantiation rate of 0.7 per 1000 children, which was the lowest in Australia (AIHW 2001).

While the purported aim was to enable a rapid and rigorous response to reports of child protection concerns (Foot 1997), such dramatic reductions in the number of notifications serve as a reminder that agencies are driven to "focus on ways to direct resources, rather than on developing practice that prevents child abuse and neglect occurring" (McCallum & Eades 2001, p. 269–70):

> Policies such as *New Directions* are not aimed at the prevention of child abuse and neglect: they aim to streamline services. The prevention of further abuse and neglect may be a by-product, but it is not a fundamental principle of such policies.
>
> ... There is danger in organisations seeking to make the numbers of notifications to which they must respond less, rather than working to reduce the incidence of child abuse and neglect: the former is a reshuffling of the cases, the latter is effective intervention. (McCallum & Eades 2001, p. 270)

The new Act, with $1.5 million allocated for its implementation, is founded on a philosophy which maintains the notion of families having primary responsibility for the care and protection of their children, and Government having a responsibility to make the necessary support services and resources available for families to meet this responsibility (Tomison & Poole 2000). It represented "a strong move away from a coercive interventionist approach to a more supportive family focused practice that recognises and reinforces the strengths of families" (Foot 1997, p. 2/16). This move served to bring child protection services more in line with other states and territories

with an increased focus on early intervention, which was and still is carried out in partnership with the non-Government sector. The legislation inaugurated the appointment of a Commissioner for Children and a child protection advisory panel. The state-wide Family Group Conferencing program was also implemented in 2000 as a case-planning option in circumstances where a child is perceived to be 'at risk'.

In 2003 a centralised intake service system, the Child Protection Advice and Referral Service (CPAARS), was established to manage all 'notifications' to the statutory child protection service across the three child protection regions of the State. The move to a centralised system was expected to provide more consistent assessments of risk; identification of cases that require further investigation; data collection; training, professional development and supervision of staff; and referrals to appropriate services (AIHW 2004). Implementing the new legislation proved to be a somewhat lengthy process occurring over a three-year period, with at least three different notification assessment forms being in use in the 2003 calendar year. As a result of advice from Crown Law that decision-making required for Part 3 ('Informing of concern about abuse and neglect') and Part 4 ('Assessments') of the Acts should be differentiated: Part 3 requires an assessment of the notification prior to an assessment of the circumstances of the child. The "change ensures that the intrusion into the family which an investigation represents is based on valid decision making of the state" (DHHS 2009, p.18). The following new notification procedures for receiving, recording and counting notifications and any subsequent investigations were developed to be more closely aligned to the legislation:

- Notifications became 'caller defined' – that is, reports were classified as 'notifications' or 'enquiries' according to the expectations of the reporter/caller – in accordance with Part 3 of the Act;
- Notifications about intra- and extra- familial abuse were accepted;
- Notifications were to be assessed on the basis of 'reasonable grounds' prior to an assessment of the circumstances of the child under Part 4 of the Act.

July 2003 – February 2008

Four major changes to the Tasmanian Child Protection system took place between 2003 and 2005 which had a drastic effect on the department's capacity to ensure adequate

protection and safety for many vulnerable children at the time and in the years that followed. Firstly, on the 1st of July 2003, the Department officially implemented the changes to its method of reporting, outlined above, to include all notifications to child protection services. A new electronic database was set up to cover the period starting in July 2003 and ending with the establishment of the new Child Protection Information System (CPIS) in February 2008 – which is the period covered by this study. As expected, this change had a substantial effect on the number of notifications being recorded compared to previous years, although the numbers have been steadily increasing in Australia as a whole.

Secondly, in parallel with the implementation of the changes, the Tasmanian Risk Framework (TRF) was developed, or adapted, from the Victorian Risk Framework (VRF), which has been continuously in use since July 2003. The TRF is a guided risk assessment tool to determine the level of risk to the child, which has been in use throughout the study period and continues to be used throughout the child protection process currently. (The TRF is discussed in greater detail below.) The third major development was the proclamation of the *Family Violence Act 2004* on March 31 in 2005, which amended the definition of 'a child at risk' in the 1997 Act to include 'a child affected by family violence'. The new legislation brought about a significant increase in the number of notifications from Tasmania Police which contributed substantially to the increase in the number of notifications overall (AIHW) – and to the overwhelmed state of the system.

Some other initiatives were introduced during the 2005–06 period as a result of the Tasmanian Ombudsman's Review of abuse in care; including a trial of the Early Support Program (ESP) – which was designed to divert lower priority notifications away from a statutory child protection response, by providing targeted support to families; participation in the trialling of collaboration strategies with Tasmania Police, the Department of Education and Youth Justice, Disability and Mental Health Services local government services for children with complex needs; implementation of a 'complaints in care' policy framework; and implementation of a formal 'kinship care' program for the support, training and assessment of relative carers (AIHW 2007).

The major legislative and system reforms outlined above had brought about a sudden and substantial increase in the number of notifications being brought to the attention of the Department – a 25-fold increase (from 422 to 10,788) between 1999 and 2005 (AIHW 2006). Tasmania also had the lowest percentage of finalised investigations of child maltreatment – (12%) in 2004–2005 (AIHW 2006). Concerns about the Department's capacity to deal with this and problems such as government and non-government worker relationships and roles, the high staff turnover of child protection workers, and high levels of work overload and stress were raised in the Commissioner for Children's Report on the Implementation of the United Nations Convention of the Rights of the Child in Tasmania [Youth Network of Tasmania (YNOT) & the Commissioner for Children (CCT) 2004].

In recognition of the concerns that were continuing to emerge about the ability of the child protection system to cope, the Minister for Health and Human Services at the time, David Llewellyn, commissioned the *System Development and Operation Improvement Project* in March 2006. In the ensuing Report on Child Protection Services in Tasmania in October 2006, the Deputy Secretary of Human Services at the time, Alison Jacob, and the then Commissioner for Children, David Fanning, addressed the child protection system's failure to deal with the problem, acknowledging that the system was collapsing. While the problem was not unique to Tasmania, the national data shows that the percentage of cases receiving further investigation during the period is far less than that of any other state. The specific concerns leading to the investigation were that in the three-year period from 2003 to 2006 there was an 80% increase in the number of notifications received; a 196 % increase in the number of notifications requiring further investigation; a 31% increase in the number of children placed on care and protection orders; and a 40% increase in the number of children in out-of-home care (Jacob & Fanning 2006, p. 27).

The failure of the system was particularly evident in the high rate of children being re-referred to the Department, as well as the escalating number of unallocated cases. There was also evidence to suggest that the cases were becoming increasingly complex, with the need to address multiple issues such as long-term unemployment, family violence, alcohol and drug abuse and mental health issues affecting the parents' capacity to meet the needs of their children and protect them from harm (Jacob and Fanning 2006). The

resultant high levels of work overload and stress in the child protection system during the period resulted in workplace action and reports in the media (e.g. Liddell et al., 2006; Duncan, *Mercury*, 8 Sept. 2006).

The review of the death of a young child involved with the child protection system was also conducted at this time, followed by a review of the deaths of eight other children known to the Department who died during 2005 and 2006. The report was not publicly released; however, a set of recommendations was established which were expected to be implemented over the following years as part of the planned changes to the system. The Government released its plan to improve the system in 'A Way Forward' in November 2006, which announced the planned implementation of twelve actions which took the recommendations of the child death review into account, and included the implementation of a new structure for Children and Family Services; building the capacity of Government and non-government community services to provide support and assistance to families and children, improve and build upon workforce development initiatives, complete reform of the Information and Communication Technology system, and consolidate legislative and policy reform. While the legislative reforms, described later, were not passed until 2009, the following includes some of the major changes that were implemented during the next two years, which coincided with the study period covered in this research:

1. In the latter part of 2007, the Southern child protection region was divided into the South-East and South West regions, and four Area Managers were appointed to each of the four regions (North, North-West, South-East and South-West) to replace the position of State-wide Manager for Child Protection.
2. The centralised Child Protection Advice and Referral Service (CPAARS) system was replaced by four regional Intake teams in each area.
3. At the same time, Assessment Services in each region were replaced by Response teams which were set up to respond to notifications of abuse and neglect in a more timely fashion.
4. The Family Violence and Support Service (FVSS) was also established at this time.

5. A new position was established to advise and support staff at the Royal Hobart Hospital, and to follow up any concerns.
6. In 2008, a new overarching framework was developed which outlines the principles to guide practice through each phase of the intervention process when dealing with children and their families (see Table A2.1)
7. The new electronic Child Protection Information System (CPIS) was fully implemented in February 2008. It is a centrally-based state-wide information and work management system which supports the Intake and Assessment functions in particular, and provides information to all authorised staff. The information system was developed to provide complete, up-to-date and reliable historical documentation and information necessary for the complex decision-making tasks at the heart of child protection work.

Child Protection in Tasmania: The Current Model

The Tasmanian Child Protection system is governed by the *Children, Young Persons and Their Families Act 1997* (CYPFA, or the Act); the object of which is to provide for "the care and protection of children in a manner that maximises a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential" (Part 1, Section 7). The administration of the Act is founded on a set of principles which must be observed in dealing with all children; a supplementary set of principles relates specifically to Aboriginal children. The founding principles emphasise the importance of families having primary responsibility for the care of their children and of providing support for families to carry out that responsibility. The legislation "reflects the view that all efforts should be directed towards accurately balancing assessment of safety and risk of children and young people with strengthening positive aspects in the individual, family and community systems" (DHHS 2009, p. 19). (Box A2.2 in Appendix A provides the principles outlined in the Act)

In accordance with the focus of the research being presented, particular attention is given to the initial intake and assessment phases of the child protection process in the following overview. The overall process is briefly outlined, followed by a more detailed description of the various definitions and procedures involved. The information

provided below comes from the Act itself or the various manuals and reports produced by the Department; including the *Beginning Practice* training manuals (DHHS 2006, 2009), *New Directions for Child Protection in Tasmania* (DHHS 2008), the *Initial Engagement and Assessment* operational guide for practitioners (DHHS 2007).

The child protection process

The child protection process is a series of phases of intervention, with each having particular functions and procedures. The current training manual outlines eight phases of the process, all of which will not necessarily eventuate for all families and do not necessarily occur in the following order:

- receipt and assessment of initial information about a concern;
- secondary information gathering and response;
- short-term protective intervention – without Orders;
- seeking a protective Court Order;
- longer-term protective intervention;
- provision of out-of-home care services;
- referral to non-Government services; and
- case closure.

These functions are currently provided by four different sections or teams – Intake (previously the centralised CPAARS), Response (previously known as Assessment Services), Case Management, and Out of Home Care – in each of the four areas (see Table 2.1).

Intake. Intake services in each region are responsible for the receipt and assessment of the initial information or advice about a concern relating to the safety and wellbeing of children and young people[10], known under the Act as a *notification*. Notifications of suspicions or concerns about abuse or neglect may be made by family members, any member of the community, *mandated reporters* or the affected child themselves. If the Child Protection worker believes that the notification "is based on 'reasonable grounds', considering the credibility and motivation of the notifier" (DHHS 2009, p. 151), and is provided with enough information to show that the child may be *at risk*, an initial *risk*

[10] From now on 'children' will be used to include children and young people

assessment of the circumstances of the child is conducted within the guidelines of the *Tasmanian Risk Assessment Framework*. The notification is categorised according to the general type of maltreatment being reported – that is, as physical, sexual or emotional abuse or neglect – or as a combination of primary and secondary forms of maltreatment. The notification is finally classified according to whether or not it is assessed as providing reasonable grounds for intervention under Sections 17 or 18 of the Act and given a priority rating. Senior workers are involved in the assessment and decision-making processes and are responsible for the priority rating (DHHS 2007).

Decisions about an appropriate response to the notification take place in consultation with the Intake team supervisor, and are based on the type and seriousness of the risk involved. There are currently three broad categories of possible responses to notifications at the Intake stage of the process. A 'forensic-protective type response' is appropriate for "urgent or high risk cases, for example, most sexual or serious physical abuse cases that may require legal or criminal and protective action" (DHHS 2009, p. 153). A 'protective-community type response' is advisable in cases requiring further investigations, which can be conducted in partnership with other services. Lastly, a 'community type response' may be appropriate when there is insufficient risk to warrant further protective investigation but some intervention is required; in which case the notification can be referred to appropriate support services within the division or to other community services. Intake workers respond to *enquiries* by providing advice and information about child protection matters and they also play an important role in developing partnerships with other agencies and raising awareness of child protection issues. (DHHS 2009) (See Figure 2.2 for a model of the various notification pathways)

Response. Notifications that require further investigation and assessment are referred on to the Response team where it is allocated to a worker who then proceeds by planning and conducting an investigation and a secondary risk assessment. The main aims of the investigation are: to gather more information; sight the child(ren); interview the parents and interview or observe the children; observe family interactions; obtain assessments of the child and/or family; establish degree of immediate risk to the child and the likelihood of harm in the foreseeable future; ensure immediate and long-term safety and wellbeing of the child; and establish whether the allegations are *substantiated*

or not. The decision to substantiate the allegation or not is the most important outcome of the investigation, which is always made in consultation with the team supervisor.

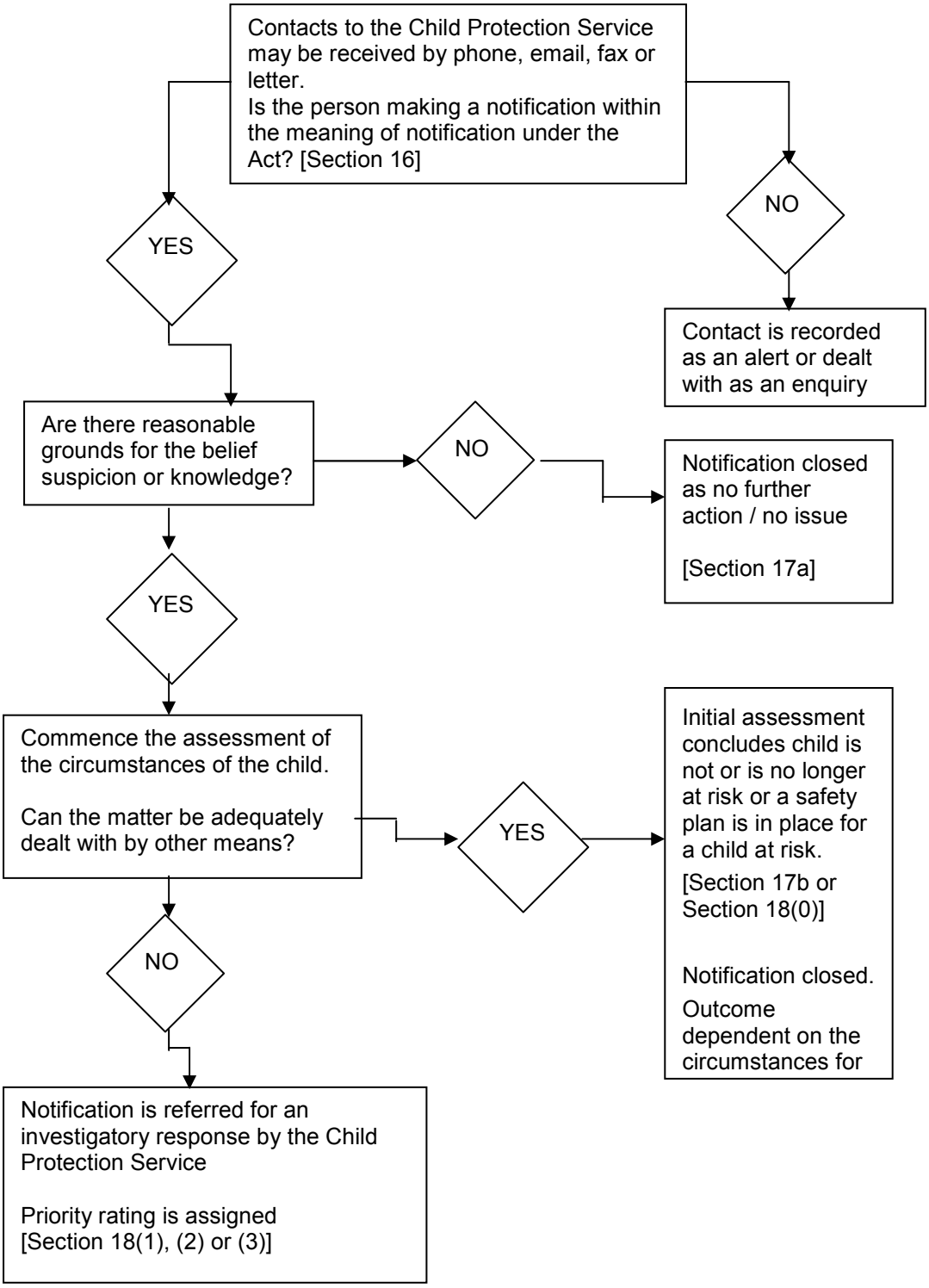
With the child-centred family-led approach to practice, most of the home visits and face-to face contacts with the family are now previously arranged. Unannounced visits are only made in extreme situations requiring a more 'forensic-protective' approach, such as situations where allegations relate to significant physical or sexual harm, a non-offending parent cannot be identified, there may be a high degree of potential violence, or where a family is transient and may move if forewarned (DHHS 2009, p. 157). The decision to substantiate the allegation or not is the most important outcome of the investigation, which is always made in consultation with the team supervisor. (See Table 2.1 for a list of the services provided by Response teams.)

Case management. Case management teams are responsible for the ongoing care and protection of children who are under longer-term Care and Protection Orders. They are principally involved in the collaborative development, implementation and review of care plans which are based on the Child Protection Service Practice Framework (see Table A2.1, Appendix A). They are also responsible for assisting the child as they prepare to leave care with the end of the order or when they reach adulthood. The overall management role is to monitor the child's development and progress and to ensure the individual needs of the child are being assessed and met in accordance with the Practice Framework (see Table 2.1 for a list of Case Management functions).

Out of home care. When the risk for children is too high, the only option is to remove the child, and child protection workers must arrange a suitable placement with Out of Home Care (OHC) on a short- , medium- or long-term basis. There are a range of options available through OHC, such as kinship care (extended family), kith care (friends or a member of the community), foster care, adolescent community placement, cottage and residential care, and rostered care. The service also provides recruitment, training and support to carers, and a suitability assessment of kinship carers. All placement decisions relating to Aboriginal children must be made in accordance with the Aboriginal Child Placement Principle.

Table 2.1 Core functions operating within the system (DHHS 2009, p. 50)

Teams	Functions
Child Protection Intake [Previously **CPAARS**]* Including After Hours Service operating from Hobart	• Receives notifications of child abuse and neglect • Conducts an initial risk assessment based on notification details • Conducts follow-up phone calls with professionals to verify and gather information in relation to notifications • Determines if further investigation is required • Refers cases, where applicable, to community-based agencies • Refers cases to Response [previously Assessment] teams in the respective Area offices.
Response [previously **Assessment**]* (based in each area) * inserted by author	• Directly investigates Child Protection Intake referrals of abuse and neglect • Formally assesses the likelihood of harm to the child/young person • Establishes if allegations of abuse are substantiated • generally works with a family for up to 28 days following notification in order to make a more intensive assessment, develop a community plan, or effect a referral to a community-based agency (where Court action is not considered necessary) • Determines if action is required in the Magistrate's Court (Children's Division), and initiates Court action. • Meets Court requirements; e.g., writing reports, acting as an applicant in the Magistrate's Court (Children's Division).
Case Management (based in each Area)	• Provides medium to long-term management of the Care and Protection Orders • Continually assesses the ongoing risk to children and young people by implementing Case and care Plans directed at improving family functioning • Meets Court requirements; e.g., writing reports and being a Court witness • Develops reunification plans and supervises access • Where required, ensures that children/young people on Orders have a permanent substitute family when parental rights have been terminated • networks with the community sector and provides some community education about child protection matters • Negotiates the transfer of case management to the community sector
Out of Home care (based in each Area)	• Provides placements to children and young people in need of short-, medium- and long-term care • Provides recruitment, assessment training and support for carers



Note: Relevant section of the Tasmanian Act added in square parentheses

Figure 2.2 Notification Pathways (DHHS 2007, p. 23/74)

Definitions

Abuse and neglect. Abuse and neglect have corresponding meanings under the CYPF Act. "'Abuse or neglect' means: (a) sexual abuse; or (b) physical or emotional injury or other abuse, or neglect, to the extent that (i) the injured, abused or neglected person has suffered, or is likely to suffer, physical or psychological harm detrimental to the person's wellbeing; or (ii) the injured, abused or neglected person's physical or psychological development is in jeopardy – and 'abused or neglected' has a corresponding meaning". [Part 1, Section 3(1)]

A variety of working definitions were available for child practitioners at the time when the data for the study was being gathered. The following working definitions of abuse and neglect for child protection practice were developed by the DHHS' Professional Development and Training Team (2006) for the Beginning Practice training session which the researcher attended:

> ### Physical abuse
>
> [Physical abuse] Refers to non-accidental injury to a child. Physical abuse may result in a range of injuries from cuts, bruises, burns, soft tissue injuries to dislocations and fractures and caused by a range of acts such as excessive discipline, severe beatings or shakings. It may also include poisoning, attempted suffocation or strangulation and death.
>
> Physical abuse includes the deliberate denial of a child's basic needs such as food, shelter or supervision to the extent that injury or impaired development is inevitable.
>
> ### Emotional abuse
>
> [Emotional abuse] Refers to a chronic attitude or behaviour directed at a child or young person, or the creation of and emotional environment, which is seriously detrimental to or impairs the child's social, emotional, cognitive, intellectual, psychological and/or physical development resulting from behaviours of family members or other caregivers such as:
> - persistent hostility,
> - rejection or
> - scapegoating.
>
> Emotional abuse – family violence
>
> Children can also experience emotional harm when they are not protected from family violence. Children can suffer harm either directly or indirectly. For example when:
> - they witness repeated domestic/family violence
> - violence is frequent within the home; and
> - they are assaulted when attempting to intervene.

Sexual Abuse

Child sexual abuse refers to any sexual behaviour between a child and an adult or an older, bigger, or more powerful person for that person's sexual gratification. The range of sexual behaviours that are considered harmful to children is very broad. It includes

- any form of sexual touching (fondling genitals, buttocks, breasts, abdomen, thighs; any oral/genital contact; penile or digital penetration);
- any form of sexual suggestion to children, including the showing of pornographic videos;
- the use of children in the production of pornographic videos or films;
- exhibitionism; and
- child prostitution

Sexual abuse often involves a progression in behaviour from fondling to intercourse; this may occur quickly or over a period of years.

Neglect

Neglect occurs when a child is harmed as a result of their carer's failure to meet their physical and emotional needs. (Unlike other forms of abuse it is an act of omission by those responsible for the welfare of a child).

It is the failure to provide a child with the basic needs of life such as food, clothing, shelter and care to the extent that a child's health is placed at risk and their development impaired. A child who is neglected may be at risk of injury or harm due to inadequate supervision.

Neglect of the basic physical needs of a child includes the failure to provide children with adequate:

- food, clothing, shelter
- medical care
- supervision or general care

Neglect of the basic psychological needs include:

- not providing a child appropriate levels of interaction, encouragement, nurturing, stimulation
- continually ignoring a child's distress, e.g., pleas for help, comfort or acceptance

(DHHS, Professional Development and Training Team, 2006)

Mandated reporters. Certain professionals and people working with children (listed as a 'prescribed person' in the CYPF Act) are mandated to report to Child Protection if, in the course of their work, they know or suspect on reasonable grounds that a child is suffering, has suffered or is likely to suffer abuse or neglect. And any adult who has such concerns has a (non-mandatory) responsibility under Sections 13 and 14 of the Act to report them to the Department. (See Box A2.3 in Appendix A for a complete list of 'prescribed persons')

Notification. A notification is "the information from a person who believes, suspects or knows that a child has been or is being abused or neglected or that there is a reasonable likelihood of a child being killed or abused or neglected" (Section 16, the Act). In

practice terms, a 'completed' or 'finalised' notification is one that has undergone a risk assessment, has been classified according to the necessary type of response and has been signed off by the Child Protection worker and a senior worker, and recorded on the information system[11]. A point of time analysis on 17 March 2006 showed that there was a cumulative total of 1,194 notifications that had not been completed (Jacob & fanning 2006, p. 33).

Since 2003, all referrals (or concerns reported) to the Department are counted as notifications whether or not the worker believes the notification is warranted. (Whereas in some states or territories, the reports undergo an initial screening process and only those deemed to meet certain criteria are recorded as notifications – as was the case previously in Tasmania.) Until 2007 a new notification was recorded whether or not the case was still open or currently under investigation for the same issues (DHHS 2006). However, since 2007, where subsequent reports about a case are the same as those currently being assessed or investigated, the new information is able to be recorded on the already existing notification if it is within the six-week timeframe and/or the case has not been closed or finalised, the new information is recorded as case-note on the already existing notification. If the new notification upgrades the risk level in the current notification, the original risk assessment can be updated. A new notification is required only when new concerns are raised and/or a different person is believed to be responsible, or if the notification has been finalised or it is outside the six-week timeframe. Obviously, this reduces the number of notifications being produced.

Notifier. A notifier is anyone, mandated or otherwise, who provides such information to the Department (Section 16, the Act).

Unborn child alert. An unborn child alert is created where it is believed an unborn child will be at risk once born. The 2009 changes to the Act state that that health, safety and wellbeing concerns should be considered significant risks if the child, once born, "is reasonably likely to suffer abuse or neglect" or "is reasonably likely to require medical treatment or other intervention as a result of the behaviour of the woman, or another

[11] A point of time analysis on 17 March 2006 showed that there was a cumulative total of 1,194 notifications that had not been completed (Jacob & Fanning 2006, p. 33).

person with whom the woman resides or is likely to reside before the birth of the child" (Part 3, s13, 2009 amendments to the Act). The Act has been amended to allow the Department to receive information and for authorised officers to investigate the circumstances of a pregnant woman and/or her partner, where the child may be in need of protection after he or she is born. Mandatory Reporters have always had a duty to report concerns about children and this amendment now means that their duty is extended to unborn children as well. Once a notification has been received effective planning will be in place at the birth of the child. Other appropriate action, such as referring a woman or her partner for relevant services or support during the antenatal period, is possible; however, parents' engagement with such services is still voluntary.

Unallocated list. Those notifications which have been assessed by CPAARS [Intake] as requiring investigation and have been referred to a Service Centre but have not yet been investigated – in 2006, the unallocated list included almost all Priority 2 and 3 notifications (Jacob & Fanning 2006, p. 25).

At risk. The definition of 'at risk' provides the legal grounds for child protection intervention, in the same way that the legislation in other jurisdictions defines 'a child in need of care and protection'. It is defined in terms of abuse and neglect and the parents' unwillingness or inability to prevent it. *Risk* is defined in the TRF as "the relationship between the degree of harm and the probability of the harm occurring (or of protection being provided)" (Brearly 1982, in DHHS 2006, p. 168). Box 2.1 provides the legal definition of 'abuse and neglect' and the meaning of a child 'at risk'.

Substantiation. "Substantiation means a determination following an investigation of whether there was reasonable cause to believe that a child or young person (the subject of the notification) *had been, was being, or was likely to be abused or neglected or otherwise harmed*" (DHHS 2009, p. 160; 2006 p. 250; author's emphasis). It is simultaneously described as the "final outcome decision confirming whether or not a child was/is *at risk* of abuse or neglect" (DHHS 2007, p. 66/74, author's emphasis). A decision to substantiate the allegation provides a transparent entry point for ongoing protective intervention and an opportunity to clarify/address the areas of concern (DHHS 2007, p. 66/74). In other words, a substantiated or unsubstantiated allegation claim may relate to an actual instance of abuse or neglect, or it may refer to the child

being at risk of future abuse or neglect at the time of the assessment. Furthermore, a substantiation of an allegation does not necessarily mean that an intervention is necessary – the circumstances surrounding the allegation may have changed and either reduced the risk to acceptable levels or removed the risk entirely.

Box 2.1 Legal definition of 'abuse' and 'neglect' and 'at risk'

Section 3(1), Part 1, of the Act, 'abuse' and 'neglect' are defined as follows:

"abuse or neglect" means –
(a) sexual abuse; or
(b) physical or emotional injury or other abuse, or neglect, to the extent that –
(i) the injured, abused or neglected person has suffered, or is likely to suffer, physical or psychological harm detrimental to the person's wellbeing; or
(ii) the injured, abused or neglected person's physical or psychological development is in jeopardy –
and "abused or neglected" has a corresponding meaning.

Section 4 of the Act describes the meaning of "at risk" [i.e. legal grounds for intervention]:
(1) For the purposes of this Act, a child is at risk if –
(a) the child has been, is being, or is likely to be, abused or neglected; or
(b) any person with whom the child resides or who has frequent contact with the child (whether the person is or is not a guardian of the child) –
(i) has threatened to kill or abuse or neglect the child and there is a reasonable likelihood of the threat being carried out; or
(ii) has killed or abused or neglected some other child or an adult and there is some reasonable likelihood of the child in question being killed, abused or neglected by that person; or
(ba) the child is an affected child within the meaning of *the Family Violence Act 2004*; or

(c) the guardians of the child are –
(i) unable to maintain the child; or
(ii) unable to exercise adequate supervision and control over the child; or
(iii) unwilling to maintain the child; or
(iv) unwilling to maintain adequate supervision and control over the child; or
(v) dead, have abandoned the child, or cannot be found after reasonable inquiry; or
(vi) are unwilling or unable to prevent the child from suffering abuse or neglect; or
(d) the child is under 16 years of age and does not, without lawful excuse, attend school regularly.

The Tasmanian Risk Framework (TRF)

The Tasmanian Risk Framework (TRF) is "a guided 'professional judgement approach'" to the assessment of risk; it is an evidence-based framework used to support judgements and decision-making at vital points in the ongoing child protection process which begins when a notification is made and continues throughout the investigative and case management stages until case closure (DHHS 2009, p. 112). The TRF was adapted from the Victorian Risk Assessment Framework (VRF) and is primarily based on the work of Brearly (1982), Meddin (1985), Hemsworth, McNamara and McPherson (1997), the Manitoba Risk Estimation System (Reid & Sigurdson 1990; Sigurdson, Reid, Christianson-Wood & Wright 1995), and the work of the Victorian Child Protection and Juvenile Justice Branch (DHS) and the Victorian Child Protection Guidelines (all cited in DHHS 2009, p. 112).

The TRF brings together theory, practice principles and assessment tools, or recording formats, in a three-phase approach to risk assessment which includes information gathering, analysis of risk, and a final judgement (see Figure 2.3). At the Initial reporting stage of the process, the information provided by the notifier is recorded on a Notification Report form which incorporates a guided risk assessment process (see Appendix B). The Report form guides the worker through a process as follows:

- the worker receives the information from the notifier
- the information is then assessed as to whether the concerns are based on 'reasonable grounds', considering the credibility and motivation of the notifier;
- Departmental databases are reviewed for any previous history of the child or family
- an initial risk assessment of the child's safety and wellbeing, by
  - gathering information from a range of sources
  - using the Risk Factor Warning List
  - Recording the Risk Analysis and Safety Statement
  - Consulting the relevant Specialist Assessment Guides (SAGs), and policy and procedural guidelines
- notifications are then given a classification that is in line with the type of response required to ensure the safety and wellbeing of the child.

Information is analysed on the basis of severity, likelihood, vulnerability and safety. Severity takes into account the type and degree of the harm consequences for the child, with consideration also being given to the accumulated effects of harm. Likelihood, or probability, is assessed in terms of 'pattern and history', 'beliefs', and 'complicating factors'. Vulnerability is assessed in terms of the individual's susceptibility to negative developmental outcomes or an individual response to particular factors. And safety is assessed in terms of any identified relationship or personal strengths and protections that may take the form of a person, action, or a situation.

The final judgement of risk is based on harm consequence and harm probability, which considers the effect of the actual harm on the child. The key determinants of whether or not a child is in need of protection are "that parents/caregivers are unable or unwilling to prevent the risk of child abuse or the child has suffered or is likely to suffer abuse [or neglect]" (DHHS 2006, 2009, p. 112).

Classification system

Notifications are classified according to whether or not the information provided warrants further investigation and assessment or referral in accordance with the relevant Section of the Act. The department is not obliged to initiate action in relation to a notification if the information provided was judged to be "not sufficient to constitute reasonable grounds" for doing so, under Section 17(a); or where there are reasonable grounds, the matter has been or is being adequately dealt with, under Section 17(b). Section 18 of the Act makes provision for the Department to intervene if there are reasonable grounds to believe or suspect that a child is 'at risk' (See Box 2.2 below). Notifications classified under 'Section 18 of the Act are prioritised according to the response time required, which is directly related to the level of risk to the child at the time of the notification. Priority 1 requires a service centre response within ½ a day; Priority 2, within 5 days; and Priority 3, within 10 days (DHHS 2007, p. 45/74).

Box 2.2. Statutory grounds for intervention

17. Secretary not obliged to take action in certain circumstances

Nothing in this Act requires the Secretary to take or initiate any action under this Act when informed by a person of the belief, suspicion or knowledge that a child has been or is being abused or neglected or that there is a reasonable likelihood of a child being killed or abused or neglected if the Secretary is satisfied –

(a) that the information or observations on which the belief, suspicion or knowledge was based were not sufficient to constitute reasonable grounds for the belief, suspicion or knowledge; or
(b) that, while there are reasonable grounds for such a belief, suspicion or knowledge, proper arrangements exist for the care and protection of the child and the matter of the apparent abuse or neglect or the likelihood of the child being killed or abused or neglected has been or is adequately being dealt with.

18. Assessment by Secretary

(1) If the Secretary believes, or suspects, on reasonable grounds that a child is at risk, the Secretary may carry out an assessment of the circumstances of the child.

(2) [The provision of any previous relevant written reports of assessments, tests, treatments etc. may be required.]

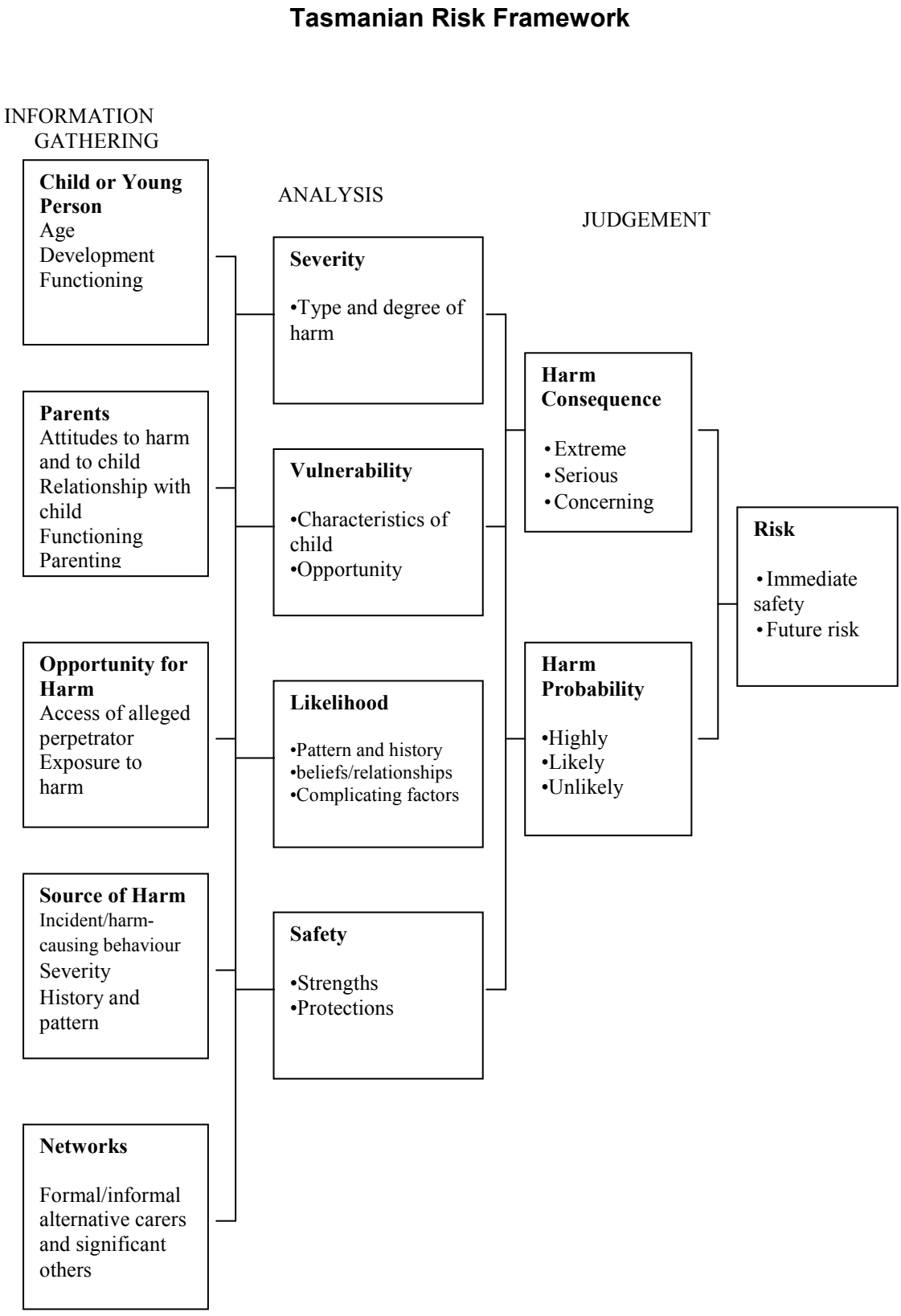


Figure 2.3. Tasmanian Risk Framework Overview, TRF Assessment Guidelines: *Comprehensive Assessment of Safety and Well-Being in Tasmanian Child Protection Services* (p. 3 of 16).

Subsequent and ongoing reform to the system

The need for more radical and widespread reform arose from the continuing failure of the child and family service system to cope with the demands being placed on it; in particular, its limited capacity to respond in a timely and effective manner to vulnerable children and children at risk of harm or maltreatment, the need for earlier and more preventive intervention, and the need for better and more localised services. In 2008, *New Directions for Child Protection in Tasmania: An Integrated Strategic Framework* presented the findings of the KPMG consultancy on the review and redevelopment of child protection services, which had been undertaken in 2007, and the new model for the provision of child protection services in Tasmania. The re-organisation and restructuring of the system, which was modelled on recent reforms in the United Kingdom and in the Australian state of Victoria, is currently being implemented (2009-10) and will continue within a five-year timeframe.

The overall reform included the development of three separate strategic frameworks: the Child Protection strategic framework, the Family Services strategic framework, and the Out of Home Care strategic framework. A new child protection framework had originally been called for by the child protection workers themselves, and its need was established in Jacob and Fanning's (2006) Child Protection review. It has been adapted from the New Zealand Practice Framework which had recognised the problem of practice increasingly becoming concerned with information systems and technology at the expense of attentive and proactive social work practice. The Child Protection strategic framework provides details for the reforms to the child protection program which has been designed to provide "more timely responses that are informed by the developmental needs of children and based on the collaborative relationships with family services and other services (such as Police)" (DHHS 2008, p. 27). The Family Services strategic framework "outlines an enhanced Family Services system that is built upon service provision by local services working in partnership with each other and with Child Protection" (DHHS 2008, p. 27). The Out of Home Care strategic framework "outlines reforms to the Out of Home care system that will provide children with greater care options and improved outcomes" (DHHS 2008, p. 27).

A major aspect of the reforms was the establishment of Community Based Intake Services (CBIS) which are being carried out by the new non-Government Gateway Services, which commenced in August 2009 in each of the four regions. Under the amended legislation, mandatory reporters can now report concerns about children in the care of their family to the Gateway Services:

> The aim of Gateway Services is to provide a single, well publicised access point for individuals, agencies, services, and other professionals such as teachers, community agencies and general practitioners to refer clients for services and to obtain information and advice in relation to family support and specialist disability services in each area. (Reform Implementation Unit, DHHS)
>
> The services to be provided include:
>
> 1. A community intake point providing a visible entry point for vulnerable children, young people, people with a disability and families, through a 1800 contact number, email, SMS call-back facility and other emerging technology solutions;
> 2. Screening assessments of the needs/issues of the child, young person, family or person with a disability;
> 3. Determination of the appropriate service response to the client which will entail allocation to either an appropriate family service for a case management or other service, and/or a specialist disability service;
> 4. Provision of information and support or one-off crisis or episodic brief intervention;
> 5. Provide short term "active holding" where allocation cannot occur immediately in a way that ensures the continuing safety and wellbeing of the child, young person or person with a disability, with understanding that transition to more tailored services will occur very shortly;
> 6. Development of clear linkages and processes with other referral pathways/ services in the area and a collaborative process with Child Protection for referral from Child Protection to family services and vice versa; and
> 7. Maintenance of comprehensive information on all services potentially relevant to the client group, including eligibility and entitlements, referral points and processes. [12] (Reform Implementation Unit, DHHS, 2008)

Recent legislative changes

On the 1 August 2009 the following new provisions under the Act came into being, providing:

- the ability for prescribed persons (known as mandatory reporters) under section 14 of the Act to report concerns about the care of a child (within his or her family unit) to the new non-government Gateway Services (referred to in the Act as

[12] Reform Implementation Unit
www.dhhs.tas.gov.au/future_communities/reform_implementation_unit

Community Based Intake Services). This complements the ability to notify Child Protection Services when a child is at risk of significant harm;

- broader powers allowing the sharing of information relevant to the best interests of a child;
- the Secretary of the DHHS with the ability to receive information concerning unborn children to ensure effective planning is in place at the birth of the child; [this extends the mandatory duty of prescribed persons to report to include unborn children]
- greater options for permanent care arrangements in cases where the reunification of a child with their birth family is not an option; and
- for the creation of a Youth Detention Centre Residents' Advocate position within the Commissioner for Children's Office to assist in promoting the interests of young people in custody. (Disability, Child, Youth and Family Services, DHHS, 2009)

Conclusion

One of the most striking aspects of the historical account of the welfare legislation is how little the circumstances of a neglected child have changed since the Children's Charter 1918. The problem of neglect had been conceived as central to child 'ill-treatment' and child welfare from the earliest days of settlement in Australia until, with the discovery of the 'battered child' in the United States, the focus of attention rapidly turned to the matter of physical abuse, and then sexual abuse. Since then, the concept of physical abuse as an aspect of neglect can bee seen to have undergone an almost complete inversion, with neglect increasingly being conceptualised as a form of abuse in Australia and in other parts of the English-speaking world such as the United Kingdom, the United States and Canada.

According to Wolock and Horowitz (1984), the changing definitions and concepts of abuse and neglect can be seen to have occurred in conjunction with, and as a consequence of, the shift in approach from child welfare to child protection. The continuing increase in referrals and re-referrals of neglect cases has led to the belief that going back to the welfare approach is the only way to go. It is argued in this thesis and

elsewhere, however, that in light of the increase in knowledge about neglect and its detrimental effects, a combined and more unified approach is required, which has the capacity to take into account the complex and multi-disciplinary nature of the problem, including its causes and effects (e.g. Barnett, Manly & Cichetti 1993; Goddard & Tucci 2008).

This overview of the child protection system highlights the serial nature of child protection reforms within Tasmania, and throughout Australia, which tend to be instigated at times of crisis and are primarily concerned with systemic and management issues. Its similarity to the incident-driven basis of the response to the problem of neglect itself is remarkable – and points to the veracity of the observation that neglect exemplifies the aforementioned tensions and the failure to come to grips with the centrality of neglect in child protection (Parton 1995; Wolock & Horowitz 1984; Wilson & Horner 2005). At the very least, the management driven focus of such reforms inevitably gives rise to new or unforeseen problems. The continuing growth in the number of referrals, and the rate at which families are being re-referred, in relation to neglect and exposure to family violence (AIHW 2012, DHHS 2012), indicates a failure to adequately address the more complex underlying issues and the need for proven and effective support systems to be in place beforehand.

The preceding overview describes the shift in focus that has taken place, away from neglect and towards abuse, and the complete conceptual reversal from abuse as a form of neglect to neglect as a form of abuse. It is hypothesised here that conceptualising this less visible and less dramatic form of maltreatment as a type of abuse will ensure the ongoing neglect of neglect and the inadequate response it already receives in child protection systems, policies and practices. The issue of definition has serious ramifications for chronically neglected children, which have been brought to public attention in a number of reports – such as the *Little Children are Sacred* (Wild & Anderson 2007), *Fatally Flawed* (Sammut & O'Brien 2009) and the NSW Government's (2005) *Child Death Group Analysis* – and will be explored further in this thesis. However, the primary focus on sexual abuse rather than the overwhelming problem of chronic neglect in the *Little Children are Sacred* report exemplifies the ongoing neglect of neglect (see Flaherty & Goddard 2008).

The multiple problems in the child protection system that had wrought the changes outlined above had wide-ranging flow-on effects which permeated numerous aspects of the research, particularly in the data collection phase of the project. A more in-depth look at what was happening at the time provides a useful introduction and background for the following chapter, which will describe the methods involved in the incidence study.

CHAPTER 3

Study Context and Methods

> … Lack of good data on the extent and consequences of abuse and neglect has held back the development of appropriate responses in most parts of the world. Without good local data, it is also difficult to develop a proper awareness of child abuse and neglect … (World Health Organisation 2002: 78, cited in Liddell et al. 2006)

The previous chapters describe a range of definitional, practice and systemic issues which one way or another have an impact on the quality of the research on abuse and neglect. Given the somewhat turbulent times that the Tasmanian child protection system was facing during the period covered by the studies, the chapter begins with an overview of the changes and challenges that are likely to have had a bearing on the present research. The main purpose of this chapter is to describe the methods that were common to both studies and those that applied to each of the studies individually. The chapter ends with a description of the problems that were encountered during the data collection process and the procedures that were necessary to bring the data to the highest possible standard.

The Context

This research focuses on a period in the history of child protection in this country that was characterised by numerous inquiries, investigations and proposals which, one way or another, brought to light the overstretched and overstressed state of child protection systems across Australia (Liddell et al. 2006). Jacob and Fanning's (2006) *Report on Child Protection Services in Tasmania* revealed that the child protection system in place at that time was "not only overwhelmed and struggling to cope", it was "failing to ensure the safety and well being of children to the extent that would be expected by the Government and the wider community" (p. 3).

While the report on the Tasmanian system was certainly damning, the situation was not considered to be unique; according to Liddell et al. (2006), the problems depicted in Tasmania "could be a description with Australia-wide application" (p. 31). Even when the lack of comparability of child protection systems is taken into account, the fact that

Tasmania had the lowest rate of finalised initial investigations in the country suggests that the system was one of those least able to deal with the influx of notifications between 2004 and 2008. As the first point of contact, Intake Services would have borne the brunt of the overload, and since the primary source of information for the research was the notification records from that time, it stands to reason that this situation would have implications for the research process and for the study findings. As this overview and the following description of the research process show, the effects on a system that has been subjected to chronic neglect and stress are serious, pervasive and long-term.

With the extended mandatory reporting requirements in the new Act, the new centralised intake service system in 2003, new counting procedures and later the *Family Violence Act* (FVA 2004), the notification rate soared: numbers increased almost tenfold from 741 in the 2002–03 period to 7,248 in 2003–04 and then up again by 80% to 13, 029 in 2005–06 when the effects of the family violence legislation were more fully realised (AIHW 2007). In light of findings that repeat referrals indicate that the initial decisions, assessments and/or actions being taken are failing to address the needs of the children concerned (Forrester 2007), the high re-notification rate provided further evidence of dysfunction within the system at the time (Jacob & Fanning, 2006).

As the number of unallocated cases and the backlog of uncompleted notifications were continuing to grow, industrial action was continually being threatened and sometimes instigated by the "over worked and overwhelmed" staff (Jacob & Fanning 2006, p. 3).[13] Child protection workers were speaking out publicly at this time, concerned that even the most vulnerable children were not being protected. A report in the *Mercury* newspaper during this period stated that "newborn babies suffering drug withdrawals are among the record 1,648 cases of suspected child abuse or neglect not being investigated in Tasmania" and that there are "more than 30 newborn babies in the state's south on the struggling department's growing unallocated list" (Duncan, *Mercury*, 8 Sept. 2006, pp. 1, 4). Jacob and Fanning's (2006) report confirms that in May 2006, there were 1,486 'unallocated cases', 45 of which had a priority 1 rating, 1,206 were priority 2, and 235 had a priority 3 rating (p. 37).

[13] The industrial action taken by the workers in Tasmania was subsequently commended by researchers and writers in the field of child protection who suggested that workers are well-placed to "draw public attention to system inadequacies" (Liddell et al. 2006, *The State of Child Protection*, p. 31).

In terms of this research, with its focus on the initial investigation and assessment stage of the child protection process, the situation raises questions about the purpose of the risk assessments and how meaningful the priority classification system was during that time. The potential danger of such overwhelming workload pressures is the likelihood that it will engender a narrowing of workers perceptions, and departmental policy, about what exactly is and is not a child protection issue. It is fairly clear from the data revealed in the Report that thresholds for what constituted a child protection concern at that time would have to have been raised in order to attend to the most serious and imminent concerns. And for those cases that did manage to qualify for some form of intervention, some renegotiation of the priority level of the response would have been necessary. The relatively new risk assessment framework compounded the problems, in that it is a professional judgement tool that requires expertise; yet there was minimal training in place and the high staff turnover rate was leaving fewer experienced workers to carry out this task (Jacob & Fanning 2006).[14]

Jacob and Fanning (2006) note the growing lack of professional expertise among the staff; they acknowledge that a "high level of professional judgement ... is most likely to develop from extensive experience in the field as well as specific training" (p. 81). Whereas child protection workers were being directly recruited from various backgrounds at this time, with no requirement to have prior child protection experience; they were being trained on the job, with minimal induction or supervision in carrying out complex assessments (Jacob & Fanning 2006). One of the findings of the consultation process conducted by the Department was that practitioners perceived the model of operation at Intake Services to be repetitive and unsatisfying and a generally unattractive mode of work [Child and Family Services (CFS) 2005]. This was believed to have led to the high turnover rate and the tendency for the job to attract new recruits rather than experienced workers. It is not surprising, therefore, that the consultative investigation also found evidence of poor professional practice [Child and Family Services (CFS) 2005].

[14] In the Commissioner for Children's (2005) *Report on the Implementation of the Rights of the Child in Tasmania*, one staff member noted a turnover of 40% in the previous 9 months (YNOT & CCT 2005, p. 11).

The general ethos in the department throughout this period was reported to "result in an environment of prioritisation leading to a focus on young children who are perceived as most vulnerable"; with the unmet need in rural and isolated areas also rating a particular mention (YNOT & CCT[15] 2005, p. 11). Research confirms that workload pressures, resources and local systems have all been shown to have an influence on how the assessment task is interpreted in practice (Horwath 2005a, 2007). Given the body of research described previously which shows that neglect is more difficult to assess and less likely to be investigated than abuse, even in more optimal circumstances, the situation does not augur well for chronically neglected infants reported to child protection at this time.

Preliminary Procedures

Ethics and departmental approval

This research was undertaken as part of the Partners in Health (PIH) Research Scholarship Program. 'Partners in Health' is a collaborative partnership between the University of Tasmania and the Tasmanian Department of Health and Human Services (DHHS). A particular aim of the program was to enhance understandings of the health and wellbeing of those in their early years and/or those in their later years, with the ultimate objective of strengthening Tasmanian communities. As part of the research program, a senior officer in the Department was nominated to carry out a liaison and mentoring role to help facilitate the data collection process at Children and Family Services (CAFS).

A Social Sciences Full Application (for full committee approval) was submitted to the Human Research Ethics Committee (Tasmania) Network (HREC) – which conjointly administers the ethics approval process for the University of Tasmania and the Department of Health and Human Services – and full ethics approval for the research was granted (see Appendix B3.1). The Deputy Secretary of the Department of Human Services provided a letter of support for the project and consent for the researcher to access child protection case files, participate in training sessions and observe in the field.

[15] Youth Network of Tasmania and Commissioner for Children, Tasmania

The child protection training course, 'Beginning Practice', provided a useful opportunity for the researcher to become familiar with the general approach to child protection practice. The relatively extensive (22-month) data collection period provided a unique opportunity to gain a more in-depth understanding and knowledge of the child protection system, through first hand observation and experience through participation in case conferences, and in discussions with Managers, Child Protection Workers, Child Health Nurses, and Social Workers. Most of all, it presented an invaluable opportunity to observe the day-to-day business of child protection workers at Intake Services, as well as in the newly formed Response and Case Management sections, particularly as the changes in policy and practice were being implemented at during that period.

Confidentiality and privacy issues

Access to 'personal information' for the purposes of the research was provided in accordance with Clause 2, Sub-clause 1(c) in "Schedule 1 – Personal Information Protection Principles" of the *Personal Information Protection Act 2004* and in keeping with the object of the *Children, Young Persons and Their Families Act 1997* [Section 7, Clause 2 (j)]. The relevant Clauses 1 and 2 (i, j & l) of the CYPF Act state:

> (1) The object of this Act is to provide for the care and protection of children in a manner that maximises a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential.
>
> (2) The Minister must seek to further the object of this Act and, to that end, should endeavour –
>
> (i) to collect and publish relevant data or statistics or to assist in their collection or publication; and
>
> (j) to promote, encourage and undertake research into child abuse and neglect; and
>
> (l) generally to do such other things which the Minister believes will further the object of this Act. [Section 7, Clauses 1 & 2 (i, j, l), CYPF Act 1997]

The data were collected from the Children and Family Services section of the Department of Health and Human Services between September 2007 and August 2009. In order to maintain confidentiality and protect the privacy of the information, the data undergoing quantitative analysis were de-identified and extracted onto spreadsheets, and a thorough de-identification process was carried out for the smaller dataset undergoing

qualitative analysis in Study Two. The data were then stored electronically on a password protected computer. An assurance was given that no identifying information would be used in the thesis or in any published form. The only people (other than the researcher) who had access to the de-identified data were the supervisors of the research.

Data sources

The main sources of data that were used for Study One and Study Two were notifications of abuse and neglect made in relation to the 'subject infants' and their siblings during the period covered by the studies. However, notifications were reported, recorded, and stored in a number of different ways during that time. All notifications made to the Department during the study period were stored in hard-copy case files held in the relevant service centre for each child protection region. From 1998 onwards, though, notification and enquiry reports were produced and stored electronically, as follows:

1. All concerns reported across the state between 1998 and July 2003 were recorded as either 'notifications' requiring further investigation or 'Child and Family Concerns' (consultations) and stored on a separate electronic database. Notification reports from this period followed different formats, including an interim notification form that was used while the new TRF guided risk assessment format were being introduced. These did not follow the same guided risk assessment process as those used subsequently.
2. All notifications made between July 2003 and February 2008 were held on a separate central database covering the four regions of the State, which was established to coincide with the implementation of the Tasmanian Risk Framework (TRF). Two different notification report formats were used during the first year of establishment of the new database and the TRF, before the new TRF report format was introduced. The various report formats for this period are described in chronological order as follows:
    a) The notification form from the previous period (before July 2003) continued in use as an interim measure for approximately six months until the end of December 2003. A brief risk assessment guide was included in notifications

requiring further investigation. The lack of consistency with the assessment process used in the latter part of 2003 meant that notification data from this period could not be used for the purposes of the statistical analysis in Study One. Information from these records was only collected for, and relevant to, some of the families who were part of the small sample of cases involved in Study Two.

b) A temporary guided risk assessment report form gradually replaced those described above over a 5-6 month period (approximately) starting in November 2003 before the introduction of the new report forms in June 2004.[16] These notification report forms did follow the new risk assessment framework and were able to be used in both studies.

c) From June 2004 onwards the newly designed Tasmanian Risk Framework (TRF) notification pro forma included two different versions for two different classes of notification – both of which are counted as notifications. One is an abbreviated version, called an 'Amended Notification Form' – which includes a brief risk assessment under the heading 'Safety Statement and Recommendation' – for notifications concluded at 'Intake' (previously known as CPAARS) without further investigation outside the Department. The other is a 'Notification Report' form which includes the full guided Risk Assessment procedure for cases requiring more extensive investigation and possible further assessment. These notification records provided the main sources of data being analysed for both studies. (An example of the 'Notification Report' form is provided in Appendix B3.2.)

3. With the implementation of the new Child Protection Information System (CPIS) in February 2008, the TRF assessment format just described underwent some modifications to meet the needs of the new interactive communication system (see Appendix B3.3). While the modified form was essentially the same in terms of the risk assessment procedure it followed, it provided a much more extensive (if somewhat repetitious) record of the history of the investigation, and the communications and assessment procedures that were carried. The other important change to come in with the new information system was that notifications were

[16] There were some serious problems to do with accessing the data on many of these notification records, which are described in the issues section.

recorded on a per-child basis, rather than on a family basis as was previously the case. These notification records were a source of information that was collected for the sample of cases being investigated in Study Two.

Additional sources

Additional information for Study Two such as assessment reports and case notes were available on the information system between February 2008 and July 2009 and/or hard copy case files. Information relating to the child death cases, such as reports of inquiries into the death of a child and/or reports of Coroner's findings were sourced from case files or, in the case of subsequent or more recent findings, from publicly available Coroners' records of investigation on the Tasmanian Magistrate's Court website.[17]

Child protection data: Advantages and disadvantages

The use of case records for research generally is known to have certain limitations – such as inconsistent use of definitions, bias or distortion involved in interpretation, inconsistent reporting styles, and incorrect or conflicting factual information – however, their usefulness more than compensates for their disadvantages, and many of the limitations can be overcome where necessary (Black & Dubowitz 1999; Zuravin 2001). While the matter of having to rely on child protection service classifications of neglect and emotional abuse is problematic in some ways, the fact that one of the objectives of Study One was to explore the child protection response to notifications of abuse and neglect justifies the use of CP classifications. Although it would have been preferable to establish *a priori* definitions for the purposes of establishing more realistic 'incidence' levels, the timeframes for the research did not permit it.

However, one of the primary aims of the research, and one of the main purposes of Study Two, was to develop operational definitions of neglect that can be applied to child protection records for research purposes, and the case files provide a wonderful source of information to help meet that aim. Thorpe (1994), for example, argues that case files are a source of data that "tells a story, delivers a chronicle" (p. 43) – and not just about child protection practice, but about the day-to-day experiences of children.

[17] Coroners' records of investigations are available at: http://www.magistratescourt.tas.gov.au/decisions/coronial_numeric_index

Child protection records provide an existing electronic record of a notification of abuse or neglect, which (theoretically) includes pre-recorded demographic and other information: date of birth (or age), sex, and place of residence of each child covered by the notification and the parent(s); a summary profile of other family members or other informal network details and any formal professional involvement; the child protection region; date and source of the notification; type of alleged abuse and/or neglect under Section 3 of the Act; the relevant risk classification in accordance Section 4 of the Act; the outcome of the assessment and a priority classification (where applicable).

Notifications are also an existing record of the circumstances and maltreatment experience for the child over time and practitioners' assessments of these within the terms and conditions set out in the policy and legislative guidelines. They contain, or should contain, vital information such as previous notification history, a detailed record of the notifier's concerns (usually) from the point of view of the notifier; any relevant case note records of additional information gathered during the investigation and of the worker's assessment of that information; and a rationale for the final decision. The inbuilt record of the structured risk assessment guidelines and procedures are a source of invaluable insight into how workers understand, assess and respond to the concerns being reported.

Overview of initial procedures

The data were collected from the Child Protection Services unit of the Department of Health and Human Services between September 2007 and August 2009. Due to the interesting challenges that the data collection process presented, a more detailed account of the identification, tracking and checking procedures that were carried out to ensure the integrity and validity of the data is provided in the section on 'collection procedures' and 'data collection issues' below. The following provides a general overview of the procedures that were followed during the data collection phase:

1. A handout was distributed to child protection staff which provided a brief outline of the proposed research, information relating to ethical approval and Departmental authorisation, assurances relating to confidentiality and privacy issues, and contact details for any queries or concerns.

2. A preliminary reading of a small selection of case files was carried out to ascertain the most appropriate sources of information for the purposes of the study.

3. The database containing all notifications of abuse and/or neglect between July 2003 and February 2008 across two out of four regions of the State of Tasmania was examined. All notifications made in relation to the Subject Infants in the 2005 calendar year were identified and collected manually from the CP database (rather than by electronic means).

4. Any siblings of the Subject Group were also identified, and all notifications made in relation to the subject children and/or their co-residing siblings between July 2003 and February 2008 were tracked down and collected manually.

5. All notifications relating to the two additional families included in the Study Two child sub-sample of child death cases, who did not meet the selection criteria for the Study One sample, were also collected at this time.

6. A coding system was set up during the collection process which was used for identifying and case-tracking purposes once the data were extracted and/or de-identified.

7. Systematic checking and updating procedures were undertaken to ensure the integrity and validity of the notification dataset. Additional and/or missing information was collected from the earlier database (1998-2003), hard-copy case files and the Child Protection Information System (CPIS – from Feb. 2008 onwards) and added to the relevant notification report form.

8. Once the dataset was finalised, de-identified and/or coded data were then extracted from the files onto Excel spreadsheets on the researcher's password-protected computer for quantitative analysis.

9. Additional or missing information was simultaneously being collected for the purposes of Study Two, which was sourced from historical records collected from the earlier database (1998-2003), hard-copy case files and from the Child Protection Information System (CPIS), and secondary investigation and risk assessment case files. (A more detailed account of the procedures for this study is provided in the procedures section for Study Two below.)

10. The coding system was modified to meet the different requirements of the Study Two sample. The coding system was used to carry out a complete de-identification process for all notification data and documentation which pertained to the Study Two sample. All identifying information was removed to ensure the anonymity of all children, parents, individuals, groups, institutions and place names. Any demographic and other data undergoing quantitative analysis were extracted onto the data abstraction instrument and/or Excel Spreadsheets. The de-identified datasets were stored on a password protected computer.

Study One Methods

Aims and objectives

The overall aim of Study One was to investigate the rate and the general pattern of referral of neglect and abuse for infants (<48 months) in an Australian context. The main objectives of the study were to investigate –

1. the 'incidence', or notification rate, of abuse and neglect for infants (< 48 months) notified to child protection services in the 2005 calendar year in two rural and urban regions of Tasmania;
2. the general pattern of referral and response for the 0–4 age group notified during the 2005 calendar year in rural and urban Tasmania; and
3. the pattern of referral for the infants and their sibling family groups over a period of four years

Study One Design

A single-method design, with cross-sectional and longitudinal elements, was chosen to investigate the annual rate and the general pattern of referral of neglect and abuse relating to infants (<48 months) over time. The main datasets undergoing analysis were extracted from (a) a complete set of notifications made in relation to a sample of all 'subject infants' (SIs) in the 2005 calendar year, and then (b) a set of all notifications for the subject infants and their co-residing siblings going backwards one year and then

forwards through the 4-year period from 2004 to 2008. The sampling procedures are described below.

Design aims

A complete (100%) sample of cases for quantitative analysis was selected in order to address the current lack of child protection data relating to the 'incidence' of abuse and neglect in the 0–4 age group in either a Tasmanian or an Australian context. A complete sample of this size had the added advantage of being large enough to allow further exploration of relationships and differences between the data variables undergoing analysis. The research design was also employed to help overcome the limitations imposed by the relatively narrow timeframe covered by the notification database, the restricted age range of the subject group of infants, and the restricted period of time in which a consistent guided risk assessment (TRF) report format was in use (see data sources below). Notification records have a longitudinal aspect inherent in them, in that they contain historical information about the child and about the family from previous notification history; therefore, including notification reports for co-residing siblings within a longitudinal design allows even greater access to current and historical demographic and other information which may otherwise be unavailable.

The longitudinal aspect of the design best fits the purposes of exploring the issues of chronicity, repeat referrals, and the relationship between neglect and other types of maltreatment over time. Tracking sibling groups through time allows for a more holistic exploration of the maltreatment experience and a more holistic picture of the families in which the problem occurs – or from a departmental perspective, the families that are "adding to the overload and system dysfunction and [who] must be a focus for attention" (Jacob & Fanning 2006:61).

Subject groups, datasets, and procedures

Sample selection

The sample of infants <48 months and their sibling family groups were selected from the child protection population in two child protection regions in Tasmania, which encompass approximately half of the State and include both urban and rural areas (49.2

percent of total population of Tasmania)[18]. The primary objective was to collate some child protection data for this most vulnerable group within the child protection population, and to explore any relationships and differences found in the pattern of referral and response to these abuse and neglect concerns.

The 'subject infants' (SIs)[19] were selected on the basis of being less than 48 months of age at the time they were first notified to Child Protection Services in relation to abuse and neglect in the 2005 calendar year. The 'subject infants' (SIs) includes *all* children less than 48 months of age in each family at the time the notification was made, in order to establish per-child notification rates for all SIs in the child protection population. The family groupings of subject infants are referred to as the Infant Family Group (IFG). The primary dataset for quantitative analysis was extracted from the set of all notification reports made in relation to the Subject Infants in the 2005 calendar year.

A second dataset was based on all co-residing siblings less than 17 years of age (including the SIs) in the subject infant group of families – referred to as the Subject Family Group (SFG) – in order to provide a picture of the family as a whole. The Subject Family Group sample included all co-residing Subject Infants and older siblings (< 17 years) who were in the primary care of the SIs' primary caregiver(s).

The data for analysis

Data were collated and/or extracted from the dataset of notifications collected and processed as described above, and then entered onto Excel spreadsheets. Separate datasets, or databases, were created for the analysis of information for each SI notified in 2005, for each notification record in 2005, for each Subject Infant Group (SIG), and for every Subject Family Group (SFG) from 1 January 2004 through to 1 January 2008. The first two sets of data for quantitative analysis were collated from the 1,305 notification records for the Subject Infants who were notified to the Department in the 2005 calendar year. The SFG dataset summarised information concerning the number of notifications recorded for the SG and/or their siblings throughout the 4-year period from the beginning of 2004 to the end of 2007. There were 11 infants in the SG who were

[18] That is: 234,872 of a total population of 477,646 in 2006 (ABS).
[19] The term 'infants' will sometimes be used to denote both infants and toddlers within the 0-4 age range.

unable to be identified, and these were not included in the analyses for the 588 identified families (SFG).

Reliability and validity

In light of the multiple problems and errors, identified below, which were inherent in the data itself and in the filing and storage systems in place at the time, the data were identified, collected and extracted manually, rather than electronically, in order to enhanced the validity and reliability of the variables being measured. In order to further ensure that the measures were valid, systematic checking and updating procedures were a substantial part of the data collection and initial analysis processes.

There were some major policy and practice changes implemented during the period covered by the research that would have affected the reliability of the data. The introduction of the Family Violence legislation in March 2005 was accompanied by a sudden and steep rise in the number of reports which the workforce was unable to adequately deal with. As outlined above, new risk assessment framework and guidelines were in the process of being implemented, and two different report formats were being used to record the notifications during the first six months of 2004, which would have had a negative impact on the consistency of the initial assessment of the notifications that were carried out at the time.

On the positive side, the new legislation had already undergone a relatively long implementation period since its introduction in 2000, and the database from which the data were collected covers the entire period that the centralised intake service system (CPAARS) and the new and consistent counting procedures were in place. Apart from the initial implementation period, with the two different report formats in use in the first six months, the new risk assessment guidelines and procedures (under the TRF) and the new report format were in consistent use from June 2004 onwards. Despite the many problems and their ramifications discussed in this chapter and elsewhere, a relatively consistent policy framework was in use throughout the timeframe of the study. It is hoped that the 100% sample covering two of the four regions can make a useful contribution to the existing child protection data in this state.

Initial exploration and update

The data collection involved, firstly, identifying the subject group of infants and any co-residing siblings, and 'tracking down' all notifications on the database pertaining to them. It proved to be an unexpectedly time consuming and challenging task, which profoundly affected the progress of the data collection and necessitated ongoing checking and updating procedures. (The many challenges presented by the state of the files and the database filing system are set out in more detail later.) The system for recording and filing notification records at that time was such that all notifications are recorded in alphabetical order under the last name(s) of the children being reported. And at that time, theoretically, all of the children in one family – that is, all children known by the notifier – were included on a single notification. However, in the relatively common circumstance that the children in the family may be known by more than one last name and/or have different names from their siblings, the notification may (or may not) be recorded again under an alternate name or another child's name, which, in turn, may (or may not) include the alternative names under which each child may be known.

This was just one aspect of one of many problems that affected the collection process, but it is sufficient at this point to note that the naming issues and errors and inconsistent work practices necessitated ongoing checking and updating procedures to ascertain that all possible naming options and locations had been checked and that only one copy of the notification was finally included.

Data checking and collection updates

After the initial collection was finalised, the following checks and updates were carried out:

- A systematic recheck of the notification records collected in the initial stages was carried out to ensure integrity, because of the idiosyncrasies of the CP database filing 'system', which at that time the researcher was still in the process of mastering.
- Missing data recorded on some of the fdf electronic notification forms used between November 2003 and June 2004, which hitherto had not been accessible, was accessed and transposed onto Word documents.

- Data that was not yet existent at the beginning of the collection period (September 2007 – February 2008) was retrieved to complete the dataset.

Initial examination and quality check

A final quality check of the dataset was carried out and the dataset was collated into a suitable form for data to be extracted for the initial quantitative analysis, as follows:

- Because of the naming issues, all files in the dataset were renamed for the purposes of improving integrity and consistency and chronologically ordering the data. This occurred in 2 stages:
  - Partial renaming of the files was carried out during the collection phase by gathering together the notifications for infants and children (listed under different family names) and filing them together in sibling groups under the name of the subject child.
  - Further re-formatting of the file name was carried out to provide easier and less time-consuming data cleansing and error checking procedures, and to present a clearer picture of events over time.
- A systematic check of the dataset was carried out as follows:
  - Any duplicated records of a single notification were identified and excluded (e.g. notification records were often duplicated due to the nature of the electronic filing system, or as a result of worker error, or because of a re-assessment process which resulted in some further investigation and a different classification being assigned to the case);
  - information errors in file names were identified and corrected;
  - missing notifications identified in subsequent notifications were located;
  - missing, incorrect, or questionable demographic or other information was identified and corrected; (Due to work overload and a growing backlog of notifications waiting to be written up at the time, workers were permitted to file incomplete records in many instances.)
  - any relevant information from separate ‘Enquiry’ or ‘Action’ records was transposed onto the related notification.

Finalising the dataset

Incomplete notification data were included as long as the following information was either provided or locatable: the notification date, the name and/or age of the child, and the alleged maltreatment type. Data relating to unknown children in the subject age group were included in the initial quantitative analysis but not for the longitudinal part of the study at the family level. In instances where notifications were duplicated as a result of undergoing further investigation and/or re-assessment and classification, the final version only was included.

Quantitative analysis

Successive datasets, or databases, were created – data were collated and/or extracted from the dataset of notifications collected and processed as described above, and then entered onto Excel spreadsheets. The spreadsheets were subsequently imported into SPSS and R statistical programs. Ongoing problems with the licensing arrangements precluded subsequent use of the SPSS program and necessitated use of the R program instead. Technical advice and assistance with the statistical analysis was provided from within the University of Tasmania's Department of Mathematics.

Data abstraction

The following information was extracted and collated for the initial quantitative analysis:

- Family code; Subject Infant code; older sibling code;
- Date of each notification(s) per 'subject infant' in 2005 calendar;
- Month and year of birth; sex of Subject Infant(s);
- Primary and secondary maltreatment classifications per 2005 notification;
- Child Protection response classification and priority level per 2005 notification;
- Postcode and rural/urban status in 2005;
- Source of the notification, and mandatory status of notifier;
- Number of co-residing siblings over time (2004–2008);
- Number of recorded notifications per family during each time period: 2004 (T-1), 2005, (T1), 2006 (T2), 2007 (T3).

Data analysis

The following descriptive and statistical analyses were carried out:

1. Notification rate or 'incidence' of abuse and neglect in the 0–4 age group in the 2005 calendar year; and re-notification rate in 2005 calendar year;
2. Average notification rate for sibling family groups in the 2005 calendar year, by number and age of children being referred;
3. Referral and re-referral pattern of notifications made in relation to the above families within the entire sample period (January 2004 to January 2008), pre-2005, and post-2005; relationship between number of notifications and number of children in family;
4. Primary, secondary and combined maltreatment types notified for the SIs; and comparison with general child protection population;
5. Maltreatment type by age group (0–1; 1–2; 2–3; 3–4 years) in 2005 calendar year; statistical differences between groups; gender differences;
6. Notification rates in rural and urban areas; rural-urban differences;
7. Socio-Economic Indexes for Areas (SEIFA) relative socio-economic disadvantage scores and rankings in urban and rural areas;
8. Notification priority classifications: child protection response for each maltreatment type; exploration of differences
9. Source of notifications; maltreatment type; and rural/urban comparisons
10. Total number of reports made in relation to unborn children per calendar year from 2005 to 2007 (inclusive)

Defining 'rural' and 'urban'

Geographical classifications such as 'Rural Remote and Metropolitan Areas' (RRMA), Accessibility/Remoteness Index of Australia (ARIA) and, more recently, ARIA+ are currently used throughout Australia to measure accessibility to services for rural health funding programs and in rural health research. The remoteness measures for all of these systems are based on combinations and variations among population size and density and distance from the nearest service centre or urban area. The Australian Institute of

Health and Welfare's (2004) *Rural, Regional and Remote Health* guide to the various classification system sets out the limitations of using the remoteness classifications.

According to the Guide, remoteness classifications "only indicate relative levels of accessibility to goods and services", whereas several variables other than remoteness may be pertinent to health issues – for example, there have been findings showing a strong relationship between population size and availability of health services (DHAC & GISCA 2001, cited in AIHW 2004b, p. 20). Furthermore, "remoteness is not intended to be a 'stand alone' indicator of advantage or disadvantage" (ABS 2003, in AIHW 2004b, p. 21). All three geographic classifications are said to be most valid for large geographic areas and may be misleading for smaller areas – and under the RRMA classification, rural classifications are based on remoteness measures.

Tasmania is unique among the states in Australia in that it covers a relatively small geographical area and has a relatively small population. Only a minor proportion of Tasmania comes within the remote categories of any of the classification systems. In the RRMA system, everywhere except the capital city of Hobart and the small more remote regions is classified as rural. With one of the aims of the study being to explore rural/urban differences, rather than remoteness per se – and given the issues relating to the use of the RRMA system for Tasmania anyway – a more appropriate method of defining rurality was established for the specific purposes of the study. The two classifications of rural and urban (or non-rural) were deemed to be sufficient for comparison purposes. The classifications are based on the Australian Bureau of Statistics (2008) 2006 census of population and housing in its social atlas of the capital city of Hobart and the large urban centres of Launceston and Burnie-Devonport.

Definition. The term 'rural' is used to describe all areas outside the three main urban centres in the state; that is, any area outside the capital city of Hobart in the South, Launceston in the North, and Burnie-Devonport in the North-West. Conversely, the term 'urban' is used to describe all areas defined as such within the Australian Bureau of Statistics (2008) social atlas of Hobart (including Launceston and Burnie-Devonport).

Study Two Methods

Aims and objectives

The dual and inter-connected aims of Study Two were to gain a better understanding of the nature of neglect experience in infancy and early childhood and to further develop conceptual and operational definitions of the problem into a practical classification and measurement system for early childhood neglect. A secondary or ancillary purpose was to demonstrate and evaluate the capacity of the system to identify the individual sub-types of neglect in order to provide a better method of measuring of the overall level of severity and chronicity, or level of risk, being experienced by infants and toddlers.

The main objectives of Study Two were to –

1. develop a classification and measurement system for the research, which provides conceptually sound operational definitions of neglect in infancy and early childhood that can be applied across the domains of research, practice and policy;
2. explore the nature of neglect in the early developmental period from before birth through infancy and early childhood (< 48 months of age) – in terms of unmet basic care and developmental needs – and identify any specific unmet needs relating to cases in which infants or young children have died;
3. clarify the definitional issues that are currently impeding effective research, policy and practice;

Study Two design

A mixed method retrospective longitudinal design was employed to meet the concurrent aims of the study outlined above. Quantitative and qualitative analyses were carried out on notification data relating to a purposively selected sample of infants and their siblings from the same child protection population as the previous study. The sample was selected on the basis of a referent infant who died or who suffered serious harm in neglect-related or preventable circumstances. A classification and/or coding system within the data abstraction tool was developed for the purpose of quantitatively and qualitatively analysing the data.

The small size of the sample (i.e. 39 Subject Infants from 14 families) used in the study, together with the fact that it was not randomly selected, place constraints on making inferences from the analytical procedures that are carried out. However, it had the overall advantages of providing a rich source of information about this age group and allowing a more in-depth and thorough content analysis of the data.

The Negative Outcome Sample (NOS)

The Negative Outcome Sample (NOS) was selected to best meet the two distinct but inter-related aims of the research: first, to develop the conceptual framework and operational definitions for the research, and second, to explore the nature of neglect in families where neglect was known to have occurred insofar as it had contributed to or caused identifiable harm. The sample consists of two sub-samples of seven families each from the same child protection region as the subject group of infants in the prevalence study (Study 1). The group of infants and very young children (N=39) who are the subject of investigation for the current study, referred to as the Subject Infant Group (SIG), consists of all children in the subject group of families in the Negative Outcome Sample (NOS) who were less than 48 months of age in 2005 and any siblings subsequently born between 2005 and 2009.

Sub-sample 1 (NOS-S1) is based on a group of 7 referent Subject Infants (< 48 months) residing in families previously known to child protection who died in circumstances that involved neglect and/or were considered preventable. Sub-sample 2 (NOS-S2) is based on a group of 11 referent Subject Infants (n=11) identified as having suffered a range of harmful outcomes and sub-types of neglect. The selection of cases in Sub-sample 2 on the basis of harmful child outcomes was undertaken to reflect the fact that the children who are the subjects of the current investigation can legally be considered to have been neglected and/or abused, or 'at risk' thereof, and in need of care and protection under the Act. The latter grounds for selection are in line with those proposed by Dubowitz, Pitts et al. (2005) in their study on defining neglect based on child protection notification data. The referent SIs in Sub-sample 2 were also selected on the basis of providing as wide a range of the various sub-types of neglect as possible to take into

account its heterogeneity and to allow a more thorough exploration of its nature and inter-relationships with other forms of maltreatment.

It is worth noting, though, that the majority of the cases were not unique among the families within the child protection population under investigation in Study One. In fact, in terms of the type of neglect being experienced by the subject children, many of the cases exemplified a large proportion of the cases identified in the process of collecting the data for Study One. However, the selection of Sub-sample 2 was restricted by the availability of information relating to the child outcomes.

The New South Wales Department of Community Services (DOCS) policy on neglect alluded to "the sometimes fatal consequences of neglect, and the disturbing fact that the characteristics of families in which neglect-related deaths occur are not distinguishable from the characteristics of families in which neglect is chronic" (DOCS 2006, p. 9). Although cases in which child deaths occur are at the extreme end in terms of the severity of the outcomes, Study Two will explore the question of whether the families in which neglect-related harm has occurred and the families in which neglect-related deaths have occurred display any differences in the different pattern of neglect experienced by the infants.

It is increasingly being argued that since neglect in the early phases of child development is a continuous phenomenon, with effects that are both immediate and ongoing, all neglect in this age group should be considered 'chronic' (e.g. De Bellis 2005; Dubowitz, Newton et al. 2005; Perry 2001). Cases in which neglect is known to have had serious harmful outcomes provide an opportunity for an in-depth exploration of the nature of chronic neglect in a range of forms and outcomes for the subject children within the families in this particular population sample.

Sub-sample 1

Sub-sample 1 (NOS-S1) consists of seven families (n=7) previously known to child protection who suffered the loss, through death, of an infant or very young child between 2005 and 2009, and the child's death was subject to police investigation or

coronial enquiry as a result of concerns relating to neglect and/or abuse, or where there was evidence of parental 'risk factors'. By the end of the study period there were a total of 21 Subject Infants, including the seven referent Subject Infants, in Sub-sample 1.

Two of the families in S-S1 were not part of the original Subject Infant Family Group described in Study 1 as the subject infants were not notified to the Department in Tasmania in 2005. Although these 2 families were not actually notified in this state until 2006, one of the reports outlines serious child protection concerns relating to the two young children (< 24 mos) in the family, who were being exposed to extreme violence (including the father's suicide) and parental drug use during 2005, but who were living in another state at the time. However, no enquiries were made to the corresponding department in that state to establish whether or not there was any child protection history for the family. The other subject infant, who was living in a rural area at the time, was also exposed to a number of family violence incidents in 2005 but they were not reported as legally required. Both families were well known to the Department prior to the infants' deaths.

Three of the seven deaths were classified as either 'sudden infant death syndrome' (SIDS) or 'sudden unexplained death of an infant' (SUDI).[20] Current categorical descriptions of causes of neonatal and paediatric deaths in Australia do not include child neglect; although abuse is included. However, the reported existence of risk factors being present at the time in all three cases and suggestions that their deaths may have been prevented are regarded as being reason enough to explore the nature of neglect in relation to them.[21] The Coroner's report on the death of one of the infants, for example, includes the following explanatory statement relating to the findings that the infant's death should be categorised as a sudden unexpected death in infancy (SUDI) while co-sleeping with an adult:

[20] "The term *Sudden Unexplained Death of an Infant* (SUDI) is now often used instead of *Sudden Infant Death Syndrome* (SIDS) because some coroners prefer to use the term 'undetermined' for a death previously considered to be SIDS." (COPMM 2011). There appears to be some variation in understandings of what the acronym 'SUDI' stands for, with some professionals interpreting the term as 'sudden unexpected death in infancy'.

[21] See the Council of Obstetric and Paediatric Mortality and Morbidity Annual reports (COPMM 2005, 2006: DHHS 2007, 2009), available at: www.dhhs.tas.gov.au ; and the Coroners' records of investigations, available at: http://www.magistratescourt.tas.gov.au/decisions/coronial_numeric_index

> It is not possible, within the current state of medical science, to distinguish death due to the sudden infant death syndrome (SIDS) and suffocation due to compression by an overlaying adult. SIDS is defined as, the sudden death of an infant under one year of age which remains unexplained after thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. The autopsy findings in cases of SIDS are variable and non-specific. Petechiae are frequently present on the thymus, pleura and pericardium but neither their presence nor absence confirms or precludes the diagnosis of SIDS. Most recent studies suggest that co-sleeping, or placing an infant in an adult bed, is a potentially dangerous practice. (Forensic pathologist's report)

The final outcomes of the police inquiries into the circumstances surrounding the deaths in the three cases involving abuse and/or neglect were unknown because the cases remained unresolved, or not finalised, and/or there was no further information available at the time the data was collected.

Sub-sample 2

Sub-sample 2 (NOS-S2) consists of seven purposively selected families (n=7) from the original Subject Family Group in Study One, which by the end of the study period included 18 Subject Infants (n=18). The families were selected on the following grounds:

1. that one or more of the Subject Infants were professionally diagnosed or assessed as having suffered identifiable harm to their physical or psychological development and/or wellbeing;
2. that a range of different types of neglect, harm and/or risk factors characteristically found in the 0–4 age group are represented in the sample – including cases involving abuse;
3. that they include at least one notification and/or risk assessment carried out in the latter part of the study period (2007-09), by which time the system and policy changes had been more fully implemented and child protection practitioners had a chance to become familiarised with the new framework for protecting children (as described in Chapter Two).

The decision to include all infants under 48 months of age in each family, rather than choosing one subject child per family, was based on research findings that the neglect experience of siblings tends to be similar to experience (Hines, KaufmanKantor & Holt 2006), and it was considered to provide a number of benefits. Firstly, because for most

of the study period notifications for more than one child were usually recorded as a group in a single notification – notifications were recorded on a per-child basis when the new system was implemented in early 2008. Secondly, and more importantly, it provided a greater opportunity to explore the full extent of both the neglect experience and the harmful outcomes for any or all subject infants within the family. Thirdly, it allowed access to what was regarded as highly important historical information which was able to contribute to understandings of the nature of neglect and how best to define it.

The decision to make the number of cases in the two sub-samples equal was primarily for the sake of balance and what was deemed to be practicable in the timeframe – considering the substantial number of notifications (209) that were subject of analysis. However, the amount information provided in the notifications about the children's development and general health and wellbeing was remarkable for its absence. While there was quite detailed information provided about physical signs of abuse and neglect, such as cuts and bruising, or issues such as the children being unwashed or suffering from head lice, language and cognitive developmental problems in particular were rarely enquired about or reported except obliquely, such as when a child reaches school age, in terms of reference to their special needs teacher or speech therapy appointments. Developmental problems such as cognitive, language and other socio-emotional issues other than behavioural problems were rarely reported or even regarded as a child protection concern.

Supplementary sample

A supplementary sample of 25 cases was selected for in-depth examination by the researcher for the purpose of gaining a solid understanding of the issues to meet the aims and objectives of Study 2. This was carried out in order to consolidate and add to understandings gleaned during the initial examination of the data and the processes of identifying the children and their families and extracting the quantitative data for Study One. The sample of 25 families was randomly selected from the original Infant Family Group in Study 1 who had been notified to the Department on more than two occasions throughout the four-year period and who had at least one notification in 2005 which had been given either a primary or secondary classification of neglect. An in-depth reading

of all notifications made in relation to those families throughout the period and beyond was carried out during the extensive data collection phase of the research at Child and Family Services.

The Subject Infants

The subject group of infants consisted of 25 male and 14 female infants and toddlers who were aged between zero days[22] and 38 months at the time of their first notification to the Tasmanian Child Protection Service. The SIG is comprised of the following:

1. all 'Subject Infants' (n=22) in the 12 families who were selected from the original Infant Family Group in Study 1 – that is, they were notified to the Department in 2005 and were under the age of 48 months at the time (as above).
2. all infants (n=4) in the two families in Sub-sample 1 (the sample of child death cases) who were not in the original group of Subject Infants in Study 1 – that is they were not notified to the Department in Tasmania in 2005 – but who were less than 48 months old when they were first notified in 2006;
3. all younger siblings (n=13) of the children identified above who were subsequently born into the subject group of families between 2005 and 2009.

The data

The primary dataset for analysis consisted of the set of de-identified notifications of abuse and neglect (N=209) made to the Department between mid-2003 and mid-2009 in relation to the purposively selected sample of 14 families (the Negative Outcome Sample) described above. The changeover to the new integrated Child Protection Information System early in 2008 allowed some additional information relating to the secondary risk assessment process to be collected for six of the families who were subject to further investigation during that period; the secondary Risk Assessment records were collected and de-identified. Additional information regarding the seven

[22] Subsequent changes to the legislation have meant that reports relating to unborn children, which were previously not covered by the Act and were classified as unborn 'enquiries', are now treated as notified concerns, and are treated as such in the present study, although they were not considered to be notifications at the time.

cases of child deaths was collected from the case files and the Coroner's reports of investigations into the deaths of three of the infants.[23]

Data collection procedures

All notifications made to the Department between July 2003 and July 2009 in relation to all of the co-residing siblings of the Subject Group of Families (N=14), and 2 notifications relating to the Subject Infants which were made prior to July 2003; secondary Risk Assessment reports and/or case notes available on the information system between 2008 and 2009, were collected electronically from the child protection database and the new Child protection Information System (CPIS) at the Child and Family Services section of the Department of Health and Human Services. The two families who were not part of the original SFG in Study 1 were identified in the process of collecting the data for that study, and all notifications (2006-2009) and Secondary Risk Assessments (from the 2008-09 period) relating to the family were collected at the same time.

A thorough de-identification process was undertaken for the entire dataset to ensure the anonymity of all individuals, groups, institutions and place names. The difficulties associated with the recorded information – such as the divergent spelling of both first and last names and the numerous names under which a child in any one family might appear – necessitated a thorough reading of the files to ensure that the entire range of possible variations would be accounted for in the process. All identifying information was removed and replaced with a code for case tracking and data collection purposes. Demographic and other identifying information was extracted from the files directly onto the data abstraction tool and/or Excel spreadsheets for quantitative analysis.

The family codes for the 12 families from the original Subject Family Group in Study 1 were retained, in a modified form, and new codes were provided for the two families who were not included in the original sample population. However, because the subject group of infants in the present study differs from the original subject group, in that it includes all infants born since that time up until the end of 2008, a new coding system

[23] Coroners' records of the investigations are available at: http://www.magistratescourt.tas.gov.au/decisions/coronial_numeric_index

for the Subject Infants in the family was applied, whereby SIC1 would refer to the eldest child in the subject infant group and SIC2, SIC3 and so on refers to subsequent/younger infants the family. Individuals and professional groups such as child protection workers, police, social workers and support workers, teachers, medical practitioners, family members and so on were also assigned distinctive codes for analytical purposes.

Because of the sensitive nature of the information, minor details have not been revealed or have been changed in order to further protect privacy – for example, in cases in which an infant has died, the infants and their families are discussed as a group as much as possible, some potentially identifying information such as the sex of the child, the exact age at time of death and specific information such as the year during which particular events occurred are not provided in discussions of individual families. The children's ages are provided only to show the age at which they were first notified; details about the sex of the children are provided in a group situation; and age and sex of children may be changed for case study purposes. It is worth noting, however, that at least three of the child death cases – one baby whose death was determined to be 'unexplained' and two cases involving non-accidental or suspicious injuries – have been the subject of media reports.

Data abstraction – content analysis

An instrument was developed for the purposes of the data abstraction and analysis processes; a copy of which has been appended (see Appendix E). The data abstraction instrument includes the Classification and Measurement System for early childhood neglect which was developed for the research (described in Chapter Five). The operational definitions of each sub-type of neglect were applied to the records of concerns being reported in notifications made to the Department between 2003 and mid-2009, and any additional information received as a result of further investigation of the case, to classify and quantify constructs of unmet need and neglect-sub-types identified by the researcher through an in-depth qualitative analysis of the concerns being reported. The instrument was designed to take account of the full range and type of neglect concerns reported during the period covered by the study. The data was collated

and analysed in chronological order as a means of taking account of the accumulative nature of neglect and potential risk of harm.

Descriptive statistics and demographic information

Demographic and statistical data were collated and entered onto Excel spreadsheets for the purposes of quantifying the data and conducting some basic analyses. The following variables were extracted for further analysis:

- identified constructs of unmet need within the relevant neglect sub-types (see below)
- professionally identified negative outcomes and/or harm reported for the Subject Group of Infants at time of birth and in the early childhood period;
- instances of physical, emotional or sexual abuse of the Subject Infants
- neglect sub-types relating to co-residing older siblings in the family

There was a general lack of consistent or reliable information regarding the indigenous status of the families, which prevented its inclusion in the demographic information being collected; although there were at least 2 families in which the fathers of the children were known to identify as Aboriginal. Data relating to the number of families in which domestic violence, criminal activity and drug and/or alcohol mis-use by the primary caregiver were abstracted for descriptive and quantitative analyses. The following is a summary of the demographic and other information that was collected:

- Subject Infants' gender and age at time of first notification, and age at time of death for the referent children in Sub-Sample 1;
- The total number of biological children of the primary caregiver born prior to 2009, including those who died or are no longer in the care of the primary caregiver (mother);
- Total number of Subject infants and (primarily) co-residing children;
- Rural and/or Urban status during the majority of the study period – in accordance with the classification system described in the methods for Study 1, where 'urban' refers to all areas defined as such within the Australian Bureau of Statistics (2008) social atlas, and 'rural' refers to all non-urban areas;
- Family Type is described in terms of the number of co-residing biological parents in the family during the notification period; that is, 1 = single parent/mother; 2 = 2

biological parents. In families where the parents separated during the period, or where some or all of the children have different fathers, the number reflects the proportion of time that one of the biological fathers spent residing with the family; for example, 1.5 means a biological father of at least one child was residing in the home for half of the period during which the family was being notified.

- Number of mothers who were less than 20 years old when their first child was born;
- Number of 'biological' fathers of all children born to the mother in the NOS;
- The SEIFA Relative Socio-Economic Disadvantage scores for the postal area where the family was residing at the time of their last notification.

Variables

The dependent variables are the child outcomes, which are measured in terms of the number of Subject Infants in each family whose development and/or health were affected within each of the seven neo-natal outcomes and the sixteen child outcomes. There is some overlap in the categories due to the fact that the concerns were often stage related; for example, the subject infant may have been assessed as being developmentally delayed at an earlier stage of infancy, and diagnosed at a later stage with more specific problems, such us language or learning developmental delays or difficulties.

The primary sets of variables being measured consist of the 39 constructs of need and the 8 sub-types of neglect relating to the subject infants, as outlined in the research framework (see the Classification and Measurement System for infant neglect in Appendix D and the Content analysis Instrument in Appendix E for a complete list of construct variables). The need constructs are identified within the following eight neglect sub-types or categories:

1. provision of basic needs;
2. provision of emotional needs (emotional security and stability);
3. protection from physical and psychological harm;
4. provision of cognitive and language developmental needs;
5. provision of socio-emotional needs (behavioural and autonomy);
6. provision of moral developmental needs;

7. 'risk' of (unspecified) unmet physical and/or psychological needs as a result of serious and/or chronic parental issues.
8. protection from prenatal harm

Frequency

'Frequency' was measured in terms of the following:

1. the number of times a need construct was reported by the notifier to be unmet or likely to be unmet, or identified as such by the researcher based on the information provided in the notification (that is, for all constructs of need other than those of caregiver, family and residential stability – see below);
2. a transitions index based on the number of changes that occurred over the notification period, was established for each of the constructs of caregiver stability, family stability and residential stability (categories 203, 204.1, 204.2), in line with the measurement procedures used in previous definitional research based on study samples of children less than 48 months of age (see, e.g., Dubowitz et al. 2005a; English et al. 2005c).

All notifications containing information about neglect or abuse concerns that were relevant to any SI in the family – whether or not they had been included in the notification – were used to establish frequency scores for the constructs of unmet need.[24] However, the older siblings were the sole subject of the notifications in only three of the four families who had older children in their part-time or permanent care. In the case of one of the families with older (primarily) co-residing siblings, the subject infants were included in all of the notifications referred during the study period. Although in another family where the older siblings were often residing but were not classified as co-residing, there were 3 notifications which did not include the SIs.

Notifications during the data collection period were caller defined, which meant that it was up to the caller to identify the subject of the notification and the nature of the

[24] It is worth noting that notifications in Tasmania at the time were caller-defined, and the overloaded system meant that workers would be less inclined to investigate whether or not there were younger children in the family who should have been added to the notification – which given the state of the records may well take some time or otherwise add to their workload.

concern. As a result, unless the family was well known by the notifier, younger (more vulnerable) siblings especially were often not included despite the fact that the reported concerns were equally or even more relevant to them. On that basis, the decision was made to include all notifications for the purpose of establishing per-notification frequency scores, rather than only those nominating a Subject Infant.

Severity and chronicity

While adhering to the notion that all neglect in this age group is regarded as serious and chronic, in order to describe the nature of the problem, measures of the level of severity and chronicity, or level of risk, are provided by aggregating the frequency of constructs within each neglect sub-type, and then aggregating the total frequencies across the sub-types for each family.

Data analysis

The quantitative aspect of the analysis was undertaken primarily for descriptive purposes and to provide a measure of frequency – as an indication of levels of severity and chronicity and/or a measure of accumulated risk – relating to the various types of neglect being experienced by the subject group of infants. Because the number of cases is small (14 families; 39 SIs) – particularly in comparison with the numbers of variables (39 constructs; 16 child outcomes; 7 neonatal outcomes) – it was not possible for any analysis to yield predictive inferences. In addition, the outcomes experienced by subject children are expected to depend in some way on the level of risk to which they are exposed. Although the frequency scores for a given family indicate, *a priori,* the level of severity and chronicity (or risk), the length of the notification period and the number of SIs and other co-resident children in each family affect the number of notifications and the number of concerns reported, which in turn affects the frequency scores for each family. And, again, there were too few cases to permit the identification of the direct effects of risk levels in the presence of these confounding factors.

In order to conduct some basic analytical tests, the data was normalised in two separate ways: one, by changing the frequency scores for the need constructs to

presence/absence data for the constructs, and two, by changing the total frequency scores to frequency rates per subject child in each family.

Data collection issues

The data collection process essentially involved a certain amount of 'detective work' which took the form of identifying and tracking the subject children and their siblings via the notifications that were made in relation to them. It proved to be an unexpectedly time consuming and challenging task which profoundly affected the progress of the data collection and necessitated ongoing checking and updating procedures. The problems that presented themselves in the collection and early analytical phases of the study not only made it a challenging and time-consuming process, they also gave rise to concerns about the consequences for child protection practice. Informal observation did nothing to quell the concerns that there was an over-reliance on the summarised accounts of previous concerns and assessments that were included in the notification record forms. The issues are outlined here to serve as a basis for understanding the reasons for such an extensive set of data collection and analysis procedures. They are also included because of the concern at the time, that the new electronic information system had inherited many of the same problems.

The database is divided into the then three different child protection regions. Within each region folders were organised alphabetically, and the notification files were then listed in alphabetical order within the folders. The files are named according to the family name(s) of the children being notified (the individual children listed may have different family names which may or may not be included); followed by the given names of the child(ren); then the section of the Act under which the notification is classified and the priority rating (e.g. S17b); followed by the notification date; and then the initials of the worker(s) who took the notification and carried out the assessment. The file names were not always set out in the correct order or with consistent formatting procedures; nor were they constrained or limited in terms of correct or consistent approaches to spelling, or to formatting the date of the notification. This made the use of electronic methods to track notifications time consuming at best and, at worst, ineffective. The following provides a more detailed account of the problems and their ramifications.

1. The recorded material had to be extracted manually because the data – and the data entry system – did not permit automated collection procedures due to the issues outlined below.
2. It was expected that the new electronic Child Protection Information System, which was scheduled to be implemented in October 2007, would be a useful and time-saving automated searching and data checking tool. However, when it was eventually set up in February 2008, ongoing problems meant that the data retrieved from the system would not be reliable. The system had not lived up to its expectations at that point, at least, and proved to be an inadequate and unreliable source of information, and very limited in its usefulness as a research aid. Many of the problems with the new information system were due to the failure during the (extended) setting-up period to adequately address those very issues encountered by the researcher. While some improvements had been made to the system over time, there were ongoing problems which staff were told were expected to take at least 2 years to fully address.
3. The primary cause of the difficulties experienced in collecting the data resided in the the following issues which were basically due to the ill-management of the filing system on the database, as outlined below.
    - Naming issues: files on the database were named according to the last and first names of the children being notified at the time.
        - A particular child in any one family may be listed under several different possible surnames: for example, the mother's original, current or past family or married name(s); the father's name; the (different) surname of a sibling or step-sibling; or a blended family name. Furthermore, a substantial number of the parents involved with Child Protection follow certain kinds of lifestyles that require the use of aliases.
        - The report may be filed again under one or more of these alternative names, or it may not – practice varied according to changing work practices over the years, time constraints at the time, the extent of the information provided by the notifier, available history and so on.
        - Inconsistent and incorrect spelling of first and last names, and incorrect or insufficient or unknown identifying information in the file names was a major issue in the identification and tracking processes – compounded by the files being alphabetically sequenced.

- Formatting issues: the inconsistent formatting of the file names, particularly in the earlier years covered by the database, radically affected the order of the files and the family groupings in the common circumstance where different families have the same or similar names; specifically,
  - the file name may or may not include all children covered by the notification;
  - all/any aliases may or may not be included;
  - notification dates, especially in the early period, follow randomly variable formats.
- The identification and tracking issues were further compounded in many cases where families were related, and/or resided at the same address, were transient, shared common first and last names, or where partners were changed regularly.
- Other identifying information such as dates of birth were not always provided, and dates of birth provided were unreliable, or incorrect/inconsistent information (e.g. to police) appeared to have been either unknown or purposely provided. The new information system includes the age of the child at the time of the report, rather than the date of birth.

Information and communication problems

The identifying and tracking issues described above were compounded by the fact that the accuracy of information was not adequately checked, or corrected, especially in cases not regarded as serious enough to warrant further investigation – undoubtedly as a result of the workload pressures at the time. There were noted instances in the notifications and on the new information system of failure to identify all the relevant information relating to the individuals involved. And there were a number of instances of confusion between families and children who were related, or resided at the same address, or shared common first and last names. They were observed to lead to communication errors which, in turn, affected the assessments that were carried out.

There were several instances noted in the process of collating the data for Study One, in which individual infants and children had been overlooked in family group notifications, especially in the cases involving ('low level') chronic neglect concerns. The main source of the problem was the fact that, again, with the workload issues at the

time, practitioners relied heavily on the information from the previous notification and the summarised record of the child(ren)'s history that each notification was supposed to include, which was simply transferred form one notification to the next. This brief, and necessarily subjective, report summary of the main concerns and the outcome of the assessment appeared to be the main source of information used to check the children's past experience of neglect and/or abuse. Any identified errors or sources of confusion were noted on the actual notification only.

Few corrections appeared to have been made to the original information errors and spelling errors in the original files and file names over the years that the database was in use (July 2003 – Feb. 2008). The Child Protection Information System (CPIS) was eventually introduced to Intake Services at the beginning of 2008. It was expected by staff and the researcher alike to be a useful and time-saving automated searching and data checking tool, however, it was plagued by ongoing failures and problems – with information and historical records being either non-existent, incomplete, incorrect and generally unreliable. It was clear that many if not all of the errors in the original database had been directly transferred into 'CiPIS'

It was not unusual in the early months of the implementation period to find the same child recorded under (at least) two different identities, (a) because they might be known to others by two different names, and (b) as a result of the information errors and inconsistencies which had not been addressed in the setting up period – especially identifying information such as names and birthdates. It was an ongoing issue for Child Protection workers, which had the potential to seriously jeopardise children's safety – which staff were informed was expected to take at least two years to fully address. It is a matter of some concern that the aforementioned errors and problems may have been perpetuated in an information system which a wide range of professionals depend upon to make decisions of the most serious kind.

Conclusion

This chapter has provided a description of the methods, processes and procedures that were carried out to fulfil the aims and objectives of the two studies that are presented in the following chapters. The methods for the study were described in the context of the

series of legislative, policy and system changes and the ongoing effects of those changes on the practitioners, practice, and ultimately the data being used for the study. The process of identifying and collating the data confirmed to the researcher that an electronic data collection process would not have achieved the level accuracy that has been attempted here.[25] The following chapter describes the results of the data analysis, including the findings relating to the incidence of neglect and abuse, and the overall pattern of referral and response, for infants and toddlers living in rural and urban Tasmania.

[25] According to Jacob & Fanning's (2006) report, the data at that time was collected manually, but this was regarded as a limitation in terms of the integrity of the data (p. 32).

CHAPTER 4

Study One:
Patterns of Child Protection Referrals in the 0–4 Age Group

The preceding chapters provided an overview of the child protection system(s) and legislation governing the care and protection of children in this state, and the methods and procedures that were used for Studies One and Two. The study presented in this chapter was carried out in response to the need for neglect research that focuses on children in the vulnerable 0–4 age group. This chapter presents the results of the quantitative analysis of child protection notification data relating to children less than 48 months of age in rural and urban Tasmania.

The two child protection regions covered by the study encompassed rural and urban areas, including a major metropolitan centre, which covered approximately half of the state, and included approximately half of the total population of Tasmania at the time.[26] The overall aim of the following study was to provide a statistical picture of the yearly rate and pattern of referral for neglect and abuse relating to infants (<48 months) in rural and urban regions of Tasmania. The objectives of the study were to investigate:

a. the 'incidence', or notification rate, of abuse and neglect for infants (< 48 months of age) in Tasmania in the 2005 calendar year;
b. the general pattern of referral and response for the 0–4 age group notified during the 2005 calendar year in rural and urban Tasmania; and
c. referral patterns for the infants and their sibling family groups over a period of four years.

First, notified cases of abuse and neglect for the 'subject infants' are explored in terms of notification numbers and rates; differences relating to maltreatment type, age, child protection response classifications; and any additional rural-urban differences.

[26] The combined general population for the two regions was calculated from the ABS' 2006 census data to be approximately half of the total population of Tasmania at that time, which was 477,646.

Secondly, the course of notified concerns of neglect and abuse is followed at a family level over a period of four and a half years. Notification data relating to the Subject Group of Infants (N = 788) and the corresponding Subject Family Group (N = 588) were collated for descriptive and statistical analysis.

Although neglect is the primary focus of the research overall, this study focuses on both abuse and neglect in children less than 48 months of age for the following reasons: 1) to make comparisons between them, in terms of notification rates and child protection response; 2) to accommodate different conceptualisations of exposure to family violence, which is conceived as a form of neglect in the current research but as a form of abuse in policy and practice; and 3) to take into account the understanding that neglect underlies all form of maltreatment. The study follows the course of notified cases of neglect and abuse for both the subject group of infants and for their siblings over a four-year period to gain a more holistic picture of the pattern of notified concerns within families in rural and urban communities over time.

Referral Rates

There were 1714 *notifications* of abuse and neglect for 788 Subject Infants (<48 months) in the 2005 calendar year, which constitute an overall notification rate of 15.1 per 100 children under 4 years of age in the general population.[27] Alternatively, 6.9 per 100 children of the same age in the general population were the subject of one or more notifications in the year. The method of counting notifications is the same as that used by the AIHW; that is, in cases where a single notification involves more than one Subject Infant (SI), a notification is counted for each SI being reported. The number of actual notification records for the SIs was 1,305. The number of notifications per Subject Infant (SI) in 2005 ranged from 1 to 16, with a mean of 2.2 notifications per SI (SD=1.9). The per-child notifications relating only to the SIs for each family group IFG (N=599) ranged from 1 to 32 with a mean of 2.9 (SD=3.3).

[27] There were 11,362 children < 4 years of age in the general population in the regions covered by the study, calculated using ABS 2006 census data for postcode areas covering the entire region.

The SIs and IFG were re-referred to the Department in the same year at a rate of 46.3% and 56.6% respectively, with 26.8% of the SIs and 32.4% of the IFG re-notified on more than one occasion. The notification data for SIs and the IFG are summarised in Table 4.1a. Notification frequencies per Subject Infant and per Infant Family Group are represented as a histogram in Figure 4.1a below, and the complete set of frequencies is presented in Table A4.1b (in Appendix C).

Table 4.1a. Summary of notification frequencies for the Subject Infants and the Infant Family Group in 2005

2005 Calendar Year	Subject Infants (N=788)	Infant Family Group (N=599)
Mean notifications	2.18	2.86
Std. Deviation	1.94	3.29
No. re-notified	365 (46.3%)	339 (56.6%)
No. re-notified >once	211 (26.8%)	194 (32.4%)
Total Notifications	1714	1714

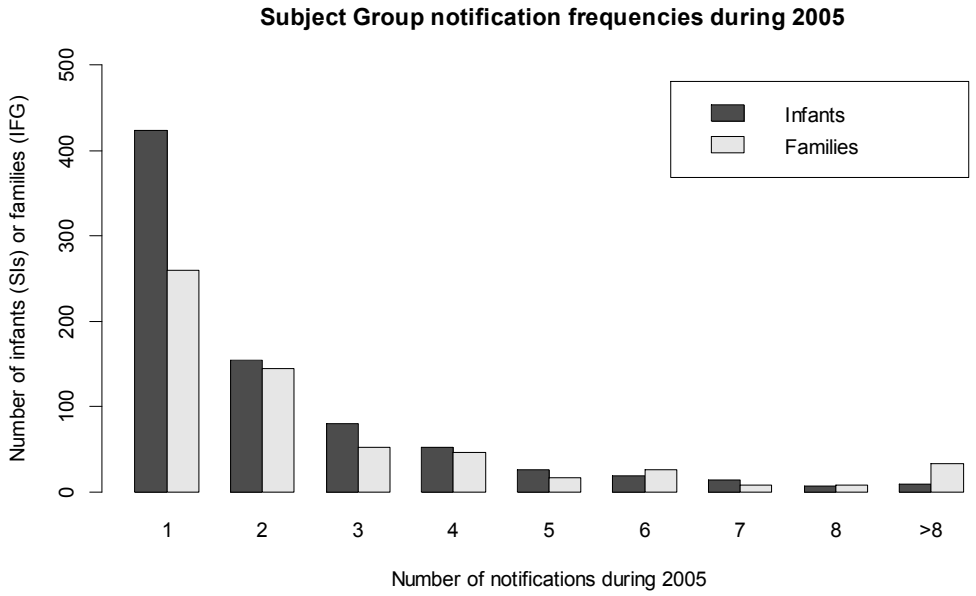


Figure 4.1a. Notification frequencies for the Subject Infants and the corresponding Infant Family Group re-notified in the 2005 calendar year

Referral patterns over time

The SFG (N=588) encompasses all co-residing siblings (including SIs) under the age of 17 years – it does not include 11 infants who were unable to be identified. The number

of 'notifications' relating to the SFG over the four-year period reflect the number of times any member(s) of the SFG is (are) notified, irrespective of the number of children who are included in the particular notification – they are not the *per-child notifications* that are used to establish notification rates (referred to previously). Table 4.1c presents an overview of the notification history for the SFG across the four calendar-years from T1 (2004) to T3 (2007).

Table 4.1c: Summary of notification frequencies for the Subject Family Group (N=588) from 2004 to 2007.

	T−1 (2004)	T1 (2005)	T2 (2006)	T3 (2007)
Mean Ns per family	2.88	2.61	3.29	3.36
Max. no. of Ns	16	22	21	23
Min. no. of Ns	0	1	0	0
Total Ns	601	1537	1068	860
Total Families	209	588	325	256
Total Children	N/A	1328	849	12
Mean no. of Children/Family	N/A	2.25	2.6	2.8

Chronicity

The matter of measuring and defining chronicity in maltreatment research is as yet unresolved, which is a problem is discussed in more detail in Chapter Five. In this research, all neglect during the early stages of a child's development is regarded as inherently chronic, in line with De Bellis (2005), and with Dubowitz, Newton et al. (2005), for whom neglect is understood as a continuous rather than a dichotomous, or incident-based phenomenon, in which children's needs can be seen along a continuum of being fully met to not being met all.

However, the level of maltreatment chronicity or persistence is commonly measured in terms of frequency and duration (Strauss & Kaufman-Kantor 2005). In this study, 81.8% of all families were re-notified one or more times during the 4-year period: 209 (35.5%) families were notified in the previous year (2004), 325 (55.1%) in 2006, and 256 (43.5%) in 2007. For those families who did remain in the system, the mean notifications per family increased from 2.62 in 2005 to 3.36 in 2007, which was accompanied by an increase in the mean number of co-residing siblings from (2.25 to 2.8).

Figure 4.1b represents patterns over time for those families who were notified on one or more occasions in 2006 (n=325) and/or in 2007 (n=256) against the number of times they were notified in 2005. This graph represents the *average* number of notifications received for all subject families and those families receiving one or more notifications in subsequent years (2006 and 2007). Families classified according to the number of times they were notified in 2005 by the number of times they were notified in 2006 and again in 2007 are presented in Tables A4.1c and A4.1d (Appendix C). The figure shows that for those families who are renotified in the following years, the average annual referral rates tend to be maintained. A large proportion of those families who were only notified once in 2005 were still being notified in 2006 and 2007, often at a marginally higher rate.

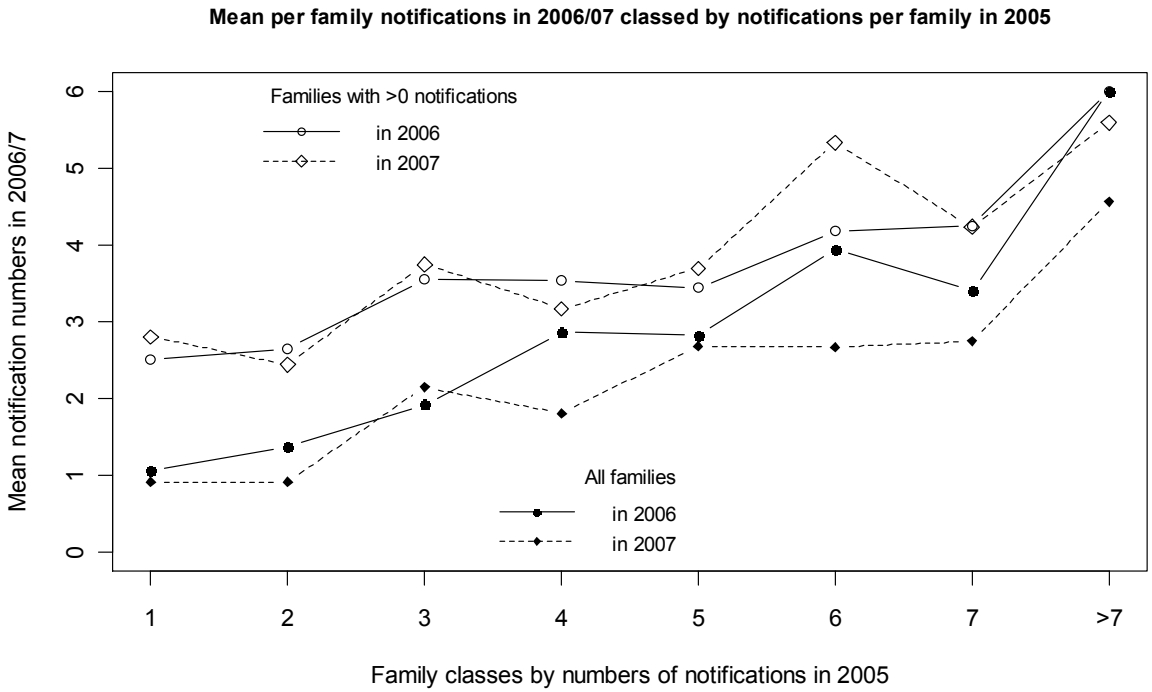


Figure 4.1b: Mean number of notifications per family against the number of notifications per family in the 2005 calendar year – for all families (N=588) and for families with one or more notifications in 2006 (n=325) and/or 2007 (n=256)

Number of children and number of notifications per family over time

Given previous research findings that family size is considered to be a risk factor for child maltreatment (e.g. Connell, Bergeron, Katz, Saunders & Tebes 2007), the effects of number of children in the family on the number of recorded notifications for the family as a whole, and per-child were explored. The relationship between the number of children residing in the family at the time and the number of notifications for families during 2005, 2006 and 2007 is represented graphically in Figure 4.1c. The average number of recorded notifications for families increased with the number of children up until the sixth child, but after that there is a suggestion of a decrease in the number of notifications with the number of children. One explanation for this phenomenon could be that larger families received some additional support within the community and/or there would be more likely to be a higher proportion of older siblings in the families with more than five children, than in those with less than five children, who would be able to contribute to the care of the younger children.

However, when the average number of notifications per child was examined against the number of children in the family for each of the three years, there was a clear downwards trend. A possible cause is the fact that the notifications are recorded for family groups of children as well as for individual children, and consequently, the per-child rate as calculated underestimates the effective per-child notification rate. Nonetheless, it does indicate that the average notification rate for the larger families is not necessarily due to the number of children in the family; nor can it be assumed that the number of children is necessarily a risk factor for child neglect or abuse. The per-child notification rate measured in relation to the number of children in the family at the time across the three years is represented in Figure 4.1d.

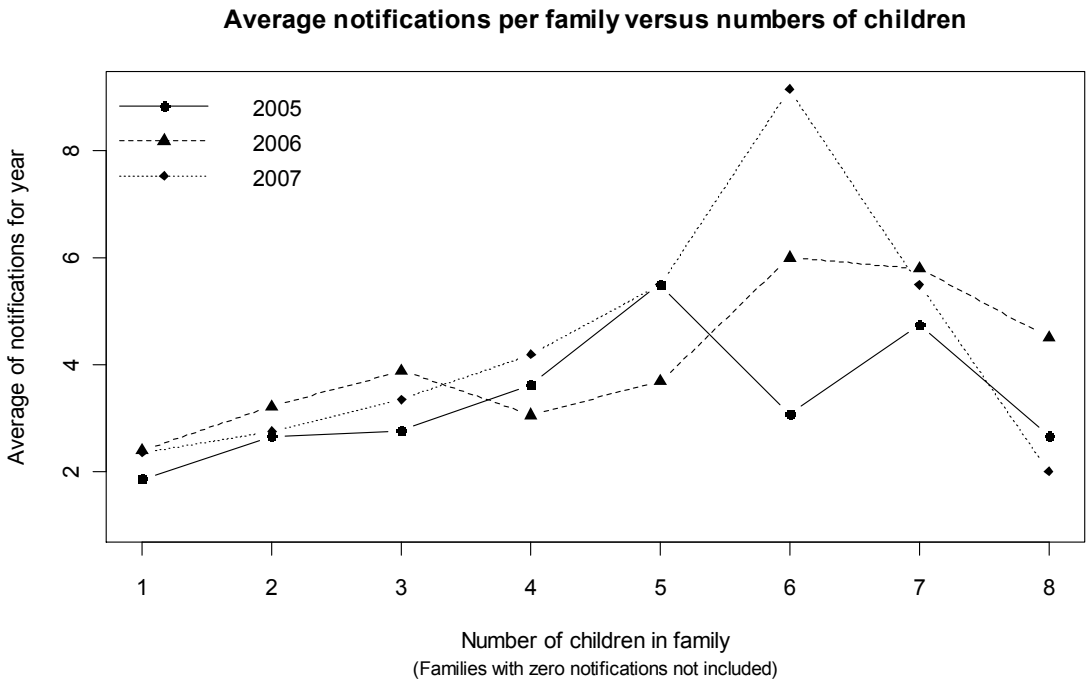


Figure 4.1c: Average number of recorded notifications per family by the number of children per family in 2005, 2006 and 2007

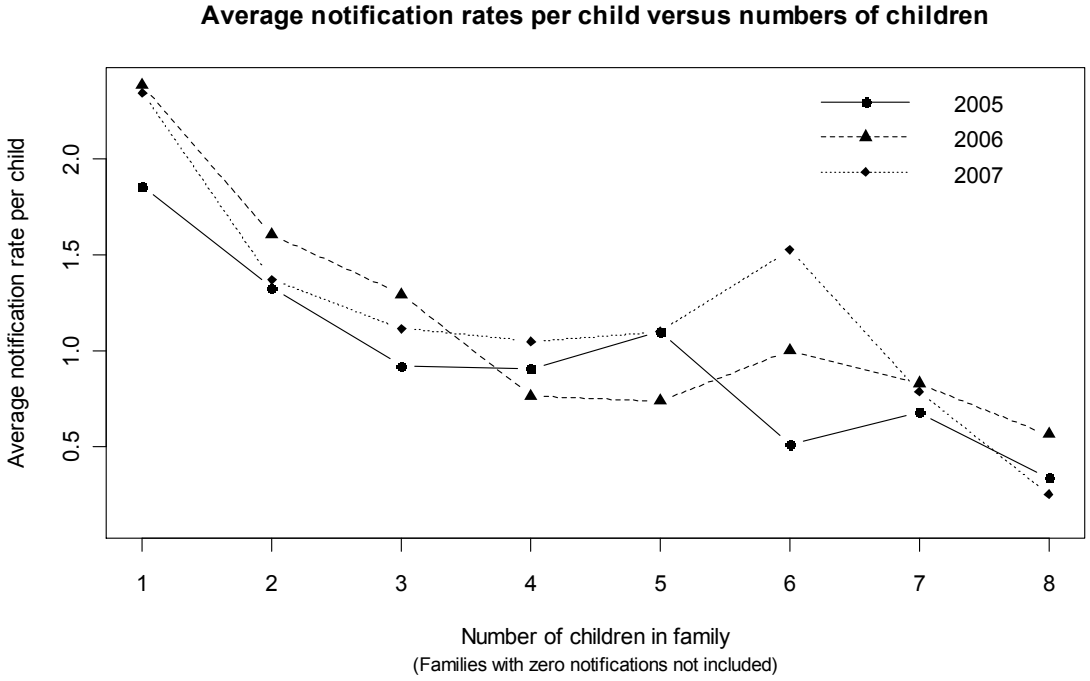


Figure 4.1d: Average notification rates per child by the number of children in each family in 2005, 2006 and 2007

Type of Maltreatment

A summary of notification numbers and incidence of child protection classifications of abuse and neglect in the population (aged < 48 months) is included in Table 4.2a. As expected, neglect was the most common type of maltreatment notified, or maltreatment classification provided, for this age group. Notifications for neglect occurred at a rate of 7.6 per 100 children in the general population. There were 758 notifications (45.3%) with a primary neglect classification and an additional 106 notifications with a secondary classification of neglect making a total of 864 (51.6%) in total.[28] Emotional abuse (EA) was the second most common maltreatment type, with 642 notifications given a primary classification of EA (33.4%) and an additional 132 secondary classifications for EA, making a total of 774 (46.2%). A total of 305 notifications were classified as physical abuse (18.2%) and 88 notifications (5.25%) were classified as sexual abuse. There were 40 notifications (2.3%) which were not classified according to type of abuse or neglect.

For the sake of argument, if exposure to family violence were classified as a form of psychological or emotional neglect rather than emotional abuse, the notification rate for neglect would be substantially higher. Under the assumption that reports of emotional abuse from police (at the very least) relate to exposure to family violence, the notification rate for neglect (864 plus 279= 1143 notifications) would make up 68% of all notifications. In that case, the notification rate for neglect would be approximately 10 notifications per 100 infants under 48 months of age in the general population. This would be regarded as a minimum rate considering that a large proportion of the remaining notifications of 'emotional abuse', especially from non-government organisations, would also be referring to exposure to family violence, rather than emotional abuse *per se*.

[28] Once all the secondary classifications are included, the total percentages will be greater than 100% of total number of notifications.

Table 4.2a: Number, proportion and rate of notifications for each maltreatment type

Neglect/Abuse	Primary No. Ns	Secondary No. Ns	Proportion of Total Ns[a]	Incidence % pop.
Neglect	758	106	0.516	7.6
Em. Abuse	642	132	0.462	6.8
Phys Abuse	197	108	0.182	2.7
Sex Abuse	77	11	0.052	0.8
Total	1674	357	-	-

a. Refers to proportion of total number of notifications provided with abuse/neglect classifications

Child protection population differences

For the purposes of comparison between the 0–4 age group and the general child protection population, the maltreatment types notified for the SIs in the 2005 calendar year and for the general CP population in the 2004-05 and 2005-06 data collection periods are presented as numbers and proportions of all (classified) notifications for the period in Table 4.2b.

The number of notifications for the SIs calculated in this study represents approximately 13.2 percent of the total number of notifications reported for Tasmania in the 2005–06 collection period or 15.9 percent of the total for the 2004-05 period (AIHW 2006, 2007). Given that the two regions covered by the study represent only half the state, a rough estimate of the proportion of SI notifications within the child protection population in these two regions would be approximately 30 percent. These percentages are only meant to provide an indication of the proportions of notifications for this age group within the general child protection population – the data presented here and the Department's data were sourced at different points in time, although they were reportedly manually collected (according to Jacob & Fanning 2006). (Notification data available from the Department of Communities, Child Safety and Disability services in Queensland, shows that children in the 0–4 age group account for 42.6 percent of the notifications for the general child protection population in that state.[29])

[29] Calculated from notification data (excluding notifications relating to unborn children) available on Queensland Department of Child safety website, available at: http://www.communities.qld.gov.au/resources/childsafety/about-us/performance/child-protection/notifications-4.xls

Table 4.2b: Comparison of classified maltreatment types for the Subject Infants in 2005 (SIs 2005) and the general Child Protection populations for 2004-05 (CPP 04-5) and 2005-06 (CPP 05-6) – numbers and proportions

Neglect/Abuse	No. of Notifications			Proportions		
	SIs 2005	CPP 04-05	CPP 05-06	SIs 2005	CPP 04-05	CPP 05-06
Neglect	758	4179	3528	0.453	0.394	0.392
Em. Abuse	642	3001	2858	0.384	0.283	0.317
Phys Abuse	197	2129	1655	0.118	0.201	0.184
Sex Abuse	77	1309	961	0.046	0.123	0.107
Total	1674	10618	9002	1.000	1.000	1.000

The differences between the types of maltreatment being notified for the SIs and the general Child Protection Population (CPP) were explored. Ideally the latter should be represented by the total notifications for the 2005 calendar year, but the relevant DHHS statistics are collated for financial years. Consequently, the data sets used for comparison are the DHHS figures supplied in Jacob and Fanning (2006) for 2004–05 and 2005–06 (Jacob & Fanning 2006, p. 35)[30]. And because the profiles of proportions of abuse types notified in each of these periods were found to differ ($p = 2.4 \times 10^{-8}$ with a chi-squared test), they cannot be combined to form a representative profile that might be typical for the 2005 calendar year. Accordingly, both data sets were considered alternative bases to which the SI-05 profile could be compared. Chi-squared tests were applied to compare the SIs–2005 numbers of Table 4.2b with, in turn, the CPP 04–05 and CPP 05–06 numbers. Both tests returned p-values too small to be registered, which suggests strongly that the pattern of abuse types in the group of SIs is different to that of the general CP population.

To gain insight into where the differences in maltreatment type proportions lay, simultaneous 95% confidence intervals were constructed to indicate which of those differences could reasonably said to be real and not due to random variations. This was

[30] There is a discrepancy between the total number of notifications analysed according to maltreatment type for 2005-06 in Jacob and Fanning (2006) and the AIHW data because the analysed data was collected at a different point in time to the AIHW Child Protection data (see Jacob & Fanning 2006, p. 35). The total number of notifications for 2005-06 was 13,029 (AIHW 2007).

achieved with an analytical approach described by Goodman (1964)[31] – the results are shown in Table 4.2c.

Table 4.2c: Calculated simultaneous confidence intervals (95%) for the difference in proportions of maltreatment between the SIs and the CPP for 2004-05 and 2005-06

A/N Type	Interval Points	SIs-CPP 04-5 Lower	SIs-CPP 04-5 Upper	SIs-CPP 05-6 Lower	SIs-CPP 05-6 Upper
Neglect	Estimate	0.059		0.061	
	Bounds	0.022	0.097	0.023	0.099
Emotional	Estimate	0.101		0.066	
	Bounds	0.065	0.137	0.029	0.103
Phys. Abuse	Estimate	-0.083		-0.066	
	Bounds	-0.108	-0.058	-0.092	-0.041
Sex. Abuse	Estimate	-0.077		-0.061	
	Bounds	-0.095	-0.06	-0.078	-0.043

Notes:
1. The Estimate point is the best estimate of the average difference and should be approximately half-way between the lower and upper bounds of the confidence interval.
2. The shaded cells are intervals which exclude zero – and therefore the corresponding difference can be claimed to be truly a difference at the 5% significance level.

Significant differences between the Subject Infants and each of the two Child Protection populations were found across the board for all types of maltreatment. The proportions of neglect and emotional maltreatment notified for the SIs were found to be greater than the proportions for the general CP populations, with the significance levels of the differences in each case being 5% or better. The proportions of physical abuse and sexual abuse were found to be less for the SIs than those of the two CP populations, with corresponding levels of confidence that this difference is not due to chance. It is also worth noting that there were significant differences in the proportions of emotional maltreatment, physical abuse and sexual abuse between the two general Child Protection populations, but not in those for neglect. The proportional differences for the 2004–05 and 2005–06 CP populations are included in the complete Table A4.2c provided in Appendix C.

[31] With the relatively small number of paired comparisons, most of the simultaneous confidence intervals are equivalent to individual ones constructed via normal approximations of binomial processes with Bonferroni adjusted p-values.

Secondary maltreatment classifications

Secondary maltreatment classifications were included in 357 or 20.8 percent of the total notifications (N=1714). A secondary maltreatment type was included in 40.1% of notifications with a primary classification of physical abuse, in 32.5% of notifications of sexual abuse, in 18.2% of notifications of neglect, and in 17.9% of all notifications of emotional abuse. Table 4.2e provides an overview of the number of secondary maltreatment types for all notifications relating to the Subject Group in 2005.

Table 4.2e: Summary of secondary maltreatment classifications per primary maltreatment classification for all notifications for SIs in 2005.

	Secondary Maltreatment (numbers)					
Primary	None	Neglect.	Emotional Abuse	Physical Abuse	Sexual Abuse	Total
Neg.	620		74	56	8	758
EA	527	69		44	2	642
PA	118	29	49		1	197
SA	52	8	9	8		77
Unc.	40					40
Total	1357	106	132	108	11	1714

For all notifications for which a secondary maltreatment was recorded, Table 4.2f shows the proportions of secondary maltreatment types included per primary maltreatment type, as percentages of row totals; and proportions of primary maltreatment type per secondary type, as percentages of column totals. Neglect as the primary maltreatment appears to be somewhat more strongly associated with emotional abuse as a secondary type of maltreatment (53.62% of the total secondaries) than with physical abuse (40.58% of the row total). As a secondary maltreatment type, neglect is also most strongly associated with emotional abuse (65.09% of column total), while only 27.36% of the total neglect secondaries are associated with notifications of physical abuse.

Emotional abuse as primary maltreatment type is also more strongly associated with neglect as a secondary (with 60% of the row total) than with physical abuse (38.26% of the row total). Emotional abuse is also more strongly associated with neglect (56.06%) than physical abuse (37.12%) as a secondary type of abuse. Physical abuse as the

primary maltreatment type is more strongly associated with emotional abuse (62.03%) when compared to its association with neglect (36.71%). However, as a secondary abuse type, physical abuse is more commonly associated with neglect (51.85% of column total) than it is with emotional abuse (with 40.74% of the total). As a primary abuse type, sexual abuse is associated with the other maltreatment types fairly equally but as a secondary abuse type, it is more closely associated with neglect (72.73%) than either physical (1.27%) or emotional abuse (1.74%).

Table 4.2f: Total secondary maltreatment classifications for each primary maltreatment classification for SIs in 2005 as percentages of row and column totals. (excluding cases with no secondary classifications)

	Secondary Maltreatment (percentage of row totals)				
Primary	Neglect.	Emotional Abuse	Physical Abuse	Sexual Abuse	Total
Neg.	0.00	53.62	40.58	5.80	100%
EA	60.00	0.00	38.26	1.74	100%
PA	36.71	62.03	0.00	1.27	100%
SA	32.00	36.00	32.00	0.00	100%
Total	29.69	36.97	30.25	3.08	100%
	Secondary Maltreatment (percentages of column totals)				
Primary	Neglect	Emotional	Physical	Sexual	Total
Neg.	0.00	56.06	51.85	72.73	44.22
EA	65.09	0.00	40.74	18.18	37.46
PA	27.36	37.12	0.00	9.09	11.49
SA	7.55	6.82	7.41	0.00	4.49
Total	100%	100%	100%	100 %	100%

Age Groups within the Subject Group

When the four maltreatment types were apportioned among four different age groups [N1=232 (0-1); N2=169 (1-2); N3= 191 (2-3); N4=196 (3-4)], the proportion of neglect cases was highest at the youngest age (50.6%) and declined steadily as age increased (to 38. % in the 3-4 age group). As the proportion of neglect decreased with increasing age within each age group, the proportions of physical and sexual abuse cases each

increased. Table 4.2g provides a summary of the pattern of maltreatment types within the four age groups in numbers and proportions.

Table 4.2g: Numbers of notifications and proportions of maltreatment types per age group (N=1674 classified notifications**)**

Numbers					
Age Group	Neglect	Emotional	Physical	Sexual	Total
0-1	251	172	52	8	483
1-2	175	156	38	8	377
2-3	162	141	50	25	378
3-4	170	173	57	36	436
Total	758	642	197	77	1674
Proportions					
Age Group	Neglect	Emotional	Physical	Sexual	Total
0-1	0.520	0.356	0.108	0.017	1.000
1-2	0.464	0.414	0.101	0.021	1.000
2-3	0.429	0.373	0.132	0.066	1.000
3-4	0.390	0.397	0.131	0.083	1.000
Total	0.453	0.384	0.118	0.046	1.000

A chi-squared test of independence between abuse type and age group produced a (simulated) p-value of 10^{-6}, which constitutes strong evidence that there is a dependence relationship between them. To detect which proportions of abuse type are likely to be different from one age group to the next, simultaneous 95% confidence intervals were constructed for the differences in proportions between every pair of age groups. This was performed again using Goodman's method described previously. The results are presented in Table A4.2h.

There were significantly higher proportions of neglect notifications for infants less than 1 year old than there were for those aged 3-4 years (detected at the 5% significance level). Of some note also were the differences in proportions of sexual abuse between the 0–1 and 2–3 age groups, the 0-1 and 3-4 age groups, and between the 1–2 and 3–4 age groups, with the younger group in the paired comparisons having proportionately fewer notifications for sexual abuse than the older group in each pair (see Table A4.2h).

Gender

There was no perceivable difference in the numbers of notifications for males and females; nor were there any indications of gender differences for the type of maltreatment being notified across the four age groups, except for a higher number and proportion of sexual abuse cases reported for females in the 2-3 and 3-4 age groups than there were for males. However, a chi-squared test of the contingency table of notifications for sexual abuse could not detect a relationship between age and gender, probably due to the small numbers involved. A summary of the percentage of maltreatment types according to age and gender are presented in Table A4.2i of Appendix C.

Prevalence Issues:
Rates and Rankings in Urban and Rural Areas (2005)

A summary of notification numbers and rates for infants, according to urban and rural classifications is presented in Table 4.3a. The overall rate in the table is necessarily different to the overall notification rate of 15.1 provided above, because not all notifications were able to be provided with a regional or postcode classification. An overview of the total number of notifications (in descending order) per postcode area, calculated notification rates and the number of Subject Infants notified in each of the urban and rural localities is included in Table A4.3c of Appendix C.

Five urban postcode areas (POAs) contributed half of the total number of notifications (825, 51%). The urban POA with the highest number of notifications (n=308) had a notification rate of 0.301 (or 30.1 notifications per 100 children < 4 yrs in that POA). The two urban POAs with the highest notification rates (0.366 & 0.314) contributed 56 and 126 notifications respectively. There were two high scoring rural POAs: the area with the highest number of notifications (92), the sixth highest number overall, experienced a notification rate of 0.172; the second highest, with 61 notifications, had a notification rate of 0.201.

Table 4.3a: Rates of notifications for infants <4 years old during 2005 (including mixed regions)

Regional Structure	Cs < 4 Popul'n.[32]	Notifications Number	Notifications Rate	Infants Notified Number	Infants Notified Rate	Ave Notifications per Infant
Rural	3148	348	0.111	207	0.066	1.68
Urban	6892	913	0.133	471	0.068	1.94
Mixed	1312	347	0.265	165	0.126	2.10
Overall	11352	1614	0.142	844	0.069	2.18

Note: 'Rural' values are summations of those for postcode areas (POAs) for which all notifications are for infants resident at the time in rural areas; 'Urban' ones, likewise, have all their notified children in urban areas; 'Mixed' have notifications coming from both regional classes.

The rural and urban notification rates and rates per SI had to be calculated on the basis of the ABS population data for children less than 4 years of age resident at the time in each regionally classified POA (ABS 2007). One of the problems with this is that the notification rates calculated for the postcode areas with smaller populations are highly variable. Six notifications in one rural area with a population of ten children under the age of four, for example, produced the highest notification rate (0.600; see Table A4.3c). This was regarded as an outlier and excluded from the data being analysed for the purpose of establishing rates.

There were 100 notifications in total for which no postcode was available: 81 of these were for infants residing in temporary accommodation such as shelters, or whose families were transient or homeless; the remaining 19 notifications were for infants whose address was unknown. This is why the total number of notifications in Table 4.3a below is 1614 rather than 1714. Some infants who were the subject of more than one notification changed postcodes between successive notifications; so the total number of infants notified for both regions adds up to 844 rather than what would be expected to be less than 788. There were ten postcode areas in which no children were notified – all

[32] Calculated from the data listed by postcode in the ABS Catalogue no. 2068.0 – *2006 Census Tables – Age – Full Classification by Sex.* Notionally these data apply at a particular point (the Census night) in the 2006 calendar year, while our data are annual aggregates for the 2005 calendar year. However, it was noted that, for most postcodes, the distribution of children numbers across ages of 5years and below in the Census data was remarkably uniform. A few isolated exceptions occurred in the low population POAs. It is safe to assume that the 2006 Census data for infants are good approximations for our 2005 data. Note also that the Rural SG population tabulated above includes 184 infants from ten POAs which had no notifications (for the SG at least) in 2005.

ten of these were rural areas. The population of children under four years from these areas was included in the rural population tabulated below (see Table A4.3c in Appendix C).

Chi-squared tests (of 2x2 contingency tables) showed that all three notification rates – Rural, Urban and Mixed – are significantly different to each other. The p-values for the differences, adjusted for simultaneous comparisons by Holm's method, are: Rural-Urban comparison: 0.0063; Rural-Mixed comparison: 6.6×10^{-6}; Urban-Mixed comparison: 6.6×10^{-6}. It can be concluded further that the rural rate (0.111) is less than the urban one (0.133) since the 95% simultaneous confidence interval for the difference is, at worst, $0.002 \leq 0.021 \leq 0.033$. Either there is a lower incidence of maltreatment in the subject population for rural areas, or it is detected less, or both may be true. The rural and urban rates for numbers of infants notified could not be shown to be different, but each was found to be significantly different to the mixed rate. The p-values for the comparisons were Rural-Urban: 0.659; Rural-Mixed: 3.9×10^{-10}; Urban-Mixed: 5.7×10^{-9}.

However, the comparison between rural and urban rates (above) is based on purely urban and purely rural areas. There are two postal areas which had both urban and rural notifications. The rural-urban splits for each were 25:283 (8.9%) and 1:38 (1.4%). Since the notifications in each case were predominantly urban, the minority rural ones were reclassified as urban for subsequent analyses. Table 4.3b is a revision of Table 4.3a incorporating the reclassification. Chi-squared tests of the new contingency tables showed that there was a significant difference between the rural and urban notification rates, with a p-value = 2.87×10^{-7}. The tests showed further that there was a significant difference, though not such a strong one, between the rural and urban rates at which the SIs were notified, with a p-value = 0.046.

Table 4.3b: Rates of notifications for infants <4 years old during 2005 (including mixed regions)

Regional Structure.	Cs < 4 Popul'n.	Notifications Number	Notifications Rate	SIs Notified Number	SIs Notified Rate	Notns./ infant
Rural	3148	348	0.112	207	0.069	1.68
Urban	8204	1260	0.154	638	0.078	2.68
Overall	11362	1614	0.142	844	0.078	2.18

Rates modelled on rural/urban status, and socio-economic disadvantage

The Australian Bureau of Statistics (ABS) report on the 2006 Socio-Economic Indexes for Areas (SEIFA) (ABS 2006) was consulted to extract relative socio-economic disadvantage scores and Tasmanian rankings for each of the postcode areas in which the SFGs reside. In general, the lower the socio-economic disadvantage scores, the greater the overall level of disadvantage. Lower rank numbers also indicate greater disadvantage relative to POAs with higher rank numbers.

In an attempt to explore possible reasons for the differences in urban and rural SI notification rates, an explanatory model was built to predict the rates from indicators of socio-economic disadvantage as a proxy for the complex of risk factors giving rise to child maltreatment in the subject group. The thinking was that if the observed differences in the average rural and urban notification rates could be predicted substantially from measures of socio-economic disadvantage for each POA, this would discount the possibility that maltreatment in rural areas is under-reported.

Table A4.3c is an overview of the total number of notifications (in descending order) per postcode area, calculated notification rates, the number of Subject Infants, the SEIFA Indexes of Relative Socio-economic Disadvantage (ISRD) and their Tasmanian rankings per postcode area in all urban and rural localities. The relevant parts of these data were incorporated into a negative binomial generalized linear model expressing (or predicting) the average SI notification rate in each POA as a function of its IRSD and its rural-urban classification. The model predictions are shown as curves in Figure 4.3

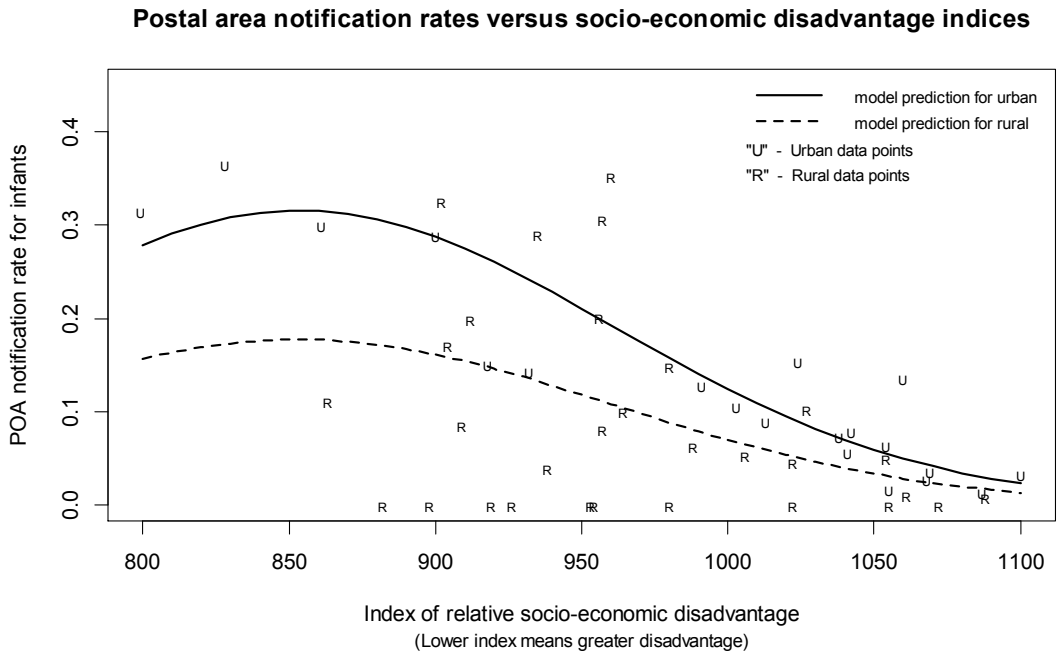


Figure 4.3: Model predictions of urban and rural average SI notification rates, from POA (Post Office Area) socio-economic disadvantage indices, superimposed on a scatter plot of actual rates and indices

The figure shows that the predicted average notification rates are greater in general for areas that have lower socio-economic indices, and, therefore, are more disadvantaged. And, for any given IRSD, the predicted rate for rural areas is less than that for urban areas – the difference being the vertical distance between the respective curves. This is not to say that socio-economic disadvantage *causes* child neglect and abuse; rather, that risk factors for child neglect and abuse – for infants at least – tend to be present more in POAs with greater disadvantage. However, it is more likely than not that the effect of any risk factor is the same for rural and urban areas. If, and only if, this is the case, then the cause of the observed differences between the rural and urban notification rates can only be under-reporting. This conclusion is contingent on there being no other (unknown) risk factors independent of IRSD that are present to a higher degree in urban POAs than in rural areas.

On that basis, it is concluded that it is more likely than not that there is under-reporting of neglect and abuse for children aged 0–4 in rural areas. While it cannot be proven, it cannot be ruled out as an explanation for the discrepancy between the rural and urban notification rates. The average rural SI notification rate is estimated from the model to

be 56% of the urban one; and the 95% confidence interval for that estimate ranges from 38% to 82%. So the difference is statistically significant.

Notification Classifications (Child Protection Response)

Almost three quarters (72%) of all notifications (N=1714) received for the SIs in 2005 were classified under sections 17a, 17b, and 18 of the Act, under which the child is considered not to be 'at risk' and/or that no further action is necessary. Approximately one third of those, in accordance with Section 18 of the Act, underwent a full initial investigation and risk assessment process. The remaining 28% of notifications were referred for further investigation and assessment: 107 (6.2% of total notifications) received a Priority 1 response classification (S.18.1), 322 (18.8% of total) received a Priority 2 classification (S.18.2), and 49 (2.8% of total) received a Priority 3 classification (S.18.3). Table 4.4a provides a summary of response classifications assigned to the different types of maltreatment for the SIs in the 2005 calendar year, as numbers and percentages.

The comparatively low number of notifications being given a Priority 3 classification reflects the fact that there was little or no chance of these notifications being investigated in a timely fashion at the time. Jacob and Fanning (2006) reported that during the 2005–06 period, there were 798 notifications for the general CPP in the regions covered by the study, which were on the 'unallocated list' (awaiting allocation to a worker). For Tasmania as a whole, by May 2006 there were 1,486 notifications that had not been allocated to a worker, which included 45 priority 1 notifications, 1,206 priority 2, and 235 with priority 3 classifications. In light of which, even some priority 1 notifications would have been left for extensive periods on the infamous unallocated list; priority 2 notifications had even less chance of being investigated in a timely fashion if at all, and a priority three rating was almost meaningless at that time.

Response classification and maltreatment type

Most of the notifications for neglect – 531 or 70% of the neglect total – were assessed as not requiring further investigation and assessment (17a, 17b and 18.0). Most of the emotional abuse notifications were assessed similarly. The corresponding number was

508 (79.1%). Physical abuse had the highest proportion of priority 1 ratings (22.3%) and sexual abuse had the highest proportion of priority 2 ratings (33.8%). Neglect had a higher proportion of priority 2 ratings (21%) than physical abuse (at 17.8%) or emotional abuse (at 15.9%). Priority 3 ratings were the least common classification within each maltreatment type overall: sexual abuse (6.5%), was followed by emotional abuse (3.3%), then neglect (2.9%), and finally physical abuse (0.5%).

Table 4.4a: Notifications by CP response classification and maltreatment type for the SIs in 2005 (numbers and percentages)

Class'n	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
17a	92	21	19	11	20	163
17b	286	311	57	19	4	677
18/0	153	176	41	12	8	390
18/1	44	9	44	4	6	107
18/2	159	102	35	26		322
18/3	22	21	1	5		49
Unc	2	2			2	6
TOTAL	758	642	197	77	40	1714

Maltreatment type percentages for each CP response classification

Class'n	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
17a	56.4	12.9	11.7	6.7	12.3	100.0
17b	42.2	45.9	8.4	2.8	0.6	100.0
18/0	39.2	45.1	10.5	3.1	2.1	100.0
18/1	41.1	8.4	41.1	3.7	5.6	100.0
18/2	49.4	31.7	10.9	8.1	0.0	100.0
18/3	44.9	42.9	2.0	10.2	0.0	100.0
Unc	33.3	33.3	0.0	0.0	33.3	100.0
TOTAL	44.2	37.5	11.5	4.5	2.3	100.0

CP response classification percentages for each maltreatment type

Class'n	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
17a	12.1	3.3	9.6	14.3	50.0	9.5
17b	37.7	48.4	28.9	24.7	10.0	39.5
18/0	20.2	27.4	20.8	15.6	20.0	22.8
18/1	5.8	1.4	22.3	5.2	15.0	6.2
18/2	21.0	15.9	17.8	33.8	0.0	18.8
18/3	2.9	3.3	0.5	6.5	0.0	2.9
Unc	0.3	0.3	0.0	0.0	5.0	0.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

When attention is restricted to the subgroup of prioritised notifications, there were indications that physical abuse is more likely to receive a priority 1 classification than neglect or the remaining types of abuse, and that neglect and sexual abuse are more likely to receive Priority 2 classifications.

A chi-squared test for association overall between the maltreatment types and classifications produced a p-value (by simulation) of less than 10^{-6}, which constitutes strong evidence of interdependence between the patterns (profiles) of the assigned response classifications and maltreatment type.

As before, the method of Goodman was used to test for significant differences between pairs of maltreatment types in the proportions of each classification type assigned to them. The results are displayed in Table A4.4b of Appendix C in the form of 95% confidence intervals. Again a difference is deemed to be significant when 0 is not included in its confidence interval – denoted by shaded areas.

The proportion of neglect cases classified as 17a was found to be significantly greater than the proportion of emotional abuse cases assigned that classification. Conversely, the proportion of neglect cases classified as 17b was significantly less than that for emotional abuse. The proportion of neglect cases receiving an 18(1) response classification was significantly less than the proportion for physical abuse but greater than that for emotional abuse.

According to Table A4.4b, there are no detectable differences between the proportions of, respectively, 17a or 17b classifications allocated to neglect and the corresponding proportions allocated to physical or sexual abuse notifications. But this result is from simultaneous testing with which the adjustments are conservative in that there is an inflated chance of missing a truly significant difference. When the 17a and 17b classifications are combined (as a Section 17 group) the resulting proportions for neglect and physical maltreatment types show a significant difference with a chi-squared test ($p = 0.006$). Given the strength of this result, along with the conservative nature of simultaneous tests, it was concluded that the proportion of neglect notifications allocated a Section 17 classification (49.9%) is significantly greater than the corresponding proportion (38.6%) for physical abuse notifications.

Source of Notifications: Notifier, Maltreatment Type, Region

Table 4.5a shows the number of notifications by each class of notifier and maltreatment type. (An explanation of the codes for the 25 notifier categories is in Box A4.1 in Appendix C). Of the 1,305 notification records for the SIs, two thirds (869 or 66.6%) were from individuals or groups legally mandated to report maltreatment and one third (436 or 33.4%) were from sources who are not legally obliged to report (see Table 4.5d). The largest source of notifications for this age group was the Department of Police and Public Safety (DPPS), providing approximately one third of all notifications (n=425; 32.6%), followed by parents (146 or 11.19%), and then NGOs (116 or 8.9%). Parents, grandparents and relatives together accounted for the 311 or 23.8% of all notifications.

Table 4.5a: Maltreatment type by notifier for Subject Infants in 2005 – numbers

NOTIFIER	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
DPPS	89	279	43	11	3	425
PARENT	63	38	20	18	7	146
NGO	49	50	11	4	2	116
GRANDP	71	23	13	1	2	110
CM	68	18	13	4	4	107
DO	25	24	3	5	1	58
REL	30	10	8	3	4	55
DEd	23	10	17	2	2	54
HOP	41	5	5		2	53
CHN	25	8	3	2	1	39
GP	9	2	3	2	1	17
CSW	12	2	2			16
COURT	4	8	2	4		18
ANON	10	1	2		2	15
DO-H	12			1	1	14
HMO	8		6			14
CCSP	2	1	6	2		11
DO-IS	6	1		1	1	9
AHP	1	2	4	1		8
CL	2	2	1			5
SASS				4		4
DO-FV	1	3				4
DC	2			1		3
DO-PC	1		2			3
DO-DS		1				1
TOTAL	554	488	164	66	33	1305

Type of maltreatment being notified

An overview of the proportions of maltreatment types being notified within the notifier groups (i.e., as a percentage of row totals) is provided in Table 4.5b. Table 4.5c provides the proportions of each of the maltreatment types being notified by the different notifier groups (i.e., as a percentage of column totals). Notifications from the DPPS were most likely to receive a classification of emotional abuse (65.7% of all their referrals) and constituted 57.2 percent of the total notifications relating to emotional abuse. The DPPS was also responsible for the highest proportion of the total notifications for neglect (89 or 16.1%) and physical abuse (43 or 26.2%), which makes up 20.9 percent and 10.1 percent, respectively, of all DPPS notifications.

Table 4.5b: **M**altreatment type by notifier for Subject Infants in 2005 (percent of row totals)

NOTIFIER	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
DPPS	20.94	65.65	10.12	2.59	0.71	100%
PARENT	43.15	26.03	13.70	12.33	4.79	100%
NGO	42.24	43.10	9.48	3.45	1.72	100%
GRANDP	64.55	20.91	11.82	0.91	1.82	100%
CM	63.55	16.82	12.15	3.74	3.74	100%
DO	43.10	41.38	5.17	8.62	1.72	100%
REL	54.55	18.18	14.55	5.45	7.27	100%
DEd	42.59	18.52	31.48	3.70	3.70	100%
HOP	77.36	9.43	9.43	0.00	3.77	100%
CHN	64.10	20.51	7.69	5.13	2.56	100%
GP	52.94	11.76	17.65	11.76	5.88	100%
CSW	75.00	12.50	12.50	0.00	0.00	100%
COURT	22.22	44.45	11.11	22.22	0.00	100%
ANON	66.67	6.67	13.33	0.00	13.33	100%
DO-H	85.71	0.00	0.00	7.14	7.14	100%
HMO	57.14	0.00	42.86	0.00	0.00	100%
CCSP	18.18	9.09	54.55	18.18	0.00	100%
DO-IS	66.67	11.11	0.00	11.11	11.11	100%
AHP	12.50	25.00	50.00	12.50	0.00	100%
CL	40.00	40.00	20.00	0.00	0.00	100%
SASS	0.00	0.00	0.00	100.00	0.00	100%
DO-FV	25.00	75.00	0.00	0.00	0.00	100%
DC	66.67	0.00	0.00	33.33	0.00	100%
DO-PC	33.33	0.00	66.67	0.00	0.00	100%
DO-DS	0.00	100.00	0.00	0.00	0.00	100%
TOTAL	42.45	37.39	12.57	5.06	2.53	100.00%

The second highest proportion and number of notifications of neglect came from grandparents (71, 12.8%), and then non-mandated members of the community (68 or 12.3%), followed by parents (63, or 11.37%) – who were usually the alternative caregivers. Neglect was the most likely form of maltreatment to be reported by all of the non-mandated groups, making up 64.6 percent of reports by grandparents, 43.2 percent of parents' reports, 63.6 percent of reports by members of the community, 54.6 percent of reports by other relatives of the family, and 66.7 percent of anonymous reporters.

Table 4.5c: **M**altreatment type by notifier for Subject Infants in 2005 (percent of column totals)

NOTIFIER	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
DPPS	16.06	57.17	26.22	16.67	9.09	32.57
PARENT	11.37	7.79	12.20	27.27	21.21	11.19
NGO	8.84	10.25	6.71	6.06	6.06	8.89
GRANDP	12.82	4.71	7.93	1.52	6.06	8.43
CM	12.27	3.69	7.93	6.06	12.12	8.20
DO	4.51	4.92	1.83	7.58	3.03	4.44
REL	5.42	2.05	4.88	4.55	12.12	4.21
DEd	4.15	2.05	10.37	3.03	6.06	4.14
HOP	7.40	1.02	3.05	0.00	6.06	4.06
CHN	4.51	1.64	1.83	3.03	3.03	2.99
GP	1.62	0.41	1.83	3.03	3.03	1.30
CSW	2.17	0.41	1.22	0.00	0.00	1.23
COURT	0.72	1.64	1.22	6.06	0.00	1.23
ANON	1.81	0.20	1.22	0.00	6.06	1.15
DO-H	2.17	0.00	0.00	1.52	3.03	1.07
HMO	1.44	0.00	3.66	0.00	0.00	1.07
CCSP	0.36	0.20	3.66	3.03	0.00	0.84
DO-IS	1.08	0.20	0.00	1.52	3.03	0.69
AHP	0.18	0.41	2.44	1.52	0.00	0.61
CL	0.36	0.41	0.61	0.00	0.00	0.38
SASS	0.00	0.00	0.00	6.06	0.00	0.31
DO-FV	0.18	0.61	0.00	0.00	0.00	0.31
DC	0.36	0.00	0.00	1.52	0.00	0.23
DO-PC	0.18	0.00	1.22	0.00	0.00	0.23
DO-DS	0.00	0.20	0.00	0.00	0.00	0.08
TOTAL	100%	100%	100%	100%	100%	100%

Neglect was also the most common type of maltreatment reported by mandated groups aligned with the provision of medical health services such as hospital health professionals (77.4%), hospital medical officers (57.1%), Child Health Nurses (64.1%) and GPs (52.94%). However, the number of neglect cases reported by Child Health Nurses (25, 4.5%) was surprisingly low, and the number of cases reported by GPs and

Medical Officers was also low (9, 8). There were 41 notifications with concerns about neglect in relation to newborn infants from hospital nurses and social workers (HOP), most of which were in response to unborn alerts sent from the Department. Neglect was also the most common maltreatment reported by the Department of Education (42.6%), departmental officers within Housing Services (85.7%) and by community social workers (75.0%).

The total number and proportion of reports for children in this age group emanating from health professionals in the community was low, with Child Health Nurses making 39 notifications (or 3% of the total) and GPs, 17 notifications (or 1.3% of the total number). Medical practitioners in general have very low notification rates, with hospital medical practitioners (HMOs) making only 14 (≈1.1% of total) notifications for this age group, compared to other hospital health professionals (HOP), with 53 notifications (4.1%). Child Protection workers (DOs) notified concerns about neglect and emotional abuse in fairly equal proportions (43.1% and 41.4% respectively). As the third most prolific reporters, NGOs also notified almost equal proportions of neglect and emotional abuse (42.2% and 43.1%). Notifications from representatives of the Family Court and the Magistrate's Court were most commonly reporting emotional abuse in relation to family violence.

The three highest sources of notifications of physical abuse were the DPPS (43% of total cases), parents (20%) and the Department of Education (17%). Although this is at the lower end of the scale with respect to quantities, it is worth noting that the only two groups of notifiers who reported proportionately more physical abuse than other types of maltreatment were child-care service providers (54.5%) and allied health professionals (50%). Also noteworthy is the fact that out of all the notifications for the SIs made by Child Protection Workers (DOs) themselves, only 5.2 percent were for physical abuse concerns. The main sources of the 33 notifications of sexual abuse were from parents (27.3%) and the DPPS (16.7%). Allied health professionals (AHP), such as psychologists, dentists and physiotherapists, are another group who did not make many reports (8 notifications or 0.6% of total).

Table 4.5d: Summary of mandated and non-mandated notification reports for Subject Infants in 2005

	Mandated	Non-mandated	Total
Number	869	436	1,305
Percentage	66.6	33.4	100

Rural-urban Comparisons

Maltreatment type and response classifications

Information regarding the rural/urban status of families was available for 1689 of the 1714 notifications for the SIs in 2005. There were no apparent differences in the pattern of maltreatment types for infants residing in rural and urban areas. Nor were there any differences evident in the CP response classifications for rural and urban notifications. Table 4.6a presents numbers and percentages of notifications for the SIs by maltreatment type and rural and urban status in the 2005 calendar year. (An overview of maltreatment type by region and Child Protection response classification is provided in Tables A4.6c and A4.6d in Appendix C.)

Table 4.6a: Notifications for the Subject Infants (<4) by maltreatment type and region in the 2005 calendar year (numbers and percentages of maltreatment types per region)

Numbers

Region	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
Rural	166	139	45	21	9	380
Urban	580	498	147	55	29	1309
TOTAL	746	637	192	76	38	1689

Percentages of row totals

Region	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
Rural	43.68	36.58	11.90	5.56	2.38	100.00
Urban	44.31	38.04	11.21	4.20	2.21	100.00
TOTAL	44.17	37.71	11.37	4.50	2.25	100.00

Table 4.6b: Notifications by age group and region

Age Group	Number Rural	Number Urban	Proportion Rural	Proportion Urban
0–1	90	400	0.237	0.306
1–2	86	291	0.226	0.222
2–3	86	301	0.226	0.230
3–4	118	317	0.311	0.242
Total	380	1309	1.000	1.000

Age group by region

When the SI sample was divided into four age groupings, there was evidence of rural-urban differences in distributions across age groups of notification proportions. Table 4.6b provides numbers in each age group and corresponding age-group profiles for urban and rural areas. A chi-squared test of the 4 x 2 contingency table on the left half of Table 4.6b yielded a p-value of 0.017, constituting evidence that, for at least one of the age groups, there is a significant difference between rural and urban notification distributions across age groups. Equivalently, from a contingency table viewpoint, there is (also) at least one significant difference between proportions of rural or urban notifications among the four different pairs of age groups.

In order to detect which age groups had significantly different rural and urban proportions, stand-alone p-values for each difference between rural and urban proportions for each age group were established with likelihood ratio tests. The p-values for each individual test are set out in the 'pval' column of Table 4.6e below. There were two age groups (0-1 and 3-4) whose p-values indicated significant differences in rural-urban proportions; therefore, it was necessary to consider simultaneous testing. The 'pvadj' column of the table gives p-values adjusted for simultaneous testing according to Holm's method. Those same age groups still displayed differences in their respective rural/urban proportions, which were significant at the 5% level with a two-tailed test. (In this case, the slightly less powerful Bonferroni type adjustments also would have implied the same significances.)

The last two columns in Table 4.6e show the lower (L) and upper (U) boundaries of the simultaneous 95% confidence intervals for the differences, calculated according to the

method of Goodman. It is concluded that the proportion of rural notifications is an estimated 6.7 percentage points less on the average than the urban proportion for the 0-1 age group, and an estimated 6.7 percent more on the average for the 3–4 years old group.

Table 4.6e: Differences in rural and urban proportions for each age group

Age Group	Propn. Rural	Propn Urban	Diff (R-U)	pval	pvadj	(R-U) L	(R-U) U
0–1	0.237	0.306	-0.069	0.010	0.037	-0.132	-0.006
1–2	0.226	0.223	0.004	0.889	1.000	-0.057	0.065
2–3	0.226	0.230	-0.004	0.945	1.000	-0.065	0.057
3–4	0.310	0.242	0.068	0.009	0.037	0.002	0.135

Age group and maltreatment type by region

Notifications for the SIs by region, age and maltreatment type are presented in Table 4.6f below. The proportions of notifications by age group for each maltreatment type are provided for rural and urban regions in Table 4.6g.

Because there are some significant differences between the rural and urban profiles of proportions of notifications over the age groups, the same might be true for rural and urban age group profiles for one or more maltreatment types. While there is some indication of lower proportions of neglect and emotional abuse being reported in rural areas for 0–1-year-olds (and higher proportions of neglect and physical abuse for 3–4-year-olds), contingency tests (Fisher's exact test) did not detect significant levels of difference.

Table 4.6f: Total notifications by region, age group and Maltreatment Type

Age Grp	Region	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
0–1	R	46	28	10	3	3	90
	U	202	142	42	5	9	400
	N/A	3	2			1	6
0–1 Total		251	172	52	8	13	496
1–2	R	37	37	8	2	2	85
	U	133	117	29	6	6	292
	N/A	5	2	1			8
1–2 Total		175	156	38	8	8	385
2–3	R	37	32	12	3	2	86
	U	124	109	37	21	10	301
	N/A	1		1	1		3
2–3 Total		162	141	50	25	12	390
3–4	R	46	42	15	13	2	117
	U	121	130	39	23	4	318
	N/A	3	1	3		1	8
3–4 Total		170	173	57	36	7	443
Total		758	642	197	77	40	1714

Table 4.6g: Proportions of notifications by age group for each maltreatment type and region (percentages)

Rural (% of column totals)

Age Group	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
0-1	27.71	20.14	22.22	14.29	33.33	23.68
1-2	22.29	26.62	17.78	9.52	22.22	22.63
2-3	22.29	23..02	26.67	14.29	22.22	22.63
3 +	27.71	30.22	33.33	61.90	22.22	31.05
TOTAL	100%	100%	100%	100%	100%	100%

Urban (% of column totals)

Age Group	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
0-1	34.83	28.51	28.57	9.09	31.03	30.56
1-2	22.93	23.49	19.73	10.91	20.69	22.23
2-3	21.38	21.89	25.17	38.18	34.48	22.99
3 +	20.86	26.10	26.53	41.82	13.79	24.22
TOTAL	100%	100%	100%	100%	100%	100%

Source of notifications

No differences were found between the proportion of mandated and non-mandated reporters in rural and urban regions – approximately one third of notifications from

either urban or rural areas will be from non-mandated sources and approximately two thirds will be from mandated sources. Table 4.6h shows the source of notifications according to the rural and urban status of the SIs in numbers and percentages of total notifications recorded (N=1305).

Table 4.6h: Source of notifications according to rural and urban status (numbers and percentages of column totals)

Number				Percent		
Rural	Urban	Rural + Urban	Notifier Group	Rural	Urban	Rural + Urban
89	333	421	DPPS	31.34	33.27	32.84
41	104	145	PARENT	14.44	10.39	11.28
13	98	111	NGO	4.58	9.79	8.64
22	86	108	GRANDP	7.75	8.59	8.40
27	78	105	CM	9.51	7.79	8.17
16	41	57	DO	5.63	4.10	4.44
17	37	54	DEd	5.99	3.70	4.20
13	41	54	REL	4.58	4.10	4.20
11	42	53	HOP	3.87	4.20	4.12
13	25	38	CHN	4.58	2.50	2.96
2	14	16	CSW	0.70	1.40	1.25
2	14	16	GP	0.70	1.40	1.25
5	10	15	ANON	1.76	1.00	1.17
1	16	17	COURT	0.35	1.60	1.32
1	13	14	DO-H	0.35	1.30	1.09
4	10	14	HMO	1.41	1.00	1.09
0	11	11	CCSP	0.00	1.10	0.86
3	5	8	AHP	1.06	0.50	0.62
1	7	8	DO-IS	0.35	.0.70	0.62
1	4	5	CL	0.35	0.40	0.39
2	12	14	Other	0.70	1.20	1.09
283	1002	1285	TOTAL	100.00	100.00	100.00

Note: 'Other' is merging of SASS, DO-FV, DO-PC, DC, DO-DS.

There was reason to suspect some differences in proportions of rural and urban notifications per notifier group. A simulation version of Pearson' chi-squared test[33] yielded a p-value of 0.030, which indicated that the proportion of rural and urban notifiers differs overall, and that there must be significantly different rural/urban proportions for at least one of the notifier groups. Each group of notifiers' rural/urban proportions were tested individually as one row of a 2 x 2 contingency table using

[33] A simulation version of the test had to be used because some cell counts are too small for the usual Pearson's chi-squared approximation to be adequate.

Fisher's exact test. The only test to uncover significance was that for the NGO group of notifiers ($p = 0.006$). (Because an overall difference had been detected, simultaneous testing was not necessary to conclude that there is a significant difference between rural and urban proportions for this group). The observed rural–urban difference is 4.59% − 9.78% = −5.19 percentage points, and is the best estimate of the mean difference in those proportions. The associated 95% confidence interval, using normal approximations to the binomial, is (−8.24% to −2.13%); alternatively, the 21-test simultaneous confidence interval (by the method of Goodman) is (−9.92% to −0.45%).

The grouping of notifier classifications might camouflage some rural-urban differences. The only obvious one found was a two-way difference in the parents grouping, which when dissected into two groups – of biological 'Mothers' and 'Fathers' – revealed that for Fathers, there were 74 urban notifications and 19 rural notifications (66% of all parent notifications, 20% of notifications by F were rural), while in the Mothers group, there were 29 urban notifications and 18 rural notifications (34% of total parent notifications, 38% of notifications by M were rural). (The total number of biological parents (N=140) is less than the total number of parents (N=145) as there were three notifiers categorised as 'parents' whose gender was unknown and two were step-parents)

It would be reasonable to suggest that the difference between the number of notifications made by fathers and the number made by mothers would be primarily due to the likelihood that a relatively large number of mothers in this population would be single and would be more likely to have primary care of the children in this age group. While the proportion of rural notifications (20%) by 'Fathers' was closer to the proportion of rural notifications overall, the proportion (38%) of rural notifications made by the mothers is relatively high. There was some evidence in the informal reading of the case files, that there were high levels of homelessness and transience for single mothers, especially those removing themselves from DV relationships, who were more likely to find cheaper accommodation in rural areas, but who may have had ongoing disputes regarding custody arrangements for the children and/or concerns about children when they are in their father's care.

Summary of Findings

Abuse and neglect concerns for children aged less than four years old were reported to child protection at the comparatively high rate of 15.1 notifications per 100 children in the general population, with a per-child notification rate of 6.9 per 100 children. Bearing in mind the problem of lack of comparability between states and countries, to put it into some sort of perspective, the national average notification rate for children of all ages is 31.9 per 1000 children in Australia (or 3.19 per 100 children) (AIHW 2012, p. 6).

A measure of the effectiveness of the child protection system is provided by the re-referral rate, which was comparatively high for this population – with 46% of the Subject Infants, and 56% of infant sibling groups, renotified to the Department on at least one occasion during the 2005 calendar year – (e.g. Connell et al. 2007; Forrester 2007). Connell et al. (2007), for example, found a re-referral rate of 27 % for children notified in the same year in the United States. The 81.8% of cases that were renotified over the four-year period compares even less favourably with the 50% rate within a 54month period found in Missouri (Connell et al. 2007).

The issue of maltreatment chronicity is particularly important for children in the early stages of childhood development in that the harm that occurs at an earlier developmental level is not restricted to that particular phase of development, it also compromises later developmental processes (English, Graham et. al. 2005). In general, families who were renotified in 2006 (55% of the original family group) and those who were still in the system in 2007 (43.5%) were being re-notified at approximately the same rate as they were in 2005. However, the families who were being notified at the lower rate of between 1 and 3 times in 2005 were renotified in subsequent years at a slightly increased average rate. Going by frequency rates, the level of chronicity and severity of these predominantly neglect concerns appeared to increase for these families with young children over the subsequent years. For those families with higher notification rates in 2005, however, the notifications did continue, but the average frequency rates appeared to be slightly reduced over time – possibly as a result of receiving some form of child protection attention or intervention. The chronic nature of the cases reported at a lower rate supports the findings that the response by the system is

inadequate, which is a particular concern for infants and toddlers at risk of accumulated effects of neglect over time. Unlike previous research, where family size is considered to be a risk factor for child maltreatment (e.g. Connell, Bergeron, Katz, Saunders & Tebes 2007), the number of children in the family was not found to be the cause of any increase in the number of notifications received over the period.

The numbers of notifications for SIs in rural areas during 2005 averaged 11.2% of the rural population of infants (< 4 years old), while the numbers of urban notifications for the same age group was 15.4% of the corresponding urban infant population. That is, 6.9 per 100 children under 4 years in rural areas were the subject of one or more notifications during the year, compared to 7.8 per 100 in urban areas. When differences in risk factors are taken into account, there is a decrease in the underlying rural rate from 73% to 56%. It was possible to conclude that the likelihood is that under-reporting is occurring in rural areas, although this cannot be shown for certain.

As expected, neglect (at 44.2%) and emotional abuse (at 36.24 %) made up the majority of referrals to child protection services for this age group. The pattern of neglect and abuse for this age group was different to that of the Tasmanian child protection population as a whole. The proportions of neglect and emotional abuse notified for children under the age of four years was found to be greater than that for the general CP populations (at 5% or greater significance levels). The study supports previous findings that neglect is most likely to receive no further action, less likely than abuse to have a Priority 1 classification and more likely than abuse to have a Priority 2 classification. Given, the circumstances in the Department at the time, level 2 Priority notifications were highly unlikely to receive a timely response.

As a group, grandparents (12.8%) and parents (11.37%) together were the most common source of notifications of neglect for children this age. Police [Department of Police and Public Safety (DPPS)] were responsible for the highest number of neglect notifications in the mandated group (16.1%). Interestingly, Child Health Nurses (CHNs) were relatively unlikely to report cases of child neglect, making up only 4.5% of all neglect notifications; hospital professionals (HOP) were more likely than CHNs to report concerns (7.4%). These figures may well reflect the informally noted reluctance of mothers in the child protection system to engage with the Child Health Nurses.

Previous findings that General Practitioners are unlikely to notify concerns were supported; however, when they did report, they were more likely to be reporting neglect than abuse.

Conclusion

Notifications for children less than 48 months of age who reside in rural and urban regions in Tasmania were explored in terms of referral rates, patterns of abuse and neglect, and re-referral patterns for sibling family groups over time. The implications of the findings are that infants and toddlers at risk of neglect are not being adequately responded to by child protection services – especially when compared to those referred for physical abuse. The findings also suggest that the 0–4 age group are a somewhat unique group within the child protection population, with significant differences found between the pattern of referral for this age group and that of the general child protection population. The findings also showed that infants under the age of 12 months living in rural areas are notified at a significantly lower rate than their urban counterparts. The referral pattern for families with infants and toddlers suggest an overall pattern of persistent neglect over time.

It is important to acknowledge, however, that studies such as this will continue to have serious limitations while the definitional problems outlined in the Introduction remain unresolved. And while it was not within the capacity or the timeframes of a project of this kind to both develop and apply a conceptually sound research definition of neglect for a child protection population of this size, the study would have been better able to provide a more realistic picture of the prevalence of neglect in this age group. The gaps between and among the legal, policy and practice definitions and how child protection workers understand and make decisions about them, is going to limit to varying degrees the comparability, validity and reliability of some of the findings. The findings regarding notification rates for abuse and neglect are not necessarily going to be comparable with those from other periods of time, other jurisdictions or other countries – notification rates here, and elsewhere, are just as likely to reflect the many and varied definitions, policies and systems that are in place in a particular jurisdiction at a particular point in time. In this jurisdiction at that time, the notification rate reflects the under-resourced department and its under-preparedness for the changes that were taking

place, the rate of occurrence of family violence, and/or the prevalence of parental substance mis-use, mental health problems, and the level of socio-economic disadvantage within the community. Although this study has been able to describe the different patterns of referral and re-referral – in terms of the community response to abuse and neglect and the differentiated nature of the child protection response to those reports – it tells us very little about the infants' and toddlers' actual maltreatment experience, other than the fact that it is chronic in nature and that neglect is more likely to occur and less likely to be responded to than abuse.

All of which points to the need for further research which is aimed more specifically at resolving the underlying definitional issues, which in this case, involves working towards the development of a definition of early childhood neglect; in particular, one which is more closely aligned with the nature of the problem and focuses more on the experience of the infant or young child. In the next chapter, conceptually sound operational definitions of neglect relating specifically to this age group are developed which serve as a conceptual framework for exploring the nature of neglect in infancy and early childhood.

CHAPTER FIVE

Towards a Conceptual and Operational Definition of Neglect in Infancy and Early Childhood

The findings in the previous chapter add support to previous research which suggests that a large proportion of neglected infants and young children are not having their care and protection needs adequately met by their families or by the systems that have been put in place for that purpose (e.g. Forrester 2008). The limitations of the study and of neglect research in general point more directly to the issue that lies at the heart of the problem: the ongoing lack of a consistently used, concise and conceptually sound definition (e.g. Dubowitz, Newton et al. 2005; English, Thompson et al. 2005; Zuravin 1999). As researchers and writers have repeatedly pointed out, improved understandings of neglect are needed to bring the nature of the problem itself into closer alignment with the way it is currently and variously conceptualised and defined across the disciplines for the purposes of research, policy and practice.

The following two chapters describe the development of a conceptually sound set of operational definitions into a system for classifying and measuring neglect in infancy and early childhood, which is applied in the following study. This chapter has two main purposes. The first is to further the argument posed in Chapter 1, regarding the need for research aimed at developing operational definitions of neglect aimed more specifically at meeting the requirements of infants and young children. The proposed definition is based on the conceptual model put forward by Dubowitz and colleagues (1993) and Dubowitz, Newton et al. (2005) which focuses on the unmet basic needs of children, rather than the intentions or behaviours of parents.

The conceptual definitions of neglect proposed by Dubowitz, Newton et al. (2005) and English, Thompson et al. (2005) are further developed to take into account a more complete range of constructs relating to the basic care and protection needs that are required for the normal development, health and wellbeing of infants, prenatally and in infancy and early childhood (children < 48 months). The second purpose of the chapter is to describe the development of the conceptual and operational definitions into a

classification system which is then used to provide the conceptual framework within which to analyse the data for Study Two.

In summary, the concurrent objectives of the research presented here and in the following chapter are to:

1. develop a classification and measurement system for the research, which provides conceptually sound operational definitions of neglect in infancy and early childhood that can be applied across the domains of research, practice and policy;
2. explore the nature of the neglect experience in the early developmental period from before birth through infancy and early childhood (< 48 months of age) – in terms of unmet basic care and developmental needs – and identify any specific unmet needs relating to cases in which infants or young children have died.

Because definitional research on early childhood neglect is itself in its infancy, a fundamental aspect of the present research involved the development of conceptually sound operational definitions of the problem. The operational definitions were further developed into a classification and measurement system, as recommended by Barnett et al. (1993), to provide a more concise and consistent method of identifying and measuring the problem. The operational definitions are conceptualised in terms of the unmet needs of the child, and take into account the cumulative aspects of chronic neglect and the potential for developmental harm, and the desirability of maintaining the focus on the experience of the infant/young child. It has been designed to serve as an instrument for classifying and measuring infant neglect – and/or assessing risk of potential developmental harm – which has potential application for both research and professional practice.

Changing Concerns – Unchanging Responses

Despite the particular vulnerability of children in the early years, neglect continues to be responded to less frequently and in a less timely fashion than physical and sexual abuse. The results of the incidence study in Chapter 4 confirmed that neglected infants (under 48 months of age) were being referred and re-referred to the Department at an unacceptably high rate. The rate at which referrals are repeated provides a measure of the overall effectiveness of the child protection system in place at the time – with a high

re-referral rate indicating an inadequate child protection response (Forrester 2007). Jacob and Fanning's (2006) report on child protection in Tasmania was one of a number of reviews and reports which confirmed that the system at the time was failing, particularly in relation to a highly vulnerable group of infants on unallocated lists awaiting further investigation and assessment.

An investigation into the deaths of ten children in Tasmania in 2005 and 2006 was conducted in order to "identify any factors that may have been involved in their quality of life and any overall systemic issues related to the child protection" (Minister for Health and Human Services, 28 November 2007).[34] Although the report was not publicly released, a ministerial media release revealed that of the eight children who were actually known to Child Protection at the time,[35] three were reported to have died as a result of abuse or neglect, two infants were found to have died of sudden infant death syndrome (with risk factors present), and three children died from natural causes or as a result of a disability. It is likely that at least two of the deaths were subject to coronial inquiries and/or police investigations which had not been finalised at the time. That review and the separate investigation into the death of another child resulted in a lengthy set of recommendations which were being gradually implemented along with the other major reforms and changes to the child protection system outlined in Chapter Two.

There is a lack of accurate statistical data on child deaths in countries such as Australia, and while physical assault is usually included in paediatric death reviews, neglect usually is not (Lamont 2010; Sidebotham, Bailey, Belderson & Brandon 2011). However, the NSW Child Death Review process does include neglect and abuse classifications, and in the Ombudsman's review of 45 deaths of children in NSW in 2009-10, for example, 29 cases (or 64%) were classified as having occurred in relation to abuse, neglect or suspicious circumstances; of these deaths, fourteen (31.1%) were due to neglect, seven (15.5%) were due to abuse, and eight (17.7%) occurred in suspicious circumstances (Lamont 2010, p. 3).

[34] Media Statement by then Minister for Health and Human Services, Lara Gidding (28 November 2007)
[35] It is likely that the families of the two children not finally included were known to the Department, but that the two children who died had not been reported up until the time when their deaths were notified.

Nonetheless, the number of fatalities due to neglect is believed to be an underestimate of the true incidence, partly due to the unresolved issues surrounding the definition of neglect and partly due to the fact that there are often unresolved questions surrounding the circumstances of paediatric and perinatal deaths (e.g. American Academy of Pediatrics 2001; Lawrence & Irvine 2004). For instance, in the New South Wales (NSW) Child death Review Team's (2003) report, neglect is conceptualised in terms of parental actions and failures which only include inadequate supervision (e.g. drowning), negligent driving, and failure to provide medical care (NSW CDRT 2003).

The NSW Department of Community Services' (DoCS 2006) policy on child neglect was developed partially in response the prevalence of neglect concerns being notified to the department and increased understanding of its adverse affects on child development, but also in response to the Child Death Review Team's criticisms of current practices in relation to neglect. In particular, the Team referred to the commonly held misconception that each neglectful incident is trivial and less serious than physical or sexual abuse; thereby affecting both the type of response and the priority that it is assigned. The "critical issues adding impetus to better understand the nature of neglect *in all the forms in which our caseworkers encounter it*, both in isolation and entangled with other forms of abuse" (p. 9), which are equally pertinent to the current study, are:

- the sometimes fatal consequences of neglect, and the disturbing fact that the characteristics of families in which neglect-related deaths occur are not distinguishable from the characteristics of families in which neglect is chronic;
- the prevalence of neglect as an underlying or co-existing factor in cases featuring both abuse and neglect, with the consequence that neglect may not receive appropriate attention;
- and the impact of neglect on both child development and functioning in later life (DoCS 2006, p. 9).

Examining cases where serious harm has occurred enables an exploration of the relationship between neglect and other forms of abuse. Sudden unexpected or unexplained death in infancy is the main cause of death of children between one month and one year of age in Australia and the US (Qld Government 2008). At the time of writing there is, as yet, no formal child death review process in place to routinely provide analyses or to report on the deaths of children known to child protection in Tasmania; however, the Department has been working towards bringing together the existing review mechanisms – the Council of Obstetric and Paediatric Mortality and

Morbidity (COPMM), the Coronial process, and child protection – with the aim of establishing a review body such as a child death review committee (Lamont 2010). The unexplained deaths of nine infants in Tasmania in 2005 and 2006 were found by the COPMM to have been attributable to unsafe sleeping practices and/or environments together with exposure to additional risk factors such as maternal alcohol, cannabis, tobacco or other legal and/or illegal drug use, with accidental overlying and/or respiratory failure evident in some of the cases (COPMM 2005, 2006 in DHHS 2007, 2008).[36]

Although all of the deaths were classified as either 'sudden infant deaths' (SIDS) or 'sudden unexplained/unexpected death of an infant' (SUDI), the Council of Obstetric and Paediatric Mortality and Morbidity (DHHS 2007) commented that in light of the findings, it was "evident that the nature of unexplained infant deaths had changed over the years" (p. 25). There are, however, some differences worth noting between the Tasmanian COPMM's definition and usage of the Acronyms SIDS and SUDI and that described in the Public Health Association of Australia's policy document outlined below. The Tasmanian COPMM defines SIDS and SUDI as follows:

> Sudden Infant Death Syndrome (SIDS): Sudden death of an infant under 1 year of age, which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and a review of the clinical history. The term Sudden *Unexplained* Death of an Infant (SUDI) is now often used instead of Sudden Infant Death Syndrome (SIDS) because some coroners prefer to use the term 'undetermined' for a death previously considered to be SIDS. (COPMM 2011; italics added)

The Public Health Association of Australia, on the other hand, uses the term 'unexpected' rather than 'unexplained' to define SUDI, and conceptualises SIDS as a subset of SUDI, as follows:

> Sudden Unexpected Death in Infancy (SUDI) is the sudden, unexpected death of an infant, usually occurring during sleep, in which a cause of death is not immediately obvious. SUDI refers to a broad category of sudden and unexpected deaths which include Sudden Infant Death Syndrome (SIDS), infections or anatomical or developmental abnormalities not recognised before death, sleep accidents due to unsafe sleep environments and sudden unexpected deaths that are revealed by investigations to have been the result of non-accidental injuries (QLD Health 2008).
>
> A death is generally classified as a SUDI if it concerns:
> - an infant less than 12 months of age
> - a death that was sudden in nature

[36] The Council of Obstetric and Paediatric Mortality and Morbidity's (COPMM) Annual Reports are available at: http://www.dhhs.tas.gov.au/about_the_department/partnerships/registration_boards/copmm

• a death that was unexpected (QLD Health 2008).

SIDS is a subset of SUDI. SIDS is defined as:

> The sudden and unexpected death of an infant under 1 year of age, with onset of lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, and review of the circumstances of death and the clinical history. (July 2004) (Public Health Association of Australia 2009)[37]

The forensic pathologist in another SIDS investigation makes the additional point that "it is not possible, within the current state of medical science, to distinguish death due to the sudden infant death syndrome (SIDS) and suffocation due to compression by an overlaying adult ... the autopsy findings in cases of SIDS are variable and non-specific" (Record of Investigation into Death, 2009). Tasmanian coronial records reveal that 33 of the 34 infants who died between May 1999 and July 2006 involved an unsafe sleeping environment – predominantly co-sleeping in an adult bed and unsafe bedding – with many of the deaths also involving factors such as parental alcohol and/or drug use and cigarette smoking (Coroner's Findings, 2008)[38].

The record of investigation into the deaths of four of the infants in 2005 and 2006 was published "in order to emphasise the significance of the issue in Tasmania in the hope that consideration can be given to ways in which further similar deaths can be prevented" (Coroner's Records 2008). Both the Coroner (2008) and the Council of Obstetric and Paediatric Mortality and Morbidity (DHHS 2008b) have expressed concern about the high rate of SIDS in Tasmania – which is second only to that of the Northern Territory. Coroner Olivia McTaggart (2008) made particular note of her concerns about the circumstances surrounding the deaths, stating that some of these may have been prevented if child protection and other health or service providers involved at the time had acted differently.

In his report of the investigation into the death of one of the infants who had died in 2006, Coroner Rod Chandler (2009) said he believed that the initial assessment and investigation of the infant's circumstances and the priority classification assigned to the case were inadequate, and that placing the child on a list of unallocated cases was

[37] This definition is a result of a pathology workshop in Victoria, attended by coroners and pathologists from all over Australia. The policy is available at: http://www.phaa.net.au/documents/policy/20091028SuddenUnexpectedDeathinInfancyandSIDsPolicy.pdf

[38] Coroners' records of investigations are available at: http://www.magistratescourt.tas.gov.au/decisions/coronial

"effectively abandoning further investigation of the infant's circumstances", which would have revealed that the infant was a 'a child at risk' and in need of protection. Although the lack of resources (with the number of unallocated cases exceeding 700 during 2006) was acknowledged to have been a contributing factor, the tragic outcome for this infant and for a number of other infants and young children brings the investigation, assessment and prioritisation practices and processes relating to neglect into question.

In the VCDRC's (2000) review of child protection infant deaths in Victoria between 1995 and 1999, nine of the fourteen cases reviewed for analysis had been attributed to SIDS. The decision to widen the scope of analysis – which was aimed at improving the relationship between maternity and child protection services – to include all infant deaths, including the SIDS cases, was based on the determination that high risk factors for child abuse and neglect were present, and that these risk factors had required an early intervention response which they had not received (VCDRC 2000). The determination to include SIDS cases was also responding to the fact that while the campaign in the early 1990s had succeeded in dramatically reducing the number of SIDS deaths in the general population, the number of cases in the child protection population has not decreased over time (VCDRC 2000). The risk factors reported in the review included the young age of the mother, maternal substance abuse, chaotic and unstable lifestyles, and the increased medical or health risk of the infant; including, prematurity, low birth weight, medical conditions, drug dependency, failure to thrive and later signs of dehydration.

It is remarkable also that while many of the reports reveal a preparedness to raise the issue of systemic neglect and to blame individual professionals for their lack of judgement or failure to take appropriate action, there is no reference to the ongoing neglect experience for and of the infant or to the omissions of care on the part of parents or primary caregivers, who are notably absent in most of the reports, existing only in terms of 'risk factors' present at the time. Whatever the reasons, there exists a deep-seated misapprehension of neglect as less critical and serious than abuse in child protection practice and in medical, health and welfare practice generally (see, e.g. Horwath 2005a, 2007; Minty et al. 1994).

The Victorian Child Death Review Committee (VCDRC 2007, 2008) reports some quite different findings and concerns. The VCDRC (2007) reported that the deaths of 14 infants aged 0-3 years known to Child Protection were categorised as follows: 7 had 'acquired/congenital illness'; 4 were 'not known – pending coronial findings'; 2 were 'accidental', and 1 case of 'SIDS'. Over the 11-year period from 1996 to 2006, there were 118 deaths of infants known to Child Protection: of these 44 were categorised as 'acquired/congenital illness', 26 as 'SIDS'; 15 as 'accidental'; 12 as 'non-accidental trauma'; and 21 were classified as 'not known'. A review of 13 child deaths between 2006 and 2007 carried out by the VCDRC found that five of the eight infants' deaths were linked directly to prematurity and/or congenital conditions. The chairperson of the VCDRC notes in the Foreword that since "children born with complex care needs require a higher standard of parenting than is usual; the consequences of neglectful parenting are particularly serious for these children" (VCDRC 2007, p. *iii*). And again, "the most significant feature of the families involved in child death reviews was the co-existence of a number of factors that are known to reduce parenting capacity", including family violence, parental substance abuse and parental mental illness (VCDRC 2007, p. *x*).

Although 'neglect' is not included as a classifiable cause of death in the annual reports or reviews of paediatric deaths in Tasmania or Victoria, while abuse is, chronic neglect is acknowledged by the VCDRC to have been significant in the lives, if not the deaths, of many of the infants and young children who died. The VCDRC (2007) had commissioned the *Child Death Group Analysis: Effective Responses to Chronic Neglect* (2006) prior to releasing the findings, which they considered to be relevant as well as "valuable and insightful" (p. *xiii*). As the Commissioner at the time observed in his introduction to the *Child Death Group Analysis*, the lives of the children who died "were characterised by an accumulation of harms associated with chronic neglect" (Victorian Child Safety Commissioner, VCDRC 2006, p. *v*). The aim of the analysis was "to contribute to the discussion regarding chronic neglect and cumulative harm and ensure that learning arising from a small group of child deaths is used to shape future policy and practice" (p. *iii*).

With the problem of maternal substance abuse worsening in recent years, there is a growing awareness of the need for further and more open discussion in the largely

unexplored area of prenatal neglect as well as infant neglect, especially because of this largely un-named association with infant mortality. Legal and illegal substance use in pregnancy is known to increase the likelihood of prematurity, low birth weight, neonatal abstinence syndrome (NAS), foetal alcohol spectrum disorders (FASD), abnormal foetal development and growth, and attachment problems (Carmichael et al. 2001; Jacobson & Jacobson 2001). It is an incongruous situation that a proportion of infants who are born with extra care needs and require higher than normal standard of care are the least likely to receive it. Infants who are born with conditions such as NAS can be very difficult to care for and to bond with – they are often inconsolable, they don't like to be touched, are difficult to settle, and have a typical high-pitched scream – they require the type of care that parents who have a substance dependency and/or mental health problem are least likely to be able to provide. Affective, sensitive, responsive, linguistically rich and protective parental care and nurture are vital to children's survival, growth and psychological development and wellbeing (WHO 2004) – children are perceived by the World Health Organisation to have a right to this kind of care. Parents with the increasingly common problem(s) of chronic substance abuse, mental health disorder or significant intellectual deficits, particularly in combination, are less likely to be able to meet those needs without intervention and support.

More specialised assessments based on developmental needs and intervention that retains a focus on the infant is lacking for this highly vulnerable group. The principles of minimal intervention and family preservation built into Australian child protection legislation, and the shift towards a 'prevention and support' approach has led to some criticism and concern about the safety of vulnerable infants in particular being left in neglectful and highly risky situations a (Goddard & Tucci 2008; Sammut & O'Brien 2009). This type approach involves an inordinate amount of trust in parents' stated willingness to engage in rehabilitation and support programs in a timely fashion, when their ability to follow through and maintain the changes is often limited due to the complex nature of the most of the parental problems.

As Cash and Wilke (2003) point out, "the central feature of substance dependence is a combination of physiological, cognitive, and behavioural indicators that signal an *inability* to control the use of alcohol or other drugs, particularly a persistence of use in the face of significant alcohol and other drug (AOD) related consequences (American

Psychiatric Association [APA] 1994)" (p. 394; emphasis added). The high rate of co-morbidity among those who mis-use substances – with affective disorders being the most common for women – means that there is no quick fix for substance dependence (Cash & Wilke 2003). It is hardly surprising to learn that a recent review of the effectiveness of intervention programs in the US provided 'limited evidence' that the programs work (Goddard 2009; Twomey et al. 2010).

In NSW child death review teams do cite neglect as a cause of death and distinguish between two types of neglect fatalities: a) those involving 'supervisory neglect' in critical incident or accident deaths, such as accidental drowning, gun accidents, choking, ingesting pills or as a result of house fires, are classified as 'supervisory neglect'; and b) those involving 'chronic neglect' due to preventable issues such as malnutrition, starvation and dehydration (DoCS 2009, p. 9). Reviews of children's deaths in NSW, like those conducted elsewhere, have highlighted the fatal consequences of neglect and the importance of gaining a better understanding of the nature of neglect – in its varied forms and in its relationship with other forms of maltreatment – as well as raising concerns about "apparent deficiencies in the Department's assessment procedures and service responses" (DoCS 2006, p. 9).

However, the belief expressed in the DoCS (2006) policy on neglect is that child fatalities due to chronic neglect are preventable and substantially different from the 'accidental' deaths due to supervisory neglect. The implication that supervisory neglect is not a feature of chronic neglect is debatable. Although deaths do occur, or at least have been found to have occurred, as a result of one-off incidents where there has been a lack of supervision, supervisory neglect is regarded as a central feature of chronic neglect [see, for example, Barnett et al.'s (1993) Maltreatment Classification System (MCS); English et al.'s (1997) Modified MCS; Trocmé's (1996) Child Neglect Index (CNI)].

The push to develop a separate definition for fatal neglect (e.g. Lawrence & Irvine 2004) to add to the expanding list of maltreatment types highlights the problem of the way new definitions of abuse and neglect emerge in a haphazard fashion without adequate attention to defining and conceptualising abuse and neglect in a way that makes it less complicated and confusing, and more easily understood and able to be

addressed. It also reflects a tendency to respond to the more dramatic and distressing events and outcomes, and points to the need to differentiate the difference between neglect as the problem that the child experiences and death as the preventable outcome.

Rather than addressing the most important issue of its nature, where it might fit within current concepts and definitions of neglect – in an effort to prevent such tragedies from happening in future – defining the problem based on harmful outcomes merely increases the likelihood of ending up with an endless list of possible forms of maltreatment. The fundamental reason for defining a problem is in order to better understand and treat it – fatal neglect is an outcome that cannot be treated.

System responses and issues

One of the most disturbing aspects of Victoria Climbié's death in England in February 2000 was the fact that she was known to child protection and in contact with other services at the time but the referrals were not considered serious enough to warrant allocation or further investigation – her case had been closed once again on the very day that she died (Laming 2003; Forrester 2008). The subsequent (publicly available) report by Lord Laming (2003) instigated significant changes in child protection practice and policy in the UK. The Government responded to Lord Laming's call for reform with the introduction of the Framework for the Assessment of Children in Need and their Families (Department of Health 2000), at the heart of which were changes to the initial assessment and decision-making processes (Forrester 2007). However, an overview of serious cases in 2008, indicated that "the single most significant practice failing" was a failure to maintain a focus on the child (Ofsted 2008, cited in Horwath 2011, p. 1072-3).

The main focus of the reform agenda in Australia has been somewhat different. The primary motivation for change has been to better manage the overloaded systems – on the assumption that a large proportion of cases are unnecessarily reported. Although new child protection strategic frameworks throughout the country are purportedly designed take the developmental needs of children into account, the fundamental risk-based approach to assessment and decision-making, which is clearly not designed for this purpose, remains for all intents and purposes unchanged. Neither the initial notification/risk assessment procedural format nor the follow-up risk assessment for that

matter provides any useful guidance or a framework to take into account the basic developmental needs of children of any age (apart from one section in which developmental concerns can be noted – see Appendix A for a copy of the new Notification and Risk Assessment procedural forms).[39]

While the Tasmanian Government's commitment to aiding the recovery of children suffering from the results of physical and emotional trauma and attachment difficulties is commendable (Tasmanian Strategic Framework), improved understandings of neglect and child development, and better assessment guidelines and processes would help to prevent the harm from occurring in the first place. The continuing high notification rates for neglect (and emotional 'abuse') in recent child protection data suggest neglect continues to be inadequately or inappropriately responded to.[40]

The Child Protection Australia 2009–10 (AIHW 2011) report makes note of the simultaneous broadening of definitions of what constitutes abuse and neglect – which is accompanied by an increase in notifications and substantiations – and a shift in focus away from the identification and investigation of incidents of abuse and neglect, towards an assessment of whether a child has suffered or is likely to suffer harm (p. 5–6). This is perceived as one of a number of problems that have been identified in relation to using a purely risk- and harm-based approach in cases of neglect which have already been outlined in Chapter 2.

Working within an overloaded system inevitably leads to changes in practice – child protection practitioners have been found to respond to work overload by raising thresholds for cases to be sent for further investigation, and research shows that, again, it is neglect cases that are most likely to be disadvantaged under these conditions (Flaherty & Goddard 2008, Buckley 2000). The emphasis on maintaining manageable caseloads and keeping unallocated cases to a minimum is a common aspect of workplace culture in under-funded and under-resourced child protection departments everywhere, and it was particularly evident during the data collection phase of this study

[39] Specialist infant and caregiver assessment guides developed by the Victorian child protection service in 2000 provide additional reference material and serves as a tool for assessing risk factors rather than needs. The infant assessment guide is designed for use in the face-to face investigation and assessment process.

[40] Although new methods of dealing with notifications may have reduced the overall numbers in some jurisdictions, the overall substantiation rates have remained the same (AIHW 2010, 2011).

and appeared likely to prevail for some time to come. The Annual Report released at the time of writing, and reports in the media, revealed that numbers of cases awaiting allocation are showing signs of increasing.

Approaches to assessing and responding to abuse and neglect which are based solely on ascertaining levels of risk lead to a focus on particular incidents and immediate safety, rather than the ongoing problems associated with chronic neglect and long-term developmental harms, and on parental risk factors and behaviours rather than children's unmet needs and wellbeing (Gillingham & Bromfield 2008; Goddard et al. 1999; Houston & Griffiths 1999). The Tasmanian Practice Framework policy of taking a child-centred approach at each stage of the child protection process is going to be difficult to achieve in the absence of any assessment of the child's actual experience of neglect and abuse and any formalised means of assessing whether or not their basic developmental, care and protection needs are being met.

The primary purpose of the risk assessment is to establish whether or not there are grounds for intervention; that is, whether the child can be considered to be 'at risk' of harm. Regardless of what type of harm may have occurred, questions of the child's immediate safety and the likelihood of continuing or subsequent harm occurring come down to judgements about parents' capacity to protect or willingness to change the circumstances or behaviours that prevent them from providing adequate care and protection. Again, for infants whose basic care and safety needs are not being met, the time it takes to establish whether or not parents make the necessary changes or engage with services can be vital in terms of their development, if not a matter of life and death.

Although practice guidelines, and definitions of abuse and neglect underlying practice, constantly refer to ensuring the safety and *wellbeing* of the child, the risk assessment itself is carried out for the purposes of assessing harm and/or safety, and the issue of wellbeing is never addressed in the process. Considering that notions of wellbeing are closely aligned with the concept of needs – in that wellbeing is achieved when basic care and developmental needs are met (O'Brien 2010; see also Redmond & Hamilton's 2010 Report on Social and Emotional Wellbeing) – it follows that an operational definition based on unmet needs would simultaneously provide a measure of the child's wellbeing.

Neglect and the Law Court: "Child abuse is what the courts say it is"[41]

The increasing numbers of infants entering foster care and/or court proceedings and the developmental problems that are increasingly bringing them there have created new challenges for judges and legal professionals (Lederman, Osofsky & Katz 2007). The Family Courts in Australia are faced with the difficulty of balancing the principles of family preservation – and the child's right to remain with the family of origin – with that of protecting infants from further harm and providing them with an opportunity for improved opportunities for future development and wellbeing. There is growing recognition that the Courts must make infant mental health and future development a priority when decisions are being made about the child's future placement, support services, and if and when parental rights are terminated (Lederman 2010).

Neglect cases in general are challenging for both the lawyers and child protection practitioners because of the differences between the legal and social work perspectives and the difficulty of providing sufficient evidence of harm or risk of harm occurring in the future (Dickens 2007). In other words, the two primary sources of the difficulties that professional practitioners face are the difference between the practice definitions and the legal definitions that govern child protection practices and systems, and the way they are defined within those disciplines.

A third complicating factor, especially in cases involving infants, is the need to balance the evidence against the various principles upon which the legislation is founded. The principles guiding child protection practice set out in the Tasmanian Act state that primary responsibility for the care and protection of a child is perceived to lie with the child's family, and a high priority is to be given to supporting and assisting the family to carry out that role (CYPTF Act, S8:1). In any exercise of powers, "the best interests of the child must be the paramount consideration"; however, serious consideration must also be given "to the desirability of keeping the child within his or her family", preserving and strengthening the family, and further, not subjecting the child to unnecessary, intrusive, or repeated assessments. In light of improved knowledge about

[41] Kempe 1972, *Children in Peril*, Xerox Films, Media Concepts, 1972, cited in Besharov 1981, p. 385

childhood and neurological development and infant mental health, there is some recognition that the emphasis on family preservation and minimal intervention in Australian legislation are incompatible with the ultimate goal of protecting children (Goddard & Tucci 2008).

It has been argued that the use of broad and *imprecise* definitions in legal practice is desirable because protective and legal practitioners need "the freedom to exercise their sound judgement" (Besharov 1981, p. 385). According to Besharov, many reported court decisions are based on the idea that since 'neglect' is regarded as the failure to provide the care that a child needs, and since the situation varies according to the specific context and facts of each case, "the word 'neglect' can have no fixed or measured meaning" – that is "although they cannot define maltreatment, they know it when they see it" (1981, pp. 385-386). He argues that the potentially arbitrary nature of the decision, and the evidence that justice frequently is not done, are cause for concern regarding the nature of current definitions.

Among the various approaches to defining child abuse and neglect, harm-based definitions are more closely aligned with the legal and medical approaches, which are likely to have resulted from the first formal definition of abuse proposed by Kempe and his colleagues (1962, cited in Zuravin 2001), which was very narrow and focused on physical injury such as that observed in the 'battered child syndrome' – and used in the 1974 Act described in Chapter 2. While the legal definition of "abuse or neglect" is suitably broad, its conceptual foundations leave much to be desired, since it fails to take into account the fundamental differences between the two forms of maltreatment, and implies that they are not only interchangeable, they are the actual or potential harm that they incur. The definition first refers to "abuse –

> "abuse or neglect" means ... (b) physical or emotional injury or other abuse, or neglect, to the extent that (i) the injured, abused or neglected person has suffered, or is likely to suffer, physical or psychological harm detrimental to the person's wellbeing; or (ii) the injured, abused or neglected person's physical or psychological development is in jeopardy" (Tasmanian Act 1997).

The difficulty of providing evidence that very young children have suffered or are likely to suffer developmental harm, especially when it is of an emotional or psychological nature, leads to a tendency to focus on particular incidents or parental behaviours that

have occurred, when it is the ongoing or chronically neglectful situations that jeopardise the child's development and wellbeing. Again, the legal grounds for intervention – that is, the definition of when a child is deemed to be 'at risk' – and the principles of the Act together mean that substantial evidence is required to show first the source of the harm, and second, that the parents are not just unable or unwilling to provide care and protection but have been shown to be unable or unwilling to change their behaviours and/or engage with relevant supports and services. If infants' health and developmental problems are ignored by parents, child protection and the justice system, the likelihood of more severe difficulties, especial in terms of psycho-pathological and serious health problems, increases over time (Lederman et al. 2007).

Formal research findings (e.g. Wotherspoon 2010), informal reports and informal observations during the data collection period have revealed that the preparation of affidavits for Court proceedings is considered to be one of the most difficult and challenging tasks that workers have to carry out. Theorists and researchers in the field recognise the need for "a more differentiated and conceptually based classificatory system" which recognises the nature of child abuse and neglect (Zigler 1976, cited in Besharov 1981, p. 386; see also Barnett, Manly et al. 1993; Dubowitz, Newton et al. 2005; Dubowitz, Pitts et al. 2005). The advantage of making an assessment of the child's circumstances within a conceptual framework based on unmet needs would allow the Court a clearer picture of the particular child's maltreatment experience as well as the necessary evidence regarding whether or not their wellbeing and development have been jeopardised and likely to continue to be at risk. Dubowitz, Newton et al. (2005) argue that, while it retains the major focus on the child, a definition based on the concept of unmet needs would necessarily point to the relevant parental factors that affect their capacity to meet those needs and any intervention or treatment that may be required within that.

Definitions and Concepts: The Vagueness, the Vagaries and the Confusion

Research definitions

"The one characteristic that all definitions share is their imprecision" – research definitions lack comparability, reliability, and taxonomic delineation (Besharov 1981, p.

385). The use of varied and imprecise definitions is a continuing concern – it remains the biggest problem facing research on abuse and neglect and it continues to restrict the possibility of making inferences about the nature and consequences of the various maltreatment types and sub-types and to make comparability across findings difficult if not impossible (see e.g. Cicchetti & Manly 2001, 1994b; Dubowitz, Newton et al. 2005a; Zuravin 1999, 2001). Most of the research is based on child protection service (CPS) classifications which, in turn, are based on practice and legal definitions which vary from one jurisdictional region to the next and from country to country. And although neglect is known for its multi-factorial and heterogeneous nature, and as integral to most types of maltreatment, it is not treated as such in either the research or in the CPS classification process (Dubowitz, Newton et al. 2005). In the initial assessment of a notification, classifications are treated as either a dichotomous variable (yes/no) or as a single type of abuse or neglect; whereas, in reality, most cases deemed serious enough to be referred to child protection would rarely involve a single or distinct type of maltreatment or sub-type of neglect (e.g. Dubowitz, Newton et al. 2005; Lau et al. 2005). And since abuse is generally regarded as being more serious than neglect, it tends to be given priority in terms of how the notification is classified.

Studies have demonstrated problematic biases in the reporting, assessment and substantiation processes which affect research on the entire range of issues from incidence to how best to treat the problem (Dubowitz, Newton et al. 2005a; English et al. 2005). While most of the research has tended to use substantiated cases of neglect only – and bearing in mind that neglect is notoriously difficult to substantiate and less likely to be investigated – findings show no difference in developmental outcomes whether a case is 'substantiated' or 'unsubstantiated' raise serious concerns for both research and practice, followed by calls to abandon the notion of substantiation (e.g. Barth 2008; Drake 1996; Hussey et al. 2005; Kohl et al. 2009; Parton & Matthews 2001; Slep & Heyman 2006). Neglect usually refers to a more complex set of circumstances than abuse which makes assessing and defining it more complex and difficult as well (English et al. 2005).

Researchers must also contend with the fact that the definition of neglect used in most of the studies in the US in particular – where most of the definitional research is conducted – refers only to physical neglect; that is, neglect of basic physical care needs,

such as food, clothing, shelter, adequate hygiene and medical care, and lack of supervision. Whereas more recent neuro-scientific research is now able to provide evidence of the harmful effects of both psychological and physical neglect on brain development, which further supports the psychopathological developmental research findings. The increasingly voluminous and consistent evidence of the impact of psycho-emotional neglect during this developmental period highlights the need to conceptualise and examine the problem as a form of neglect that is quite separate and distinct from emotional/psychological abuse, rather than conflated with it in the broader classification of 'emotional maltreatment'. The foregoing have had and continue to have serious implications for research on abuse and neglect generally and have been a major hindrance to the development of new knowledge and to the usefulness of existing knowledge about neglect across the various stages of child development.

Child protection policy and practice definitions

Definitions of neglect vary not only from one jurisdiction to the next but also across disciplines, service providers, professional groups, and even from one individual to another within those groups. They are also prone to undergo change in line with cultural mores, community expectations and expanding knowledge; however, it is becoming increasingly apparent that the range of types of abuse and neglect is expanding as a means of drawing attention to particular problems, with little thought being given to conceptual and operational definitions of the problem. The recent focus on the harmful psychological effects of exposure to domestic violence has led to an expansion of the existing types of maltreatment taking place before there has been sufficient discussion about how it is conceptualised, what constitutes each type and what distinguishes them from one another.

Apart from the five main subtypes of 'child maltreatment' listed below, the following have also been identified: foetal 'abuse'; bullying or peer abuse; sibling abuse; witnessing community violence; institutional abuse (i.e., abuse that occurs in institutions such as foster homes, group homes, voluntary organisations such as the Scouts, and child care centres); organised exploitation (e.g., child sex rings, child pornography, child prostitution); and state-sanctioned abuse (e.g., female genital mutilation in parts of Africa, the "Stolen Generations" in Australia) (Corby, 2006;

Miller-Perrin & Perrin, 2007, cited in Price-Robertson & Bromfield 2009). 'Multi-type maltreatment' has been posed to describe multiple (2 or more) types being experienced by some children (e.g. Arata, Langhinrichsen-Rohling, Bowers & O'Brien 2007). Bromfield (2005) proposes a Chronic Child Maltreatment Typology which includes the dimensions of frequency (reported 'incidents'); maltreatment sub-type (i.e. physical abuse, neglect, sexual abuse, emotional abuse and witnessing family violence); severity; perpetrators; and duration. The introduction of the term 'maltreatment' to the list to describe a separate type but encompassing both abuse and neglect serves to muddle matters even further.

The National Child Protection Clearinghouse's resource sheet, *What is child abuse and neglect?*, for example, includes five distinct types: physical abuse, emotional maltreatment, neglect, sexual abuse, and 'the witnessing of family violence' (Price-Robertson & Bromfield 2009). As an example of the current approaches to conceptual definitions of maltreatment involving physical and psychological neglect in Australia, the following extract from the resource sheet outlines the definitions of child maltreatment, physical abuse, emotional maltreatment, neglect and 'the witnessing of family violence'.

> Child maltreatment refers to any non-accidental behaviour by parents, caregivers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse) (Bromfield, 2005; Christoffel et al., 1992).
>
> Generally, child physical abuse refers to the non-accidental use of physical force against a child that results in harm to the child. A parent does not have to intend to physically harm their child to have physically abused them (e.g., physical punishment that results in bruising would generally be considered physical abuse). ...
>
> Emotional maltreatment is also sometimes called "emotional abuse", "psychological maltreatment" or "psychological abuse". Emotional maltreatment refers to a parent or caregiver's inappropriate verbal or symbolic acts toward a child and/or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Such acts of commission or omission have a high probability of damaging a child's self-esteem or social competence (Bromfield, 2005; Garbarino, Guttmann, & Seeley, 1986; WHO, 2006). According to a popular conception by Garbarino et al. (1986), emotional maltreatment takes five main behavioural forms:
>
> - rejecting: the adult refuses to acknowledge the child's worth and the legitimacy of the child's needs;

- isolating: the adult cuts the child off from normal social experiences, prevents the child from forming friendships, and makes the child believe that he or she is alone in the world;
- terrorizing: the adult verbally assaults the child, creates a climate of fear, bullies and frightens the child, and makes the child believe that the world is capricious and hostile;
- ignoring: the adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development;
- corrupting: the adult "mis-socializes" the child, stimulates the child to engage in destructive antisocial behaviour, reinforces that deviance, and makes the child unfit for normal social experience. (p. 8)

Neglect refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing (Broadbent & Bentley, 1997; Bromfield, 2005; WHO, 2006). Neglectful behaviours can be divided into different sub-categories, which include:

- physical neglect: characterised by the caregiver's failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care;
- emotional (or psychological) neglect: characterised by a lack of caregiver warmth, nurturance, encouragement and support (note that emotional neglect is sometimes considered a form of emotional maltreatment);
- educational neglect: characterised by a caregiver's failure to provide appropriate educational opportunities for the child; and,
- environmental neglect: characterised by the caregiver's failure to ensure environmental safety, opportunities and resources. (Dubowitz, Pitts, & Black, 2004)

The witnessing of family violence has been broadly defined as "a child being present (hearing or seeing) while a parent or sibling is subjected to physical abuse, sexual abuse or psychological maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behaviour" (Higgins, 1998, p. 104). Narrower definitions refer only to children being exposed to domestic violence between intimate partners. Some researchers classify the witnessing of family violence as a special form of emotional maltreatment. However, a growing number of professionals regard the witnessing of family violence as a unique and independent subtype of abuse (as it is presented in this Resource Sheet) (e.g., Bromfield, 2005; Higgins, 2004; James, 1994).
(Price-Robertson & Bromfield 2009, pp. 2–4).

One of the several issues that these definitions raise, and has been a matter of ongoing debate, concerns whether the primary focus should be on parental behaviours or inactions – in terms of assessment, intervention and treatment processes and programs – or on the experience of the child (e.g. Dubowitz et al. 1993; Dubowitz et al. 2005; Zuravin 1999). This definitional focus on parental behaviours, together with the risk assessment focus on whether or not parents represent further risk to the child, has been found to contribute to children being left in situations where physical and/or psychological harm continues and accumulates, particularly in cases of neglect. This is not to say that parenting problems should not be addressed; rather, they should not be

the sole focus of assessment, intervention or treatment and not at the expense of addressing the needs of the child – which is what the findings reported earlier reveal to be the case. This generalised focus of attention on parental behaviours is fundamentally at odds with the much proclaimed policy of taking a child-centred approach at every stage of the child protection process (e.g. DHHS Practice Framework, DHHS 2008b, 2009).

Greater awareness and increasing evidence of the harmful effects of children witnessing family violence, and its addition to the legislation in some jurisdictions, has turned the spotlight onto this problem and led to the addition of a new type of maltreatment, now generally classified in Australian child protection practice as 'emotional abuse', and by Price-Robertson and Bromfield (2009) above as a new form of 'abuse'. As well as adding to the list of possible variations and overlapping forms, and confusion, it points to a number of issues that contribute to the existent lack of conceptual clarity that plagues the field of abuse and neglect generally.

Firstly, in terms of parental behaviour, exposure to family violence is an omission of care or a failure to protect rather than a direct action against the child – even if the child is accidentally physically harmed during the incident. Within a needs-based approach, the child's safety and protection needs have not been met; in either case, it is a form neglect rather than abuse, and it is conceptualised as such by the leading writers in the field in the UK and in the US (e.g. Dubowitz, Newton et al. 2005; English, Thompson et al. 2005; Horwath 2005b; Minty 2005; Taylor & Daniel 2005). In 1999, the Minnesota state legislature, for example, added a child's exposure to family violence to the definition of child neglect (English, Thompson et al. 2005). In Australia, however, it continues to be conceptualised as a form abuse in child protection policy and practice, at least, and in the absence of any discussion about the conceptual or theoretical foundations for doing so.

The misapprehension may well arise, as some have argued, as a result of definitions of abuse and neglect being based on harmful outcomes, and/or attempts to raise awareness of the problem by focusing on those ill-effects, together with a traditional association of observable harm with abuse (e.g. Minty 2005; English, Thompson et al. 2005; Dubowitz, Newton et al. 2005). Furthermore, 'the witnessing of family violence', does

not require a separate category of abuse, according to the definitions outlined above, it already fits the classifications of both emotional maltreatment and psychological neglect. Given that the distinction often made between abuse and neglect involves the use of terms which are inherently contradictory – abuse consists of 'acts of commission' and neglect, '*acts* of omission', as in the definition of maltreatment above (Wolock & Horowitz 1984; Garbarino & Collins 1999) – it is hardly surprising that confusion is the result.

The consequences of failing to attend to such fundamental issues are evident in the latest child protection data which reveal that 'emotional abuse' is now the most prevalent and rapidly growing form of maltreatment in Australia. What the data really show is that *exposure to family violence*, or psychological neglect, is the most commonly reported concern made to the various departments, rather than emotional abuse per se. The comparatively high notification rate for the 'emotional abuse' classification is partly due to the fact that the police are mandated to report every incident to which they are called where there are children in the home, no matter how minor. It has also been suggested that prioritising one maltreatment type over another occurs when the issue is uppermost in the mind of workers as a result of being brought to their recent attention; such as occurs with the introduction of new legislation and policy, together with recent discoveries about its harmful effects adding to the general misapprehension that abuse is more serious and harmful than neglect (e.g. Horwath 2005b; Minty 2005) – the irony being that exposure to family violence is a form of neglect.

Furthermore, while the two discrete types, psychological abuse and psychological neglect, are effectively being grouped together as a singular type of maltreatment in the definition above; psychological neglect is simultaneously, but not consistently, being more accurately classified as a form of neglect (e.g. De Bellis 2005). The definition of emotional or psychological maltreatment, which is also referred to as 'emotional abuse', includes forms of psychological neglect such as failure to meet a range of developmental needs, and is conceptualised in terms of "acts of commission and omission'. It is only this more recent version of the definition of neglect that includes psychological neglect – the definition of 'neglectful behaviour' in the previous NCPC (2007) resource sheet did not – with the result that psychological neglect appears to

belong to two different categories. As previously discussed, grouping together psychological abuse and psychological neglect, whilst clearly distinguishing between physical abuse and physical neglect, is problematic for researchers and for conceptual understandings of neglect. It reflects the lack of clarity that occurs when abuse and neglect are defined inconsistently and in terms of parental behaviours rather than the experience of the child – which, in turn, should not be confused with the 'harmful consequences' to the child.

As Glaser (2011) points out, the problem goes by different names in different countries, jurisdictions and in the literature; including "emotional abuse, which may or may not include emotional neglect, emotional neglect, psychological maltreatment (APSAC, 1995) and psychological abuse (O'Hagan, 1995)" and so on, which leads to uncertainty about exactly what the problem is that needs to be addressed (p. 867). Glaser goes on to say that "consensus would now suggest that there is insufficient justification to distinguish between the terms 'psychological' and 'emotional'" (p. 867). The bottom line is that they do not all refer to the same problem. Glaser's conceptual approach to emotional abuse and neglect (FRAMEA) is based on the harmful interactions between the parent and child, and focuses on risk factors associated with the behaviour of the parent. Whereas this research takes a child-centred approach, in which the focus remains on the emotional and psychological needs of the child.

The view taken in this research is that using the terms 'emotional' and 'psychological' interchangeably is yet another problem deeply embedded in the discourse which not only adds to the confusion, it places restrictions on the type of research that can be conducted – and, consequently, on the usefulness of the research. The lack of precision and clarity in the terms themselves cannot help but lead to a lack of precision in researching, identifying and treating the problem. Using the terms emotional and psychological interchangeably, and abuse and neglect interchangeably, is yet another symptom of the failure to come to grips with the complex and potentially serious nature of the many and varied forms of neglect – including psychological neglect. (It is closely connected to the widespread failure to acknowledge the importance of differentiating between abuse and neglect.) The developmental approach to child neglect – and the focus of the legal definitions on developmental harm – assumes that distinctions do need to be made between and among the spheres of psychological development, in order

to take account of the emotional, behavioural, cognitive, language, and socio-moral development of the child. And further, to allow for some form of measurement for the purposes of research, or some form of assessment for the purposes of practice. (see, for example, Schneider et al.'s (2005) paper on outcomes in relation to emotional maltreatment, child abuse and neglect and the interaction between them. For the purpose of the current research, emotional neglect is conceptualised as a form of psychological neglect.

Conceptualisation of neglect in child protection policy

An examination of the various child protection websites across the jurisdictional regions in Australia revealed that, with the exception of Western Australia, all of the states and territories are now regarding neglect as another form of abuse. An information sheet on neglect currently available on the Tasmanian DHHS website[42], for example, is titled "Neglect is child abuse". The information, which is taken from the 2010 edition of the Child Protection Practice Manual – which, in turn, is based on the Victorian manual of the same name – includes the following explanation:

> Is neglect considered to be 'child abuse'?
> - YES – despite the fact that many people think that neglect is not really very serious and they tend to think of sexual or physical assault when they hear about 'child abuse'.
> - Neglect is a very serious form of child abuse and can have devastating consequences for children and young people, such as severe physical, emotional, social and psychological problems.
> - Neglect can take many forms and research tells us that more children die from serious neglect than from other kinds of child abuse. Survivors are often left with permanent physical or intellectual disabilities or suffer significant and chronic long-term damage. (DHHS 2010)

The rationale is that neglect is abuse because it is serious and because *it can have devastating consequences* – in that more children die from neglect than they do from ("other forms of") child abuse and survivors suffer permanent physical or intellectual harm. The fact that witnessing family violence is also classified as abuse suggests that all types of maltreatment, if they are harmful enough, are considered forms of abuse. It perfectly illustrates the sort of conceptual confusion that arises when abuse and neglect are defined in terms of children's outcomes (or degree of harm) rather than the neglect being experienced by the child. Similarly, definitions of when a child is deemed to be

[42] Retrieved from www.http://dhhs.tas.gov.au

'at risk' train the focus onto parental behaviours or acts and their capacity to meet needs, rather than examining what the unmet needs might be.

It is the centrality of harm, and risk of harm, in both the definition of the problem and the legal grounds for intervention that have led to this confusion, or muddling, of harm with abuse, which in turn has led to the focus on harm in the assessment and decision-making process. Defining abuse and neglect in terms of outcomes has been criticised as problematic (e.g. Hussey 2008), in that emotional neglect can have physical and psychological outcomes (such as in Non-organic Failure to Thrive) and physical abuse can have physical and psychological outcomes (such as Post-Traumatic Stress Disorder).

Again, the answer to the additional question in the DHHS Information Sheet, "Does the law in Tasmania also include 'neglect' in the definition of 'child abuse'?" is a resounding –

> YES. The Tasmanian child protection legislation, the Children, Young Persons and Their Families Act 1997 repeatedly uses the terms 'abuse' and 'neglect' together. Both legal intervention and Court action can result from notifications of neglect as well as allegations of physical, sexual and emotional abuse. (DHHS 2010)

No, neglect is not included in the definition of abuse within the Act. 'Abuse and neglect' are certainly defined in identical or interchangeable terms, but both abuse and neglect are referred to throughout the Act as two distinct forms of maltreatment. On the other hand, a strong argument could be made – based on historical definitions of the problem and findings from neglect research – that abuse may well be more appropriately conceptualised in terms of neglect.

Contradictory notions of what abuse and neglect are, and of the differences between them, at the fundamental levels of policy and education is a serious concern. The question of why it is important to differentiate the different types and sub-types is fundamental to the purpose of this study. Evidence from research confirms that abuse and neglect, including psychological abuse and psychological neglect, are very different groups of problems with distinct causes and consequences. Therefore, in order to provide effective intervention and treatment, they must be identified and examined separately (Egeland & Sroufe 1981; Hildyard & Wolfe 2002).

In fact the impact of different forms of abuse and neglect has been a strong evidence base for research in the fields of developmental psychopathology and neuroscience, particularly in the prenatal and early stages of childhood development and brain development (e.g. Hildyard & Wolfe 2002; Perry 2002). The relationship between maltreatment and attachment is a well-known aspect of Bowlby's (1969, 1982) attachment theory. Recent research in that field is also showing that outcomes for the child vary according to the type of maltreatment (English et al. 2005; Baer & Martinez 2006). Children under the age of four who are neglected not only manifest different characteristics from those who have been abused, they also exhibit different and more harmful developmental consequences from children in the older age group (see also Barnett et al. 1993).

As the overview of the concerns outlined in the child death reviews has shown, chronic neglect is a significant factor in cases of *preventable* deaths in infancy and toddler-hood, including those who have died at birth or later from various causes relating to exposure to harmful substances prenatally. Given the central role of neglect in all forms of maltreatment, identifying the neglect concerns, in terms of young children's basic care and protection needs, has been acknowledged to be of fundamental importance to the initial assessment process as a primary preventive measure (see e.g. VCDRC 2006). The VCDRC (2006) analysis of child death cases, for instance, highlighted the importance of recognising caregivers' 'failure to protect' several of the children from violent partners, siblings or other adults. While this research takes an approach that is more along the lines of a child's basic need for safety in terms of 'protection from harm', rather that being in terms of 'caregiver failures', nonetheless, it is one of the needs identified during the development of the classification and assessment framework that was developed for the current study as well.

Making distinctions between abuse and neglect, whilst acknowledging the relationship and interactions between them, adds to understandings of the complex nature of the problem, and provides a more detailed picture of the wider context in which the maltreatment is occurring. In terms of practice, identifying sub-types of maltreatment and differentiating between deficiencies and abusive actions helps to pinpoint the various problems – rather than just the one type perceived as the most serious – and to

respond more appropriately to them. Disentangling or differentiating between the different kinds of maltreatment is a necessary first step in the development of clear conceptual understandings of the nature of abuse and neglect which lead to clear and concise operational definitions of the problem.

The apparent confusion surrounding the concepts of abuse and neglect and harm is a major issue in the definitional field which the conceptual approach being taken to this research aims to address. The argument being posed here is that there is a need to distinguish between and separate the two distinct groups of problems of psychological abuse and psychological neglect, rather than melding them together into a single amorphous category of psychological (or emotional) maltreatment. Further, retaining just the two basic maltreatment types of abuse and neglect provides an initial conceptual foundation from which the unique sub-types of neglect can be more clearly recognised and responded to. The matter of developing an appropriate conceptual and operational definition of neglect that easily takes those sub-types into account is the issue at hand.

A conceptual framework for identifying and assessing neglect in terms of unmet care and developmental needs, its cumulative effects and the potential harm to the child's wellbeing and development would be a useful supplementary risk assessment tool. This type of assessment would provide clearer guidance for classifying the types of abuse or neglect being notified and more precise information about the actual neglect experience of the child, which would assist the risk assessment and decision-making process and provide much needed grounds for intervention and stronger foundations for applications to the Court.

The Conceptual Framework

An overview of a range of frameworks and definitional approaches and frameworks being used for research and practice is provided below for a number of reasons. Firstly, as a way of demonstrating the need for an operational definition of neglect that is able to take into account a more complete range of the developmental and care needs that are unique to this age group – in order to meet the aims and objectives of the present study . Secondly, to demonstrate how they were used to form the foundations of the overall

research framework and to guide the development of a series of definitions that are better able to meet the specific aims and objectives of the research.

The Maltreatment Classification System (MCS) (and the modified MCS)

In the US, like Australia, definitions of abuse and neglect vary from state to state and across disciplines, agencies and professional groups. However, the Federal Child Abuse Prevention and Treatment Act (CAPTA) provides the following minimum standards for definitions: 'child abuse and neglect' means "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" [42 USCA 5106g (Sec.111-2), cited in DePanfilis 2006, p. 10). The Maltreatment Classification System (MCS) is a multi-dimensional classification and assessment instrument, or coding schema, developed by Barnett, Manly and Cicchetti (1993) using data extracted from CPS case records in the United States. Its development grew out of the need for a standardized method of quantifying children's maltreatment experiences.

The MCS includes research definitions and severity ratings for six sub-types of maltreatment: physical abuse, sexual abuse, failure to provide (or physical neglect), lack of supervision (physical neglect), emotional maltreatment and moral/legal/educational maltreatment (Barnett et al. 1993). Both the MCS and the later modified version are designed to be used across all age groups. Although the developmental stage of the child is taken into account – along with sub-type, severity, frequency/chronicity, separations/placements and perpetrator – as the fourth dimension of the system, the authors acknowledge both the "difficult and essential aspects" of "incorporating developmental considerations" into the definitions of child maltreatment built into the system (Barnett et al. 1993, p. 46).

The MCS was later modified by English and the LONGSCAN Investigators (1997) (Longitudinal Studies of Child Abuse and Neglect) – LONGSCAN is a consortium of research studies investigating the aetiology and impact of child maltreatment, using common assessment measures, similar data collection methods and schedules, and

pooled analyses. The goal of the consortium is to follow children and families until the children reach adulthood project which has collected health and wellbeing data on children in the US for almost two decades. While the LONGSCAN studies have made an extraordinary contribution to maltreatment research in the US, the conceptual framework underpinning the Modified Maltreatment Classification System (MMCS; English & the LONGSCAN Cons. 1997) has many of the same limitations, for this study, as the original version.

One of the main disadvantages of this system is that only two sub-types of neglect are included and these refer to physical neglect only – 'failure to provide' basic care needs (300) and lack of supervision (400). Within the emotional maltreatment category, little if any distinction is made between emotional abuse and emotional neglect; despite the fact that it is described in terms of unmet developmental needs. While failure to meet basic physical needs is perceived as neglectful care-giving, the failure to meet basic emotional needs is conceptualised in terms of abusive actions against the child – as the "persistent or extreme thwarting of children's basic or emotional needs" or "parental acts that are harmful because they are insensitive to the child's developmental level", (p. 27) – such as when the "caregiver *ignores or refuses to acknowledge* the child's bids for attention" or "the caregiver *rejects or is inattentive to* or unaware of the child's needs for affection" (English et al. 1997, MMCS, pp. 28-9, original italics).

Conceptualising maltreatment in terms of parental behaviours can be seen here to have had a number of negative effects: it lacks conceptual clarity and confounds the fundamental understanding of the difference between abuse and neglect, it fails to reflect the nature of the maltreatment that the child is experiencing, it fails to include types of emotional neglect resulting from omissions of care which cause serious harm to young children in particular, and it lays blame on the parents. With the 800 maltreatment category of 'Drugs/Alcohol', for instance – the most commonly reported parental risk factor for neglect in early childhood – the entire focus is on parental (mis)behaviour, with examples provided such as "drug use in the home", "caregiver overdoses", "mum is a crack addict, she and her friends stay up all night doing drugs. Child comes to school late and is often tired" (MMCS, p. 33). Each of the foregoing are allotted a 'blanket severity' rating of 6, regardless of the nature of the maltreatment experience, or its impact, on the child involved.

The danger of this focus on parental behaviours is that it not only draws attention away from the types of neglect and/or abuse being experienced by the child, it fails to take account of the fact that a newborn infant whose mother is a crack addict, for instance, is in a much more vulnerable position than an older child. Furthermore the categories do not always succeed in assigning the range of neglect sub-types to a particular category in a predictable or logical way – the impact on the foetus of maternal substance use during pregnancy, for instance, is taken into account within the category of physical neglect in the sub-category of provision of medical care.

In summary, the main features of the system that render it less useful for the purpose of exploring the nature of neglect in infancy and early childhood are:

- the definitions are based on parental behaviours and fail to adequately describe the type of neglect and/or abuse or the nature of the experience for the child;
- although the developmental stage of the child is taken into account, it is only as a measure of severity; it does not include sub-types of neglect or emotional maltreatment that relate specifically to infants and very young children;
- neglect relating to the psychological development – including emotional, cognitive and language development – in early childhood is not adequately accounted for within the operational definitions;
- the neglect definition includes physical neglect only, and only in terms of 'failure to provide basic physical care needs and 'lack of supervision' (which includes environmental safety and adequate substitute care);
- the definition/category of emotional maltreatment does not distinguish between emotional neglect and emotional abuse;
- no distinctions are made between emotional neglect/maltreatment and psychological neglect/maltreatment.

A conceptual model of child neglect

The approach to defining neglect in this study is based on the work of Dubowitz and his colleagues' (1993, 1999, 2004, 2005, 2007) towards the development of a conceptual model of child neglect based on the unmet needs of the child. This is as an alternative approach to that based on parental behaviours and child outcomes, as has been the

major focus of the definitions applied in research and practice in the US and that used in the MMCS and the Ontario Child Neglect Index (CNI: Trocmé 1992, cited in Trocmé 1996). The conceptual model was developed and evaluated by identifying types of children's basic needs, and instead of measuring neglect per se (i.e. present, or not present), the extent to which each need was met was investigated in relation to children's later functioning (Dubowitz, Newton et al. 2005). Although the research does not specifically examine neglect in relation to very young children, the outcomes were assessed in children aged 4, 6 and 8 years; and the findings are based on the different types of needs not being met prior to the age of four. The findings relating to the types of needs are therefore deemed to be applicable to the younger age group and therefore able to be used in the development of the conceptual framework for the current study.

There is very little foundational work on a conceptual definition of neglect that focuses specifically on infancy and early childhood, apart from that of English and her colleagues (2005), which is based on current understandings of the basic needs of children in general. Table 5.1 provides a summary of the empirical basis for considering the types of basic needs proposed by Dubowitz, Newton et al. (2005) which are applied here in addition to those proposed to meet the specific needs of the younger age group in the present study.

Table 5.1: Empirical Basis for Considering Types of Children's Basic Needs and Neglect (from Dubowitz, Newton et al. 2005, pp. 176-77)

	Consequences	**Source**
Inadequate food	Impaired mental development Internalizing behavior problems Diminished birth weight Failure to thrive	Grantham-McGregor & Fernald, 2002 Weinreb et al., 2002 Martorell & Gonzalez-Cossio, 1987 Krugman & Dubowitz, 2003
Exposure to household hazards	House fires Access to firearms Fall from heights Toxic exposures	Squires & Busuttil, 1995 Farah, Simon, & Kellermann, 1999 Committee on Injury and Poison Prevention, 2001 Liebelt & DeAngelis, 1999
Inadequate personal hygiene	Adverse health outcomes Obesity Lissau & Sorensen, 1994	Menahem & Halasz, 2000 Lissau & Sorensen, 1994
Inadequate health care	Serious injuries not treated Several health problems not identified or treated Untreated dental problems	Overpeck & Kotch, 1995 Dubowitz, Feigelman, et al., 1992 Edelstein, 2002 Asser & Swan, 1998

	Death	
Inadequate mental health care	Suicide	Brent & Perper, 1995
	Delinquency	Lewis, Yeager, Lovely, Stein, & Cobham-Portorreal, 1994
	Poor school achievement	Flisher et al., 1997
	Psychiatric symptoms	Weisz, Weiss, Han, Granger, & Morton, 1995
Inadequate emotional support and/or affection	Externalizing problems	Egeland, Carlson, & Sroufe, 1993
	High-risk behavior Scaramella	Conger, Simons, & Whitbeck, 1998
	Poor academic performance	Pettit, Bates, & Dodge, 1997
Inadequate parental structure and/or guidance	Sexual risk taking	DiLorio, Dudley, Soet, & McCarty, 2004
	Health risk behavior (e.g., sexual behavior substance and/or drug use, drug trafficking, school truancy, and violent behaviors)	Li, Feigelman, & Stanton, 2000
Inadequate cognitive/ stimulation/opportunity	Delayed motor and social development, lower language competence and achievement test scores, behavior problems	Bradley, Corwyn, Burchinal, McAdoo, & Garcia Coll, 2001
	Externalizing problems and aggression	Dodge, Pettit, & Bates, 1994
	Delayed socioemotional and cognitive development	National Institute of Child Health & Development Early Child Care Research Network, 2002
	Aggressive coping	Hardy, Power, & Jaedicke, 1993
Unstable caregiver relationship	Insecure attachment	Capaldi & Patterson, 1991; Morton & Browne, 1998;
	Externalizing behavior	Ackerman, Brown, D'Eramo, & Izard, 2002; Ackerman, Kogos, Youngstrom, Schoff, & Izard, 1999
	Internalizing behavior	Bradley, Whiteside, et al., 1994; Miller, Cowan, Cowan, Hetherington, & Clingempeel, 1993
Unstable living situation	Externalizing behavior	Ackerman, Kogos, et al., 1999
	Internalizing behavior	Sameroff, Seifer, & Bartko, 1997
	Anxiety	Stoneman, Brody, Churchill, & Winn, 1999
Exposure to family conflict and/or violence	Poor physical health	Wickrama, Lorenz, & Conger, 1997
	Lower health status	Onyskiw, 2002
	Internalizing and externalizing behavior	Jaffee, Moffitt, Caspi, Taylor, & Arseneault, 2002
	Post-traumatic stress disorder	Mertin & Mohr, 2002
Exposure to community violence and/or lack of neighborhood safety	Behavior problems	Dubowitz, Kerr, et al., 2001
	Poor school attendance and behavior problems	Bowen & Bowen, 1999
	Distress	Dulmus & Wodarski, 2000
	Behavior problems	Linares et al., 2001
	Social maladjustment	Schwartz & Proctor, 2000

Towards a conceptual definition of neglect in early childhood

The study framework also draws on the findings of English, Thompson, Graham and Briggs (2005) who conducted one of the few recent definitional studies on neglect in early childhood. In line with Dubowitz, Newton and colleagues' (2005) research, the study supported a conceptualisation of neglect in the early years that is based on unmet needs. In consideration of theory and research – particularly the work carried out on effective care-giving by the Basic Behavioural Science Task Force (1995) described in Chapter 1 – the two domains of 'safety and security' were chosen to represent the physical and emotional/psychological needs of young children (birth to age 4).

The Ontario Child Neglect Index

The Child Neglect Index (CNI: Trocmé 1992, cited in Trocmé 1996) was "designed to provide child welfare practitioners and researchers with a validated and easy-to-use instrument" that can serve as substantiation tool that can be used as an operational definition of neglect, which includes guidance for levels of severity (p. 145).

It is one of the few instruments that was developed for research as well as assessment purposes and which takes account of children's needs, but being designed primarily as a substantiation tool, it was developed to reflect the Ontario legislation which defines neglect in terms of the various forms of physical and emotional harm to the child, and factors "associated with parental failure 'to care or provide for' the child" (Trocmé 1996, p. 146). With its main purpose being to serve as a substantiation tool after an investigation has taken place, it tends to rely upon a wide range of information being available to the researcher or practitioner.

Despite its applicability across the different developmental ages, the instrument does take some of the psychological developmental needs of infants and young children into account. However, its stated aim of providing a simple and brief measurement potentially limits its capacity to take into account the complex nature of neglect in infancy and early childhood in terms of its wide-ranging effects on their physical and psychological areas of development. For example, ensuring that a child does not suffer physical or psychological harm is not necessarily or entirely a matter of providing adequate supervision, it is a much more fundamental matter of ensuring that the child

has a sense of emotional safety and security which comes from being protected from harm; and not meeting the nutritional needs of an infant may also involve a lack of sensitivity or responsiveness to their cries of hunger – in the common situation of parents with mental health or substance abuse problems – which have both physical and psychologically harmful effects, especially in chronically neglectful situations. Its main use is as a tool to specify the type and severity of neglect, and to substantiate it having occurred, with an additional focus on the provision of remedial treatment, rather than to assessing future risk of neglect (Trocmé 1996).

The CNI provides a measure of severity and functions as an operational definition of neglect based on the following groups of needs:

1. Supervision: protection from physical harm, sexual molestation, and criminal activity
2. Physical care: food/nutrition; clothing and hygiene
3. Provision of health care: physical health care; mental health care; developmental and educational care

The Framework for the Assessment of Children in Need and their Families

The Framework for the Assessment of Children in Need and their Families (DoH 2000) was introduced in England and Wales in 2000 to address the apparent shortfalls in the existing assessment process. Horwath (2011) describes the shortfalls as practitioners' focus on immediate protection from particular incidents rather than the ongoing and underlying issues, a lack of attention to the capacity of parents to meet the specific needs of the child, and a lack of clarity about their roles that professional practitioners were experiencing at that time. The framework is a large (190-page) document which provides guidance for the assessment of 'children in need' as described under the *1989 Children Act*. The definition of a child in need in the *Children Act* 1989 is comparable with Australian definitions of 'abuse and neglect' in that it is centred on the developmental outcomes for the child: "a child shall be taken to be in need if – a. he is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority … b. his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or c. he is

disabled" (cited in DoH 2000). The overall aim of The Framework to safeguard and promote the welfare of children is carried out within an ecological theoretical approach which takes into account understandings of the developmental needs of children, parenting capacity and the family and environmental factors.

The outline of the conceptual understanding of the 'dimensions of a child's developmental needs' – developed by the Looking After Children (LAC) project – are "intended to be illustrative rather than comprehensive of the different components of each dimension" (DoH 2000, p.18). The child assessment framework's dimensions of child needs are provided in Box 1. Rather than providing a list of developmental needs per se, they describe the dimensions along which children need to progress to achieve satisfactory outcomes which, in turn, are defined as long-term wellbeing in adulthood (Ward 1995, cited in Gain & Young 1998). The dimensions of parenting capacity, on the other hand, do refer to children's developmental and care needs (see Box 2).

In Horwath's (2001) study of practitioner's concepts of child neglect in child protection and welfare practice in the UK, the views of the participating practitioners were used together with current national and international research to develop a framework for assessing child neglect across all age groups in child protection practice. An ecological approach to neglect and a child-centred approach to assessments and interventions were fundamental aspects of its development. The developmental needs that were considered in the assessment of child neglect were similar to those in the Assessment Framework described above – and those used in the current research – although they were grouped together somewhat differently. The following children's needs were taken into account for the purposes of the study: intellectual stimulation; basic care: food, clothing, warmth, and hygiene; medical care; supervision and safety; and attachment and affection (Horwath 2001, p. 135; see Table 5.2 below).

Gain and Young (1998) report some use of the LAC practice materials, to varying extents, mainly in Western Australia but also in South Australia, and following on from a pilot program in Victoria, there had been plans to introduce them in Tasmania. There are indications that some aspects of the UK Framework have been taken into account in the development of a national approach in this country.

Box 5.1. Dimensions of children's developmental needs (DH 2000)

DIMENSIONS OF CHILD'S DEVELOPMENTAL NEEDS

Health
Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment should be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations where appropriate and developmental checks, dental and optical care and, for older children ... .

Education
Covers all areas of a child's cognitive development which begins from birth. Includes opportunities: for play and interaction with other children; to have access to books; to acquire a range of skills and interests; to experience success and achievement. Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

Emotional and Behavioural Development
Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self control.

Identity
Concerns the child's growing sense of self as a separate and valued person.
Includes the child's view of self and abilities, self image and self esteem, and having a positive sense of individuality. Race, religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

Family and Social Relationships
Development of empathy and the capacity to place self in someone else's shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

Social Presentation
Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

Self Care Skills
Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills. (DoH 2000, p. 19)

Box 5.2: Dimensions of parenting capacity

DIMENSIONS OF PARENTING CAPACITY

Basic Care
Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

Ensuring Safety
Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

Emotional Warmth
Ensuring the child's emotional needs are met and giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

Stimulation
Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and Boundaries
Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability
Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development. Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others. (DoH 2000, p. 21)

Framework for analysing neglect (Australia)

Following the reviews of ten child deaths in the state of Victoria between May 2004 and June 2006, and the recognition that the lives of these children were characterised by chronic neglect and its harmful developmental consequences, the Victorian Child Death Review Committee (VCDRC) commissioned a group analysis of the ten deaths, the results of which were published in the report, *Child Death Group Analysis: Effective Responses to Chronic Neglect* (VCDRC 2006). The report coincided with a period of reform similar to that undertaken in Tasmania between 2006 and 2008. The ten children, aged between six weeks and twelve years at the time of their death, were purposively selected "to illustrate chronic neglect and cumulative harm", and although neglect had not been identified as a cause of death, it was regarded as a major risk factor in the children's lives. The analysis integrated a literature review and the construction of a framework "for analysis of child neglect to inform best practice" (VCDRC 2006, p. 2). It provides a framework for understanding areas of child development and the 'core needs' of children in the context of neglect which were drawn from the literature and overlap with the Looking After Children (LAC) Framework for the Assessment of Children in Need and their Families from the UK (DoH 2000).

However, in the VCDRC model, the LAC 'dimensions of children's developmental needs', rather than the basic care and developmental needs that are listed in the 'dimensions of parenting capacity', are (mis-)taken to be the "core needs of all children" (VCDRC 2006, p. 6). Furthermore, or consequently, the model itself does not provide an operational definition of neglect. Instead, definitions of neglect are used in the analysis of the data which are described as being 'child-oriented', with developmental neglect having harmful outcomes in its definition. The five main categories of neglect are defined as follows:

1. Physical neglect: characterised by poor hygiene, physical abandonment, insufficient food and water, and inadequate clothing; and which can include environmental neglect and medical neglect
2. Supervisory neglect: inadequate supervision on the basis of age and development
3. Developmental neglect: can refer to lack of attention or interaction, resulting in the child not reaching developmental milestones; includes educational neglect
4. Emotional neglect: "is related to rejection or absence of attachment and relational opportunities by his or her parents" (VCDRC 2006, p. 3)

A major problem with the foregoing research is that developmental theoretical and needs-based conceptual approach employed here is not compatible with the somewhat vague and haphazard mixture of definitions that were used to describe the children's experience of the problem. The brief overview of the research, and the frameworks and definitions above, highlights the need for a conceptual definition that can easily be made operational (Dubowitz, Newton et al. 2005). The frameworks and definitions described above, with their focus on outcomes and parental behaviours also highlight the need taking a different type of conceptual approach to the problem of abuse and neglect. The recent report on Victoria's vulnerable children also uses the British assessment framework.

One of the terms of reference for a report prepared by Frances and colleagues (2008) for the Western Australian Child Death Review Committee, *A Group Analysis of Aboriginal Child Death Review Cases in which Chronic Neglect is Present*, was to provide an extension of the foregoing Victorian CDRC report on chronic neglect. Their operational definition was developed to be more child-centred, although the distinction made between the notions of "inadequate nurturance or affection" in the category of emotional neglect and "lack of emotional support and love" in the category of psychological neglect" is unclear – and it does not take into account the specific needs of infants and very young children, and by extension the developing foetus. Yet again, there is confusion among psychologically harmful parental behaviours, psychological harm as an outcome, and psychological forms of neglect experienced by the child. Their working definition is as follows:

> Neglect can be further described on a continuum of episodic, reactive or chronic. It can also be categorised as:
>
> • Physical neglect of basic needs and abandonment, including poor supervision, malnutrition and dehydration, exposure to infection through poor hygiene and medical neglect. This can lead to poor physical health, developmental delays, serious injury or death.
>
> • Supervisory neglect can result in serious accidents or accidental deaths including drownings, gun accidents, choking, ingestion of pills or fires. Supervisory neglect of very young children is of particular concern because of their increased vulnerability.
>
> • Emotional neglect consists of inadequate nurturance or affection, permitted maladaptive behaviour and other emotional neglect. This can lead to inappropriate self-soothing behaviours and aggression in children.
>
> • Psychological neglect includes the lack of any emotional support and love, chronic inattention to the child, exposure to family and domestic violence or alcohol and drug abuse. Children who experience psychological neglect may show signs such as neurological impairment and high anxiety level.

• Educational neglect relates to permitted chronic truancy, failure to enrol and inattention to special educational needs. This can lead to cognitive, language and communication delays. However referrals are not usually accepted by the Department where educational neglect is the only concern. Consistent with the School Education Act 1999, schools are responsible for addressing non-attendance issues with families. (Frances et al. 2008, p. 30)

Table 5.2 provides an overview of the conceptual approaches taken to each of the conceptual frameworks and/or definitions described above.

Table 5.2. Summary of conceptual approaches to child neglect

Conceptual Framework/ Model	**Type of needs/abuse/neglect**	**Approach** to defining/assessing neglect (age group)
The Maltreatment Classification System (MCS)	physical abuse, sexual abuse, failure to provide (or physical neglect), lack of supervision (physical neglect), emotional maltreatment (includes thwarting of the following needs: psychological safety and security; acceptance and self-esteem; age-appropriate autonomy) moral/legal/educational maltreatment	Caregiver behaviour/ based on child's needs Emotional maltreatment includes caregiver behaviours in relation to psychological needs (all age groups)
Dubowitz, Newton et al. (2005) Conceptual model of child neglect	Inadequate food; Inadequate personal hygiene; Inadequate health care Inadequate mental health care Inadequate emotional support and/or affection Unstable caregiver relationship Unstable living situation Exposure to household hazards; Exposure to family conflict and/or violence Exposure to community violence and/or lack of neighborhood safety Inadequate parental structure and/or guidance Inadequate cognitive/ stimulation/opportunity	Needs-based / Child-centred (all age groups)
English et al. (2005) Conceptual and operational definitions of neglect in early childhood	Physical Needs: Clean safe abode, Medical care needs; Failure to provide: Food, clothing, shelter, medical hygiene; Lack of supervision Stimulating environment Residential stability Relational stability 1 Relational stability 2 Relationship quality Emotional neglect	Needs-based / child-centred/ (Including parental failure to provide basic care) (children< 48 months)

Ontario Child Neglect Index (CNI) (Trocmé 1992	Supervision: protection from physical harm, sexual molestation, and criminal activity; Physical care: food / nutrition; clothing and hygiene; Provision of health care: physical health care; mental health care developmental and educational care	Caregiver behaviours/ based on child's needs (all age groups)
Framework for the Assessment of Children in Need (DoH 2000) (Dimensions of parenting capacity)	Basic physical care: Food, drink, warmth, shelter, clean and appropriate clothing, adequate personal hygiene; medical and dental care; Ensuring safety: Protection from harm or danger; environmental hazards Emotional warmth: ensuring emotional needs are met; developing positive sense of identity; ensuring secure, stable, affectionate relationships with significant adults; appropriate sensitivity and responsive ness, physical contact, comforting Stimulation: Promoting intellectual development, cognitive stimulation, social opportunities Guidance and boundaries: demonstrating and modelling appropriate behaviour; appropriate moral and behavioural guidance Stability: stable family environment; secure, undisrupted attachment, maintain contact with significant others	based on child's needs / and caregiver behaviours (all age groups)
Horwath's (2001) Framework for assessing child neglect	Intellectual stimulation: school attendance; freedom/ time/ encouragement to play, interaction with others; Basic care: Food, clothing, warmth, hygiene Medical care: as needed, medical checks, immunisation etc. Supervision, safety includes psycho-social and behavioural developmental needs Attachment and affection: self esteem, self-worth	needs-based/child-centred (all ages groups)

A unified conceptual approach to defining neglect

While the conceptualisation of maltreatment helps to determine how it is defined, the theoretical definition "dictates the type of research that is conducted, as well as the manner in which research can support or change definitional policy" (Barnett et al. 1993, pp. 17-18). Barnett, Manly and Cicchetti (1993) view the major theoretical perspectives as fitting within four main groups, each with their own biases and differences in emphasis: 1. medical (diagnostic); 2. sociological (parental acts from a socio-cultural perspective); 3. legal (statutory processes for protecting children); and 4. ecological [(Garbarino 1977; Belsky 1980) – child development and child maltreatment within the family and the broader environment]. Figure 5.1 outlines Barnett and colleagues' (1993) multi-system approach to defining maltreatment.

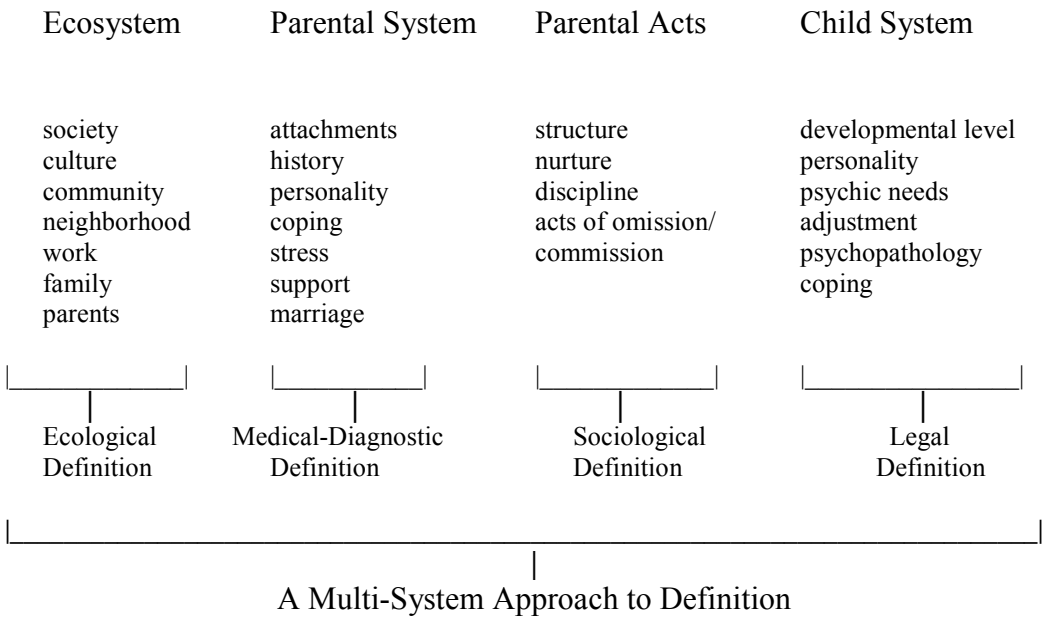


Figure 5.1. Theoretical approaches to defining maltreatment (cited in Barnett et al. 1993, Figure 2, p. 20)

Dubowitz et al. (1993) observe that an ecological theoretical framework is able to provide a general approach to the problem of neglect for researchers, clinicians, and policy makers alike. He argues that research on neglect supports the ecological approach, since it can take into account all instances in which the basic needs of

children are not met as well as the parent, community and societal factors associated with neglect (Belsky 1980; Dubowitz et al 1993; Garbarino 1977). If, as it is argued, this way of looking at neglect does succeed in expanding from a focus on individual factors, such as parental behaviours, the social and community aspects of providing care and protection increase in importance. And while parents are the ones responsible for nurturing and protecting their children, their ability to do so is affected by social factors, such as poverty, which also need to be addressed (Dubowitz et al. 1993).

Dubowitz and others (1993) argue that the ecological model points to the need for a broad perspective to be taken to the definition of neglect. There are multiple definitions of child maltreatment in existence, each of which is designed to fulfil different purposes across the various arenas in which they are used. Their view is that narrow definitions, which are focused on parental omissions of care, imply parental blameworthiness by their very narrowness, and although they are relatively easy to operationalise, they restrict the ability to fully understand the problem of neglect. Broad definitions, on the other hand, include a wide range of factors that jeopardise children's development and wellbeing, and while they may be vague and difficult to implement and may appear to absolve parents of responsibility, they are nonetheless more meaningful and effective than narrow definitions. They propose "a single broad definition of neglect based on the concept that neglect occurs when basic needs of children are not met, *regardless of cause*", as a means of ensuring children's adequate care and protection (Dubowitz et al. 1993, p. 12). An added advantage of this type of conceptual definition is that it can be readily operationalised in terms of the various types of basic needs.

In that sense, Dubowitz and his various colleagues' (1993, 1999, 2005) approach is in line with the view of Barnett and colleagues (1993), who believe that "consensus may be reached by concentrating on the shared underlying purposes across disciplines" (p. 21), and that a unified definition of child maltreatment is not simply desirable, it is essential. The disjuncture between the legal, practice and research definitions and the lack of a conceptual definition of the problem that could be more readily made operational are regarded as the most pressing of the problems facing both practitioners and researchers (Barnett et al. 1993; Besharov 1981).

The research presented here takes a combined ecological-developmental approach (see e.g. Belsky 1980, 1993; Dubowitz et al. 1993, Dubowitz 1999; English, Thompson et al. 2005; Garbarino 1977, 1999), which embraces psycho-developmental and developmental psychopathology theoretical perspectives, attachment theory (e.g. Ainsworth 1982; Bowlby 1969, 1973, 1980; Cicchetti & Toth 1995;), psycho-biological science (e.g. De Bellis 2005) and neuro-developmental science (e.g. Perry 2001, 2002). In light of the more recent neurobiological findings demonstrating the impact of neglect on child development, this unified theoretical approach is considered to provide solid foundations for the needs-based definition used to explore the nature of neglect during this vital developmental period.

Developing Operational Definitions for the Research: Towards a System for Classifying Neglect in Infancy and Early Childhood

While progress had been made towards the development of theoretical models that attempt to explain the antecedents and consequences of abuse and neglect, there is little consensus about a systematic procedure for describing the child's actual experience of the problem. There has also been little agreement about how to operationalise neglect from a developmental perspective. The way in which Australian definitions of neglect have developed so far bears the mark of a lack of any clear and consistent standards or guidelines. The classification system and/or the operational definitions were developed using a 'grounded' type of approach, similar to that described by Glaser and Strauss (1968), in that it draws on both the theoretical and empirical research on child neglect and close readings and analysis of the notification data.

It draws, in particular, on the definitional research on neglect and research focusing on neglect in early childhood (e.g. Connell-Carrick & Scannapieco 2006; Dubowitz et al. (1993, 1999, 2004, 2005; English Thompson et al. 2005), and Barnett, Manly and Cicchetti's (1993) Maltreatment Classification System. It takes into account the wider range of research and theory relating to neglect and child development; in particular, developmental psychopathological theoretical approaches (e.g. Belsky 1984; Cicchetti 1989, Cicchetti &Toth 1995; Cicchetti & Manly 2001; Egeland & Sroufe 1981b; Egeland et al. 1983) and attachment theory (Ainsworth 1982; Bowlby 1969, 1980;

Carlson & Cicchetti 1989; Cicchetti 1991; D'Cruz & Stagnitti 2010; Egeland & Sroufe 1981a), traumatology (e.g. De Bellis 2005; Perry 1997, 2001b), and ecological theory as applied to maltreatment research (Belsky 1980; Garbarino 1977). Table 5.3 provides a summary of the research findings on which the constructs of need used to further develop the operational definitions which are used to develop the classification system.

The development of the Framework also drew on the general exploration that took place in the process of collecting the data for Study One, an in-depth study of the notifications made in relation to the Subject Group of Families in Study 2, and a close reading of a sample of 25 families selected from the Subject Infant group of families in Study 1. Other than some minor refinements to the way some categories were organised, very little changes were made to the framework during the process of analysing the data for Study Two.

Table 5.3. Empirical basis for considering additional constructs of need and neglect sub-types for infants (<48 mos).

Need Construct (risk factor)	Consequences	Source
Loving care: emotional and tactile	Failure to Thrive(FTT), poor health Death Emotional, behavioural, cognitive deficits; Poor physical & psychological development psychiatric disorders Neuronal impairment	Bakwin (1942) (cited in Carlson & Earls 1997) Carlson & Earls (1997) Perry (2001a)
Sensitive and responsive care	FTT Neurological impairment Attachment disorders Right brain developmental probs Infant mental health probs Poor affect regulation Attachment insecurity (early infancy)	Perry (2002) Meins 1999 Fearon et al. (2006) Schore (2001) McElwain & Boooth-LaForce (2006)
Secure and stable maternal attachment	Emotional insecurity Attachment disorder Poor socio-emotional development Poor motor development Poor cognitive development Impaired cognitive development Failure to Thrive	Bowlby (1973, 1982) Ainsworth (1982) Baer & Martinez (2006) Egeland & Sroufe (1981a) Lyons, Connell & Zoll (1989) Mills-Koonce, Gariepy et al. (2008) Ward, Kessler & Altman (1993)
Emotionally available, sensitive and responsive care and protection(In relation to maternal mental health problems)	Attachment Socio-emotional development Psycho-patholgy Global, cognitive, behavioural, psycho-motor development	Biringen & Robinson (1991) Toth, Rogosch et al. (2009) Kingston, Tough & Whitfield 2012. Siqveland, Smith & Moe (2012) Hans, Bernstein & Henson 1999

Emotionally available, sensitive and responsive care and protection (in relation to maternal drug/alcohol mis-use/dependence)	Attachment disordersMental health problems As for attachment problems: Emotional insecurity Attachment disorder Poor socio-emotional development Poor motor development Poor cognitive development Impaired cognitive development Failure to Thrive Physical injuries	Schindler, Thomasius, Petersen & Sack 2009 Schuler, Nair & Black 2002 Suchman, De Coste, Leigh & Borelli 2010 Siqveland, Smith & Moe 2012 Carmichael Olson, O'Connor & Fitzgerald 2001 Hans, Bernstein & Henson 1999 Chester et al. 2006
Food security: adequate nutrition	FTT; malnutrition; Poor health / illness requiring hospitalisations Impaired brain development/ 'mental retardation' Delayed cognitive and physical development	Bialestock 1966 Cook, Frank, Berkowitz, Black et al. 2004 [See also Table 5.1 from Dubowitz, Newton et al. (2005)]
Protection from harm: Exposure to DV	Dissociative disorders Altered neurobiology Interpersonal relationship problems accidental injuries attachment problems aggression PTSD Behavioural problems	Perry 1997, 2001b Shonkoff & Phillips 2001 Antle et al. 2007 Scheeringa, Zeanah et al. 1995 Yates, Dodds, Egeland & Sroufe 2003
Protection from harm: Exposure to cannabis smoke/	Neurological abnormalities Lethargy Somnolence Brachycardia THC toxicity Altered consciousness	Wang, Narang, Wells & Chuang 2011 Zarfin et al 2012
Protection from harm: Exposure to abuse	Attachment problems Cognitive developmental delay Socio-emotional / behavioral problems	Egeland & Sroufe 1981b
Prenatal safety and security: protection from exposure to methadone	Depression of motor activity and heart rate NAS Low birthweight; effects on foetal neuro-behavioural functioning; Prematurity Cognitive development delays Psycho-motor developmental delay Small head circumference Neurologic symptoms	Jansson, DiPietro & Elko 2005 Rosen & Johnson (1982)
Pre-/perinatal safety: protection from harm: Prenatal exposure to prescription drug mis-use [e.g.Oxycodone; Selective Serotonin Reuptake Inhibitors (SSRIs)]	Impaired mental and psycho-motor development Neurobehavioural problems Reduced birthweight Birth defects CNS depression	Hans & Jeremy 2001 Zeskind & Stephens 2004 Broussard et al. 2011 Lam et al. 2012
Prenatal safety and security: protection from harm:	FASD Congenital defects Pre-term birth	Fried & Watkinson 1990 McElhatton et al. 1999. Hans and Jeremy 2001

Prenatal exposure to cannabis, drugs and/or alcohol	Global, cognitive, language, socio-emotional, behavioural, psycho-motor developmental deficits Negative affect Mental health problems/ psychopathology Poor psychomotor development Low birth weight Intrauterine growth retardation	Jacobson & Jacobson 2001 Carmichael, O'Connor & Fitzgerald 2001 Roebuck, Mattson & Riley (1999)
Prenatal safety and security: protection from harm Prenatal exposure to DV	Dissociative disorders Interpersonal relationship problems accidental injuries, attachment problems, PTSD	Perry 2002 Shonkoff & Phillips 2001 Antle et al. 2007

Existing conceptual frameworks have been designed for a range of purposes and uses which differ to varying extents from the purpose of the study presented here; however, they serve to illustrate some of the problems which this study attempts to overcome; including:

- current research approaches and definitions which focus on caregiver behaviours or failures and the question of intentionality at the expense of the child's experience of neglect (MMCS, CNI);
- there is a focus on outcomes in terms of identifiable and immediate harm, which fails to take account of the chronic nature of neglect and the long-term developmental harm that occurs (MMCS);
- the notion of 'protection from harm' within the general sphere of 'safety and security' in existing needs-based definitions and research frameworks (e.g. Dubowitz, Newton et al.2005; English, Thompson et al. 2005; Barnett et al. 1993) is restricted to various forms of 'lack of supervision' and is not conceptualised as a need for protection per se – the unique needs of infants and toddlers for protection from harm to their physical and psychological health and wellbeing during their most vulnerable stages of development, and (in certain not uncommon circumstances) protection from physical, emotional and sexual abuse, have been inadequately attended to in current neglect research;
- the failure of current definitions to take into account the wider range of possible harmful effects that different forms of so-called 'physical' neglect have on various aspects psychological development and, conversely, the negative impact that

psychological neglect can have on aspects of physical development (e.g. the effects of a child's nutritional needs not being met on their emotional and cognitive development, and unmet emotional needs are a fundamental aspect of non-organic Failure to Thrive) (MMCS, CNI);

- the lack of differentiation between psychological neglect and psychological or emotional abuse, and between emotional and psychological neglect;
- the need for a conceptual and operational definitions that take into account the broad range of developmental and care needs of infants and very young children,
- the need for operational and conceptual definitions of neglect that are able to incorporate actual (or immediate) as well as potential harm – since the type of harm to development that is incurred through neglect is not necessarily immediate or readily observable – and to fit more closely with the legal definitions of 'abuse and neglect' and 'at risk' thereof.
- the emerging need for a definitional approach that includes the care and protection needs of the unborn child.

The conceptual framework: Neglect sub-types

> If human babies are to develop eventually into healthy, independent, and society-minded adult individuals, they absolutely depend on being given a good start, and this good start is assured in nature by the existence of the bond between the baby's mother and the baby, the thing called love. (Winnicott 1957, p. 5)

Infancy and toddler-hood is perceived as a time when children are dependent on a parent or caregiver to both *provide* them with the basic physical and psychological requirements for healthy development and wellbeing and to *protect* them from threat or actual harm to their health, development and wellbeing. This is the premise that lies at the heart of the conceptual framework presented here. The empirically based domains and constructs of need specifically relating to infancy and early childhood were identified in the process of reading and analysing the notifications for the sample of families from the original Subject Group of Families, and the notification and case file records and documents such as the publicly available Coroner's reports relating to the sample of 14 families in which a child known to child protection has died or is known to have suffered serious harm.

100. Basic physical needs

The first group of needs listed within the Framework presented are common to most of the practice and research definitions and/or assessment frameworks; they were retained as a group because the concept is deeply embedded in child protection and welfare practice and the wider community generally and so are commonly reported in that form. However, one of the purposes of the framework is to take into account the wider range of developmental needs involved when young children are not having their basic physical care needs met. In the process of applying the operational definitions for the purposes of analysing the data, it was necessary to make clear distinctions between the provision of the five universal basic needs and the provision of other constructs of need. Meeting an infant's physical needs – such as being bathed, fed and changed – is inherently linked to meeting their psychological needs for emotionally available, sensitive and responsive care. For example, a report that there was no food in the house or that the children were not being properly fed, would be assigned the code of inadequate food/nutrition; whereas a report that a young infant was being regularly left crying and not being fed because the mother misuses drugs and spends most of the day sleeping would be classified in relation to the need constructs of sensitive and responsive emotional care and physical care (Codes 201 and 202). As is the case with the MMCS and the CNI, there are occasions such as the foregoing when a neglect concern fits within more than one sub-type (Table A5.4 in Appendix D provides a detailed outline of the different need constructs and any distinctions between them, and Table 5.5 below provides a summarised version.)

200. Psycho-emotional and physical development: Love and nurture

A number of constructs of children's needs were identified in the theoretical and empirical literature and in readings of the case files that were absent from existing needs-based models of neglect for research. Most notable for its absence in current research definitions are a set of constructs that relate to that most fundamental requirement in infancy generally accepted as that indefinable thing called 'love'. It is now well established that infants fail to thrive and sometimes die when they don't receive that love, often expressed in the type of care they receive: infants require affective, sensitive and responsive care and the development of secure attachment are

vital to every aspect of infant development and wellbeing (Bowlby 1969, 1973, 1980; Ainsworth 1982, 1989; Belsky 1982, 1984, 1993; Perry 2001a, 2001c, 2002).

The notification reports tell story after story of problematic maternal drug and alcohol misuse and dependence combined with serious affective mental health disorders, and, sometimes co-existing, intellectual disabilities – all of which drastically affect the emotional and cognitive capacity of parents to consistently provide the type of care. Existing needs-based models of neglect include the need for 'security and stability' in terms of the child's relationship with the caregiver, which so far has been limited to constructs of maternal, family and residential stability. This framework expands on the earlier model to include two separate constructs, based on empirical findings outlined below in Table 5.5, which relate to the need during infancy for loving, sensitive and responsive care.

The current model, then, proposes four different constructs of infant needs within the broader category of psychological security and stability (Refer to Section 200 in Table A5.4 for more detailed description of the constructs). In applying the definition for the purposes of the research, the needs may be identified and understood in terms of the primary caregiver's emotional availability and capacity to provide this type of care, which may be affected by substance abuse and dependence issues, including the abuse of legal drugs, and serious mental health problems such as depression and personality disorders.

300. Protection from physical and psychological harm

Another set of need constructs notably absent in current definitions of neglect and clearly evident in reading the histories in the case files of infants and young children have died and or suffered serious harm, and in the case files generally – also identified in the VCDR's (2006) Group Analysis of child deaths and in children's narratives of their own experience (D'Cruz & Stagnitti 2010) – was that they were not being protected from abuse or harm. Although the notion of lack of protection from harm may traditionally have been conceptualised in terms of parental failure, it is argued here, as it is by Dubowitz and colleagues (1993), that one of the main advantages of taking a needs-based approach is that it avoids the problem of blaming the mothers or fathers

across the spectrum of neglect concerns by focusing on the child's needs rather than parental behaviours or failures. It is worth noting, though, that the close reading of notification records raised a number of gender issues to do with blame and bias in relation to fathers and, just as concerning from a feminist perspective, the tendency to deny the mother her own authority in terms of the choices she makes in relation to the welfare and wellbeing of her children.

One of the main reasons for returning to the concept of protection from harm was, in fact, to draw attention to the fact that the basic right to and need for protection of infants and toddlers is not being met, by parents or protective services. In the majority of the cases in which the infants and toddlers have died or have been permanently psychologically and physically harmed as a result of neglect or abuse, there was clear evidence to suggest that in most of the cases, there was existing knowledge of the children's ongoing exposure to harm and/or risk of harm as well as concerns about whether or not the children's protective needs were being prioritised. There is a peculiar web of silence surrounding this particular aspect of neglect which may be the result of some misconstrued notions of what feminism requires, and consequently ends up being swept under the rug of political correctness – which some others might describe as throwing the baby out with the bathwater.

Constructs relating to protection from harm or risk of harm – in line with the legal definition of 'a child in need of protection' – were identified as the need for protection from:

1. *Physical, sexual or emotional / psychological abuse or harm* [where there is an evident lack of protection (or failure to protect the child); including exposure to family violence.
2. *Physical harm*: the category is divided into two age groups in recognition of the special needs of newborn and very young infants who were identified as being exposed to factors that placed them at higher risk of SIDS, and in light of the relatively high rate of SIDS cases in Tasmania generally and the proportion of cases where the families were known to child protection and deemed to have been preventable. Constructs of unmet need relating to protection from harm in the environment for newborn and very young infants include the risk factors

identified in the reports discussed above, such as unsafe sleeping environments and unsafe sleeping practices when maternal/paternal risk factors such as drug and/or alcohol mis-use are present. The need constructs for environmental safety for older infants and toddlers (<48 mos) are based on English and Longscan's (1997) MMCS.

3. *Harm to health and wellbeing*: also divided into the two categories described above to account for the specific needs of the two age groups. The constructs of need for protection from harm to the health and wellbeing identified in the case files for newborns and very young infants < 12 months include exposure to drugs in breast milk, marijuana, tobacco; unmet special health care needs; inappropriate diet. There was concern iitially that the provision of medical care (Code 102) and protection from harm (Code 302.2 or 302.4 – depending on the age of the infant) might overlap, but an attempt was made to make a clear distinction between the provision and protection concerns. It was often the case that both types were co-existent. In a case of medical neglect, for instance, distinctions were able to be made between say, the provision of medical attention, and lack of appropriate care to ensure health and wellbeing or protection from harm.

400. Physical and psychological development: Stimulation, sensitivity, responsiveness and interaction

Despite the legal definition of abuse and neglect focusing on harm to the child's development, it was informally observed in the research process that issues relating to children's cognitive and physical development were not often regarded as child protection concerns by professional reporters such as teachers and nurses and child protection workers alike. Nonetheless, there was evidence in the reports, particularly from within the wider family and community, to suggest that there were a large number and variety of developmental concerns present, but typically in relation to language in very young children, and then, later, learning issues were identified when the child started school.

Since language and cognitive development are so closely aligned during the early childhood, the need constructs of stimulation and opportunity were grouped according

to psychological developmental areas of need (i.e. cognitive and language) and physical developmental areas of need (i.e. fine motor development and gross motor development). For example, grandparents and relatives generally were the ones to report delays in language and gross motor development in particular. Teachers tended to report that parents were not attending speech pathology appointments for the child, or there were references to what the special needs teacher (attending to the child's learning difficulties) noticed, or missed appointments with a guidance counsellor (for behavioural problems).

500. Socio-emotional developmental needs (subjective development): provision of guidance and training in self-care

Although current frameworks include constructs of need to do with behavioural aspects of socio-emotional development, the range of different types of needs for healthy subjective development in this age group is limited, being restricted to behavioural guidance and self-care skills for older children. There were many cases noted in the files, in which chronically neglected children were not toilet trained or able to meet their own basic personal hygiene needs by the time they started kindergarten or school. These are generally the same children whose general care and hygiene needs are unmet as infants. The development of independence and self-care skills is vital to children's sense of autonomy and positive self image and to their social relationships with other children. Self-care skills are included in paediatric assessments of children's development, and are regarded here as an important aspect of physical and psycho-social development.

It was found to be necessary in the process of developing the framework, however, to distinguish children whose socio-emotional needs for behavioural guidance or opportunities to learn to care for themselves from those who were displaying symptoms of psychological disturbance, such as aggressive, violent and anti-social behaviour, or bed-wetting and soiling (eneuresis and ectopresis), which were observed to occur during times of stress for the child or as a result of other types of neglect and/or abuse.

600. Moral developmental needs: Provision of moral guidance/ Protection from exposure to immoral and/or criminal activity

The prevalence of criminal activity found in the informal reading of the case files for the families, as well as the sample of cases being analysed in this study, was

remarkable. Although infants under four may be considered by some to be too young to understand or be affected, there was ample evidence of negative outcomes for the older siblings who, besides being involved in or exposed to their parents' crimes and criminal associates, were reported for stealing and violence and illegal substance use, which led to further social isolation for these children – which left little doubt that children's moral development needs to be protected from a very early age. Furthermore, parents' engagement in criminal behaviour also places the infants and toddlers need for secure and stable maternal and and/or paternal relationships at risk, in that they risk facing regular, if not extensive, periods of imprisonment and separation which then threatens the much-needed stability and security and attachment relationship described above (see Section 600 in Table 5.5).

700. General or unspecified developmental care and protection needs: basic developmental care and protection needs (including sensitive and responsive care) unable to be met

This category of unspecified unmet needs was included to take into account the fact that the risk assessment processes and practices, and the legal definition of a child 'at risk', focus on caregiver behaviours and observable harm, and consequently, the notifications often focus on and provide more detail about caregiver issues that affect their ability and/or willingness to meet their children's basic care and protection needs, and less detail about the specific type or nature of the neglect being experienced by the infant. It is also an important category for use in professional practice as part of the risk assessment for very young and vulnerable substance-affected newborn infants who do not as yet have a detailed notification history, in that it indicates a high level of 'potential' risk.

The 700 category is coded only when the neglect issue for the infant/child is not specified and it is apparent that the particular concern(s) being notified would necessarily affect the caregiver's ability to meet the care and protection needs of infants and young child(ren) in their care – whether it is associated with drug or alcohol use, intellectual disability or a mental health concern or psychiatric disorder, or, in effect, all of the foregoing. In certain circumstances, it may be appropriate to take the age of the infant / young child into account as well, especially in the case of very young infants or drug-affected newborns. The notifier is likely to report, for instance, that the mother is

under the influence of drugs or drinking heavily on a daily basis and the child is 'being neglected'. This would be able to be coded as unmet (unspecified) care and protection needs (701) – which takes into account all unmet needs coming within the realms of the provision of sensitive and responsive care (201-2); protection from physical and psychological harm (300), adequate stimulation (gross and fine motor development, cognition and language) (400); socio-emotional developmental needs (500), and where there is illegal substance use and engagement in criminal activities or with criminal associates, moral developmental needs (500). Where a specific concern relating to the child is reported in conjunction with the caregiver's substance abuse issues, such as the infant being left lying in dirty nappies all day, that would be coded as 'failure to respond to the infant's physical needs/signals/cues' (202) as well as the general failure to provide basic care and protection (701).

800. Prenatal developmental needs: protection from harmful exposure to alcohol, drugs and family violence (including partners and siblings)

Prenatal neglect is not included in the research definitions and assessment models described above, nor is it included in legal definitions in Australia – although concerns about unborn children are now notifiable under the Tasmanian legislation. However, with the growing concerns about the effects of alcohol and drugs, both legal and illegal, on the unborn child – and about the number of SIDS or sudden unexpected deaths infancy (SUDI) in Tasmania – it seemed imperative to include prenatal neglect in overall neglect experience of the infants in the current study.

A substantial percentage of the infants who died or who were known to have suffered some form of harm in the following study were prenatally exposed to drugs and/or alcohol and were born suffering from Neonatal Abstinence Syndrome (NAS). It is difficult to quantify the harm in many cases, given the difficulty of diagnosing problems which do not manifest themselves until some years later, and the reluctance of paediatricians to diagnose such conditions as Foetal Alcohol Syndrome. The problem of underweight and/or premature and drug-affected newborns needing to be separated from their mothers and treated with morphine while they struggle to survive appears to be highly normalised by both child protection and medical practitioners. The notifications repeatedly tell of infants born prematurely and underweight, with little or no prenatal care provided. Prenatal neglect is included in the conceptual framework because it

affects that most vital period of a child development that lays the foundations of the infant's future development and wellbeing.

Conclusion

Apart from the need for an operational definition that would meet the specific aims and objectives of the following study, the framework was developed in response to a more general need for a conceptually and theoretically sound approach to defining, classifying and assessing neglect in the early period of childhood development. One of the main tasks in developing the current model, besides identifying as complete a range as possible of the needs of children in this age group, was to organise the system in a way that would help to clarify some of the definitional and conceptual problems outlined above and to improve understanding of the complex and serious nature of neglect in infancy and early childhood. The psycho-developmental theoretical approach that was chosen to form the foundations of the model, and the needs-based approach to the definition of neglect, together provided an organisational, as well as theoretical and conceptual, framework for understanding as well as conducting research or assessments.

The Classification System was designed to serve two main purposes. First, as a research tool that can be used to investigate the nature of neglect in relation to infants and toddlers who are known to child protection and are known to have suffered a range of types of harm to their development, health and/or wellbeing. Second, as a framework or classification and assessment system that can be used to identify and measure the unmet care and developmental needs of infants and toddlers, which can serve as an operational definition of neglect across the disciplines of child protection, legal, health and welfare practice generally. In providing a picture of the child's experience of neglect across the spectrum of developmental and care needs over time, it is designed to take into account levels of chronicity and severity and the accumulative nature of both potential risks and negative effects (see Bromfield 2005).

The task was to develop an instrument that was similar in purpose to the MCS (Barnett et. al 1993; and English and LONGSCAN's MMCS 1997) and the Ontario Child Neglect Index (1992, in Trocmé 1996), but different in many of its aims and aspects. For instance, this conceptual model of neglect takes a child-centred and needs-based

definitional approach, rather than one that is based on caregiver behaviours, and it applies specifically to neglect and to the early period of childhood development (< 48 months), rather than across all types of maltreatment and all age groups. It was also designed to provide an operational definition of infant neglect that was compatible with the existing legal and practice definitions of child neglect, and as an instrument that can be utilised in conjunction with the risk assessment tools and procedures currently in use.

It is important to remember that this and other research frameworks, such as the MCS, MMCS and CNI, are developed using information provided in notification reports – as well as being designed for the purpose of interrogating or assessing them – which is provided by a wide range of professionals and non-professionals with widely varying degrees of knowledge and understanding of the issues or of the criteria upon which the notifications are responded to. The nature of the information provided is extremely variable and subjective, as is the focus of the report itself; therefore, in order to minimise the amount of extrapolation that inevitably must take place in the process of analysis, the framework was designed to retain as much flexibility as possible. It was to that end that the universal notion of the five basic care needs – food, medical care, clothing, hygiene and shelter – were retained. And, as was the case with the earlier frameworks some overlap between categories is unavoidable (e.g. Barnett et al. 1993).

A primary aim in developing the operational definitions in terms of constructs of need was to take into account the wide range of needs perceived as vital to the psychological and physical development and wellbeing of very young children, and as a way of measuring the frequency, severity and/or chronicity of the problem. The needs-based approach provides a framework within which to identify unmet needs for a better understanding of the role of chronic neglect concerns relating to SIDS, and the preventable deaths of infants and young children in general, and concerns about the harmful effects of prenatal exposure to drugs (legal and illegal) and alcohol.

The main principles and objectives regarded as fundamental to the development of the Framework are:

Principles

- to take a child-centred approach – in line with practice policy (to put the focus back on the child, in terms of their development and wellbeing; to balance the current focus on caregiver concerns and immediate harm)
- to avoid the victim-perpetrator model currently implied in definitional approaches based on caregiver behaviours;
- to develop a conceptually sound and operational definition of infant neglect that fits in with the legal definition of 'abuse and neglect' and 'a child at risk'.

Objectives

- to identify the needs of infants and young children throughout the early stages of development, including prenatally – within a process that, in turn, identifies caregiver issues and concerns – for the purposes of both research and multi-disciplinary practice;
- to take into account the complete range of care and protection needs essential to children's normal development, health and wellbeing; developmental and care needs of infants/toddlers required for normal development – as a means of dealing with the question of 'reasonable standards of care';
- explicate the nature of the problem, towards an improved method of defining the neglect and better understandings for research and practice more generally;
- assess severity levels in terms of neglect, and/or assess the accumulative risk;
- to include the psycho-social developmental foundations of the Framework as part of its organisational structure, as a means of clarifying the conceptual and definitional issues of the problem.

A complete version of the System for Classifying and Assessing Neglect (SCAN) is provided in Appendix D, and a summarised version is provided below in Table 5.5. Examining cases where serious harm has occurred also enables an exploration of the relationship between neglect and other forms of abuse, which the conceptual framework developed for the present study is designed take into account. The task now is to see how this conceptual framework translates into a classification and measurement system.

Table 5.5. Basic care and protection needs in infancy, early childhood and prenatally, essential to normal development, health and wellbeing

Developmental Sphere(s)	Domains of Developmental and Care Needs (Neglect Sub-Types)	Need constructs/Measures
Physical and psychological development and wellbeing	100. Provision: basic physical needs	100. Provision of basic physical needs: 101. Food / nutrition 102. Medical care needs 103. Appropriate / adequate clothing 104.1 Personal hygiene 104.2 Environmental hygiene 105. Adequate basic shelter/ housing conditions
Physical and psychological development and wellbeing (including inter-subjective development)	200. Provision: physical and psychological developmental needs: Love and nurture; emotional and sensory experience; emotional security, stability and attachment	200. Provision of physical and psycho-emotional care and nurture: 201. Emotional care and nurture / Love: affectionate, affective, sensitive, responsive, interactive care; (requires maternal emotional availability, empathy and attunement; infants' needs prioritised) 202. Physical care and nurture: sensitivity and responsiveness to infant's physical needs, signals, cues; (sensory experience; physical affection) 203. Caregiver stability and security 204.1 Family stability and security 204.2 Residential stability and security

Physical and Psychological development, health and wellbeing	300. Protection from physical and psychological harm: physical and psychological safety and security [302.1-2. Safety needs specific to newborn infants; 302.3-4. Safety needs for all < 4 yrs]	300. Protection from physical and psychological harm: physical and psychological safety and security 301 Protection from Harm (PFH): 301.1. Physical abuse/harm (by other caregiver/family member in home) 301.2. Exposure to emotional abuse / emotional/ psychological harm 301.3. Exposure to sexual abuse /harmful experience 302. Protection from harm: 302.1. Physical safety (newborns) 302.2. Health and wellbeing (Newborns) 302.3. Physical safety and security: home environment 302.4. Health and wellbeing 302.5. Physical safety outside home: 303. Inadequate Supervision 1 (caregiver) 304. Inadequate Supervison 2 (substitute care) 305. Health, wellbeing and safety in care of alternative primary caregiver.
Global development: Cognitive, language and (fine and gross) motor development	400. Provision: cognitive, language and motor developmental needs: Stimulation and opportunity:	400. Provision: cognitive, language and motor developmental needs: 401. Stimulation of intellectual and language development (personal): sensitivity responsiveness; interaction and encouragement

		402: Opportunities for language and cognitive development (environmental/ social) 403. Opportunities for fine and gross motor development
Socio-emotional development (Subjective development: Age-appropriate behaviour, self-esteem, autonomy)	500. Provision: Socio-emotional developmental needs: [Self-regulation and appropriate behaviours; self-esteem; social inclusion; autonomy]	500. Provision of socio-emotional developmental needs: 501. Behavioural guidance: Appropriate/adequate role modelling, guidance, discipline, boundaries; opportunities for socialisation 502. Personal hygiene and self-care skill guidance / training/ development / socioal mores 503. Toilet training / self-care /social mores
Socio-moral development (social inclusion)	600. Provision and protection: Moral guidance / social inclusion and protection from conflict with the Law	Provision of moral guidance and protection from conflict with the Law 601. Moral guidance: exposure / witness to criminal activities; asking child to lie (to relatives, medical professionals, teachers) 602. Protection from conflict with the law/ illegal activities (teaching young child to steal; involving child in illegal/criminal acts)
General physical and psychological development	700. Unspecified physical and psychological care and protection needs: unable to be met or 'at risk' of not being met due to drug/alcohol dependence / mental health probs / intellectual disability of	700. Provision of basic care and/or protection from harm: 701. due to drug/alcohol dependence

	primary caregiver	702. due to intellectual disability 703. [untreated(-able)] mental health problems
Pre-natal development and wellbeing	800. Protection from harm: Prenatal health and development and peri-natal health and wellbeing	Unmet basic needs: Protection from pre- and peri-natal harm due to: 801. Exposure to alcohol or substance abuse (legal or illegal) 802. Ongoing exposure to partner violence 803. Lack of appropriate ante-natal care 804. Unmet nutritional needs of unborn (inadequate nutrition) 805. Unmet special health/care needs of newborn

CHAPTER 6

Study Two
Infant and Early Childhood Neglect
In a Child Protection Sample

The classification system outlined in the previous chapter provides a set of conceptual and operational definitions of neglect which are based on the developmental care and protection needs of infants and very young children. In this chapter, the system is used as a research framework for the following study to explore the nature of the neglect experience in a child protection sample of infants and very young children. The chapter begins with an outline of the study aims and objectives and a brief explanation of the study's dual purposes. The problem of neglect measurement is then considered in light of findings relating to its multi-dimensional aspect and current methods of measurement. A new system of measurement incorporated into the classification system is proposed which is intended to meet the aims of the present study and to provide a more versatile and precise form of measurement than is currently used in neglect research and maltreatment research generally. The main purpose of this chapter is to present the findings of the exploration of the neglect experience for this vulnerable group of infants and toddlers.

Introduction

The conceptual framework for this study is founded on the premise put forward by Garbarino and Collins (1999) that if development is to proceed effectively, a child's basic needs must be met. The conceptual definition of neglect that has been implemented in this research is the single, broad definition proposed by Dubowitz, Black, Starr and Zuravin's (1993), based on the concept that "neglect occurs when children's needs are not met, *regardless of cause*" (p. 12). As Garbarino and Collins also point out, "infancy provides the easiest context in which to observe this" (1999, p. 3). An ecological-developmental approach is used in this study to take into account children's developmental needs, to bring together research and theory from across the

range of disciplines that inform the field, and to account for the heterogeneous and multi-dimensional nature of the problem (Belsky 1980; Dubowitz et al. 1993, Dubowitz et al. 2004; Dubowitz, Newton et al. 2005; English, Thompson et al. 2005; Scannapieco & Connell-Carrick 2002).

The following study investigates the neglect experience of infants and toddlers less than 48 months of age (Subject Infants) from families known to child protection in which a referent Subject Infant has died and/or suffered identifiable harm to their development, health and/or wellbeing. The primary focus of the study is to identify the children's experience of neglect in terms of unmet basic developmental and care needs. Some discussion of the issues is interwoven with the findings. Although this is not a serious-case review as such, it does provide an opportunity to gain insight into and learn from those cases where a child has died or other serious neglect-related harm has occurred.

The purposes of the study

The dual and interconnected purposes of the following study were to develop the operational definitions for the classification and measurement system, for the present study, and to investigate the nature of the neglect experience of infants and toddlers during the prenatal and early stages of their development. However, the study also serves to demonstrate and evaluate the capacity of the classification system to (a) identify a more complete range of unmet needs, or neglect sub-types, and (b) measure the levels of severity and chronicity being experienced by the child and/or (c) assess the accumulation of risk factors that have the potential to jeopardise their ongoing development and wellbeing.

One of the expectations of conducting a study of this type is that it will shed some light on the current more general definitional issues under debate and on the entangled relationships among neglect, emotional maltreatment and abuse during the early stages of children's development. It is hoped that veering away from the definitional approach that focuses on parents' actions or omissions of care and applying this needs-based definition will help ameliorate the problems associated with differentiating between parental behaviours that cause harm and those that do not by bringing the unmet basic needs and the resultant or potential harm to the child into closer alignment.

While a definition of neglect that is as broad as this and includes such a wide range of constructs of need might be regarded by some as over-zealous, its suitability lies in its ability to identify sub-types of neglect (and unmet needs), which not only provides a more complete picture of the nature of the experience for the child, it allows levels of severity and or chronicity to be measured – and takes the accumulation of different unmet needs into account – for both researchers and professional practitioners alike.

The main objectives of the present study are to:

1. explore the nature of neglect in the early developmental period from before birth through infancy and early childhood (< 48 months of age) – in terms of unmet basic care and developmental needs – and identify any specific unmet needs relating to cases in which infants or young children have died
2. develop a classification and measurement framework for research on neglect in infancy and early childhood, which provides empirically based operational definitions that can be applied across the domains of research, practice and policy;
3. clarify the definitional issues that are currently impeding effective research, policy and practice, including the nature of the relationship between abuse and neglect;

Dimensions of Neglect and the Problem of Measurement

The argument goes that because neglect is a complex and heterogeneous problem, conceptual and operational definitions are needed that are able to take into account its various manifestations and differentiate between its multiple sub-types (Dubowitz, Pitts et al. 2005; English, Bangdiwala & Runyan 2005). Neglect is also a multi-dimensional phenomenon – it varies according to characteristics such as developmental timing, chronicity, severity and frequency as well as sub-type. It is argued further that distinguishing between the different dimensions of neglect and abuse is essential to understanding their specific developmental effects (English, Upadhyaya et al. 2005). While some research (and practice) definitions of neglect in current use take the age (or developmental stage) of the child into account in terms of the degree of 'severity' or 'risk', they usually fail to distinguish between the neglect that occurs in the early stages of a child's development and that which occurs during the ensuing developmental

stages, despite the degree of difference in the impact on the developing child. And, again, most research definitions of neglect do not include the emotional and/or psychological aspects of neglect which, as discussed in the previous chapter, are so inextricably bound with physical forms of neglect and abuse.

In Perry's (2002) neuro-archaeological account of the impact of neglect, "the earlier and more pervasive the neglect is, the more devastating the developmental problems for the child ... chaotic, inattentive and ignorant care-giving can produce pervasive developmental delay (PDD; DSMIV-R) in a young child" – but for a ten-year-old, the same inattention for the same duration "will have very different and less severe impact than inattention during the first years of life" (p. 89). Furthermore, the early experience of neglect not only has a detrimental impact on healthy growth and development at the time, the failure to achieve certain stage-appropriate tasks in the earlier stages of the developmental process is understood to have an additional negative impact on the successful negotiation of future phases of development (Cicchetti 1989; Cicchetti & Toth 1995). The achievement of particular developmental tasks and milestones in infancy and early childhood is therefore of paramount importance to all future development, and future life chances, in adulthood.

A method of measuring neglect and accumulated risk

In order to address the problems associated with using child protection service classifications of neglect, most of the current definitional research relies on instruments such as Barnett, Manly and Cicchetti's (1993) Maltreatment Classification System and/or English and LONGSCAN's (1997) modified version (the MMCS) to identify sub-types of abuse, neglect and emotional 'maltreatment' and to provide severity 'scores' which take both the level of seriousness of the outcomes and developmental timing into account. However, as Barnett, Manly and Cicchetti (1993) themselves point out, assessing the seriousness of *potential* developmental or psychological harm in relation to neglect and assessing the level of severity for neglect sub-types involving risk are much more complex and difficult tasks – a matter particularly relevant for cases of neglect in the younger age group where the developmental harm is more serious, cumulative and ongoing.

The classification and measurement system developed for this research employs a new and, arguably, more appropriate method of measuring the frequency, severity and/or chronicity of the neglect experience for research – and/or assessing levels of accumulated (or 'developmental') risk in professional practice. The system's construction is founded on neglect sub-types that are conceptualised in terms of unmet constructs of need, which are also able to be considered as risk factors that impede healthy development (see Zeanah, Boris & Larrieu 1997). As Balbernie (2002) says:

> A risk is not directly psychopathogenic, it is a representation of probability, so that a cluster may bias towards an unfavorable developmental outcome. Longitudinal studies demonstrate that "the total *number* of risk conditions affecting an infant may be more predictive of various outcomes in later life than exposure to any specific *type* of risk factor". In addition, "each specific risk factor is likely to be an aggregate of a series of smaller risk factors acting in concert" (Zeanah, Boris, & Larrieu, 1997, p. 168), insecure attachment being a case in point. ... when the impediments to development accumulate then the outlook becomes progressively bleaker. (Balbernie 2002, p. 330)

The measurement aspect of the classification system being proposed here is based on the idea that the operational definitions of neglect include a range of constructs of need within each sub-type, which when unmet can also be conceptualised as the smaller and larger risk factors for potential developmental or other harm described above, such that the neglect sub-types correspond to 'specific types of risk factors', and the constructs of unmet need as the 'series of smaller risk factors acting in concert'. In other words, neglect sub-types and constructs of need serve as independent variables which are able to be aggregated to provide a useful measure of levels of severity and chronicity – and potential risk of cumulative harm – for research purposes (as well as practice).

The dimensions of neglect

Sub-type and developmental timing

In terms of meeting the aims of the current study, the issue of sub-type and developmental timing have been addressed within the research framework, in the form of a broad range of operational definitions of neglect sub-types based on the unmet care and protection needs deemed essential for normal health and development from the prenatal period through to infancy and toddlerhood (< 48 months of age). Developmental timing has been taken into account in terms of the specific neglect need constructs; such as those relating to the provision of secure, stable, sensitive and

responsive care as well as those relating to the specific protection needs relevant to each of the three developmental phases. The proposed sub-types of neglect have been categorised according to constructs of need relating to the care and protection essential to normal development, health and wellbeing. In addition, for cases where the concerns raised refer to the caregiver rather than to the child, a further category or sub-type to take into account 'risk' of generalised or unspecified neglect such that the infant is at risk of any or all of their basic needs not being met as a result of the caregiver's alleged inappropriate (or chronic) misuse of legal or illegal substances, mental health condition or intellectual disability. (The neglect sub-types are presented in detail in Table 5.5 in Chapter 5 and in the content analysis instrument in Appendix E).

Severity

There is no universally accepted definition of maltreatment severity and there is no single (or simple) generally accepted method of measuring it. Defining maltreatment severity is dependent on the way in which the different types of maltreatment are defined; so the discussion of severity and how to define it centres on parental actions or behaviours and/or child outcomes – which, as far as neglect is concerned, brings with it the same difficulties associated with its definition. The severity measures for each sub-type in the MCS, for example, are primarily based on the parental act, with the *physical* condition of the child also taken into account (Barnett et al. 1993). Barnett, Manly and Cicchetti (1993) took the view that it was important to assess the type of maltreatment and the psychological outcomes separately. English and LONGSCAN's (1997) modified version of the MCS (MMCS) has severity ratings ranging from 1 to 6 for physical abuse and ratings of 1 to 4 or 5 for physical neglect and lack of supervision. The Ontario Child Neglect Index also employs a 4-5-level severity scale, based on a combination of parental behaviour/caregiving and child outcomes, which ranges from adequate (1) to seriously inadequate (4/5) (Trocmé 1996).

In their explanation of the new severity ratings for emotional maltreatment for the MMCS, the authors note the "growing consensus that all acts of abuse and neglect carry negative emotional/psychological messages to their victims" and that, arguably, "every act of maltreatment constitutes emotional maltreatment" (English et al. 1997, p. 27). The Emotional Maltreatment category itself includes "persistent or extreme thwarting of

children's basic or emotional needs" and "parental acts that are harmful because they are insensitive to the child's developmental level" (p. 27). The (modified) severity ratings for emotional maltreatment, primarily based as they are on the severity of the 'parental acts', are substantially higher than those for physical neglect and abuse, ranging from 11 to 55 – with parental suicide attempt, homicidal threat, abandonment and extreme methods of restraint and/or confinement of a child in an enclosed space as examples at the extreme end of the scale; rejection and exposure to marital conflict in the mid-range; and inappropriate expectations, belittling and undermining the child and ignoring bids for attention (such as, "the caregiver generally does not respond to infant cries or older child's attempts to initiate interaction") at the lower level of 11–15.

Furthermore, a blanket severity rating of 6 in the 800 category of parental drug and alcohol use for a vulnerable and possibly drug affected infant whose mother has a serious drug or alcohol addiction is patently disproportionate and inequitable. Given the capacity of recent research to provide evidence of the devastating effects of unmet physical and emotional/psychological needs such severity levels are considered inappropriate for the purposes of this study. Considering the higher incidence of maltreatment in early childhood, and the relative severity of 'emotional maltreatment' in particular, examples and ratings aimed specifically at infants and young children are notably absent.

Researchers have based measures of severity on a range of dimensions including maltreatment type, child outcomes, developmental timing and duration of exposure (English, Bangdiwala et al. 2005; English, Upadhyaya et al. 2005). Some have argued that the dimension of severity could very well mean different things for the different types of maltreatment, which require different methods of measurement (English, Bangdiwala et al. 2005). However, Strauss and Kantor (2005) argue that, in cases of neglect, neglectful behaviour and harm to the child should be measured separately. On the other hand, in Glaser's (2002, 2011) conceptual framework for emotional abuse and neglect, severity is determined by the intensity and chronicity of the maltreatment in conjunction with the resultant effect on the child. According to Glaser (2002), "there is a complex relationship between the age of the child and the severity of the effect of maltreatment on the child", which is partially "mediated by the duration of the abuse"; furthermore, early onset of maltreatment – which could negatively affect secure

attachments, for example – "is likely to increase severity, as well as to be associated with longer overall duration" (p. 709-10). Interestingly, though, Barnett et al. (1993) note that, from their initial findings in the application of their framework, they had not found direct relations between child maltreatment – defined primarily in terms of parental behaviours – and child outcomes; however they did find that mild forms of maltreatment appear to exert a powerful effect on children's adjustment. The complex and interactive nature of the relationships between and among the different measures, definitions and even type of maltreatment is clear.

The current study differs from much of the previous research in that it applies a needs-based definitional approach rather than one based on parental behaviours, and it is focused purely on neglect rather than the broader spectrum of abuse and neglect and maltreatment types. Measures of severity in this study will be based on the overall neglect experience of the infant. However, there is a certain pre-existent level of severity for this age group. The families in the sample were selected on the basis of having at least one infant child (the referent and/or subject child) who suffered identified harm directly or indirectly associated with neglect. Although there is a notable lack of detailed information about the outcomes for the non-referent and/or subsequent subject infants, research suggests that the family history places them at similar risk of neglect and harm (Hines, Kauffman Kantor & Holt 2006; Hobbs et al. 1995). Second, research shows that the age range of the subject group situates them in the most vulnerable group in terms of developmental timing (Perry 2002; Scannapieco & Connell-Carrick 2002).

In order to provide a further indication of the level of severity, as a separate dimension from child outcomes and developmental timing, this study takes the same approach as previous research, which uses a frequency measure to indicate levels of both severity and chronicity of constructs of need within each sub-type (Dubowitz et al. 2005a; and English et al. 2005c).

Frequency

Frequency is most commonly measured in terms of the number of reports of abuse and/or neglect for each family (Barnett et al. 1993; Bromfield 2005; Dubowitz, Pitts et

al. 2005b; English, Bangdiwala et al. 2005). It is generally perceived as a measure relating to the number of particular incidents or events and/or to describe "a chronic pattern with repeated instances of dysfunction" over time (Barnett et al. 1993). The notion of frequency as incident-based is common in maltreatment research, and carries with it the danger of perceiving neglect in terms of particular incidents – which is more relevant in cases of abuse and in relation to older children than to the type of continuous and chronic neglect concerns that are more characteristic of the younger age group.

Moreover, child protection reports are known to underestimate the actual prevalence of the problem. The findings of Study 1 suggest further that issues such as geographic and/or social isolation can affect the number of times infants in rural areas are notified. Furthermore, frequency measures are also dependent on the method of defining the problem and how many sub-types of neglect are included; that is, whether or not it is based on child protection classifications of 'neglect' or 'abuse', or refers to physical forms of neglect only, as is usually the case, or includes emotional neglect, and so on.

Apart from the potentially misleading aspects of a frequency measurement, though, 'the number of notifications' is believed to provide an indication of the level of chronicity of neglect over time (e.g. Dubowitz, Pitts et al. 2005). In light of that, in the present study, frequency is measured in terms of the number of unmet constructs of need reported over time' within the five-year study period. More precisely, frequency is measured in terms of the number of times any of the constructs of need outlined in the operational definitions are notified, or identified by the researcher, as not being met – that is to say, the number of notifications in which any of the need constructs relating to the subject infant and/or young child (<48 mos) is reported or identified as unmet or believed by the notifier to be at risk of being unmet. The three exceptions to this method are constructs relating to caregiver, family and residential stability, where frequency is measured in terms of the number of changes, in line with the 'transitions index' employed by Dubowitz, Newton et al. (2005) and English Thompson et al. (2005).

Chronicity

Maltreatment chronicity has been described as a complex construct made up of multiple parameters that are important in understanding how it leads to negative outcomes,

especially in relation to child development and psycho-social and behavioural problems (Graham, English, Litrownik, Thompson, Briggs & Bangdiwala 2010; English, Graham et al. 2005). It has been defined as "a persisting situation of abuse and neglect" (Éthier et al. 2004, p. 1267), and it can be measured in terms of frequency and duration (Strauss and Kaufman-Kantor 2005). Bromfield's (2005) review of the literature revealed that children's 'chronic maltreatment' experience was described and/or explored in terms of having at least one *re-referral* (meaning a repeated referral, report or allegation) or *recurrence* (meaning a repeated substantiated instance) (Bromfield 2005).

However, researchers who specialise in the field of neglect, are increasingly conceptualising neglect as a continuous rather than a dichotomous phenomenon, in which children's needs are perceived in terms of a continuum of being fully met to not being met at all (e.g. Dubowitz, Newton et al. 2005). Chronic neglect is regarded as being central to understandings of the way in which neglect causes developmental harm – De Bellis (2005), for instance, regards neglect in infancy and toddler-hood as a "chronic condition or stressor" regardless of whether it is a continuous form or a single episode or incident (p. 154).

In this study, the frequency scores for the constructs of need identified for each sub-type are aggregated to provide an indication of the *level* of severity and chronicity for each sub-type – in light of the view that all neglect in this age group is considered to be both chronic and severe – following the method used by Dubowitz, Pitts et al. (2005) in their definitional research on neglect using child protection notification data. And given the problem of low rates of investigation and substantiation of cases of neglect, chronic neglect in this age group is viewed as being at least one 're-referral' to the department. Although the concepts of frequency and chronicity have a time component associated with them – which in this context is the number of reports over time – since infancy is a period in which serious ongoing developmental harm can occur within a very brief space of time, there is a danger that too much emphasis is placed on duration in the conceptualisation of chronicity, and hence severity, in particular.

Outcomes

According to Dubowitz and colleagues (2005a), if the assumption is being made that neglect is actually harmful, proposed measures of neglect should be related to children's functioning or evidence of harm having occurred. Although it is not within the capacity of the current study to draw any inferences from the relationships between the outcomes and the various neglect sub-types or constructs used, the sample was selected on the grounds that the referent or subject infant/child in each family could be assumed to have suffered from neglect.[43] Neglect-related and/or preventable harm included all forms of developmental harm across the spectrum, physical and psychological harm, harm to health and well being, and fatal harm. These are divided into a group of eight neonatal outcomes relating to prenatal neglect and sixteen child outcomes impacted by neglect both prenatally and during infancy and early childhood. It is acknowledged, however, that there may be other factors, such as genetics or maternal health status, which may have contributed to the problems experienced by some of the children.

Although the families in Sub-sample 2 were selected on the grounds of having at least one subject infant professionally assessed as having suffered some form of 'neglect-related' harm, information relating to the developmental health and wellbeing of the non-referent children throughout the period was generally limited to what had been reported throughout the notification period, except in the few cases where a comprehensive assessment was carried out as part of the intervention process. Information relating to the children's early stages of development is very much dependent on the age at which they were first notified, or the age at which they moved to the State, and whether or not they attend Child Health or educational centres. Developmental deficits were often only identified when the older children in the subject group (those who were just less than four years when they were first notified in 2005) reached school age. However, the four infants in the family selected on the grounds of suffering severe and wide-ranging developmental harm had undergone a complete professional assessment of their development, health and well being, while other infants

[43] Although research is able to demonstrate the devastating impact that neglect and trauma have on the developing brain and on children's development, health and wellbeing in general during the early stages of development (see, e.g., Belsky 1993; Cicchetti &Toth 1995; Perry 2001a, 2002), assuming direct causal relationships between neglect and some types of developmental or other serious harm is often restricted by confounding factors such as genetics, social disadvantage or simply by lack of corroborating evidence.

were identified as ‘developmentally delayed’ by community or other professional health services. On the other hand, one of the two children who were selected on the basis of having suffered severe malnutrition was diagnosed with Failure To Thrive, yet no information relating to any aspects of their development, other than the fact that they were described as ‘tiny’ for their age and very withdrawn.

As already noted in the previous chapter, there was a general lack of information provided in relation to the developmental concerns of the children in the older age bracket, even from professionals within the school system when children reached school age. Developmental harm, particularly cognitive, language and behavioural problems, did not appear to be regarded as a child protection concern except in relation to the caregiver’s actions or inactions in relation to it. There was very little acknowledgement of the role of neglect in the severe behavioural problems exhibited by some of the children, which is generally attributed to the fact that the children are exposed to family violence.

The negative outcomes for newborns are included only when the associated risk factors were known to be present; for example, prematurity or low birth weight are only coded as a negative outcome if there is evidence of factors such as ongoing exposure to substance misuse or lack of adequate nourishment resulting from a substance-dependent lifestyle. Establishing the existence of problems such as FASD, and congenital disorders associated with prenatal exposure to both legal and illegal substances, proved difficult due to the sensitive nature of the concerns and, according to hearsay in the Department, the reluctance of medical and other professionals to either name or diagnose the problem – in the state of Tasmania, at least.

For the purposes of the study, developmental and other harms were only coded when there was evidence to suggest that neglect had played a direct role or had been a contributing factor. It was sometimes difficult, in cases involving medical or health problems, for example, to establish the extent to which neglect had contributed to the severity of the outcome. There were situations in which children with serious illnesses had special care needs which would enable them to lead fairly normal healthy lives, but if their special needs were not adequately met, could suffer serious and even fatal ill-effects. When a child in these circumstances does suffer extraordinary harm or dies, the

question arises – was the illness itself much more serious than realised or was the unexpected harm or death a result of their special or even basic needs not being met. Every effort was made to ensure that negative outcomes were only included where there was evidence that neglect was a causal factor, such as that provided by a medical professional. (A full list of outcomes is provided in Table 6.3 below.)

Addressing the definition and measurement issues

The main issues of concern for neglect research which have been discussed earlier, include (a) the variability of what constitutes neglect across the jurisdictions; (b) its use of child protection services' (unreliable and/or inaccurate) designations of 'neglect', and therefore as a general category rather than distinct sub-types; (c) frequent use of only substantiated cases of 'neglect' – a process also found to be unreliable and/or inaccurate (e.g. Hussey et al. 2005); (d) most research fails to include psychological forms of neglect in their classifications of neglect – the general category of emotional maltreatment is most often used in current research, which fails to differentiate between emotional and/or psychological neglect and abuse; (e) the tendency to focus on sub-types of neglect in terms of physical neglect only and the failure to include and/or distinguish between the entire spectrum of psychological neglect sub-types; and finally (f) the lack of research that examines the experience of neglect in terms of the developmental needs of the child, rather than into account into terms of the , other than in terms of measuring severity.

The conceptual framework for the research takes the form of a classification and measurement system that uses conceptually sound operational definitions of the problem based on unmet needs, and capable of identifying, describing and measuring neglect from the point of view of the child. This study attempts to address the foregoing issues that impact on our ability to measure, describe and distinguish between neglect sub-types in the following ways:

- clear and concise *a priori* operational definitions were established which do not rely on either child protection service classifications of neglect or substantiated cases of neglect (see Zuravin 2001);

- the operational definitions take the complex and heterogeneous nature of neglect into account by identifying both physical and psychological neglect sub-types in terms of constructs of unmet basic care and protection needs essential to normal development, health and wellbeing;
- the dimension of developmental stage is addressed in terms of the unmet care and protection needs that are unique to the early stages of development from before birth, through infancy and early childhood (children< 48 months of age);
- the research framework and methods used in the study include dimensions of sub-type, developmental timing, chronicity, severity and frequency;
- a new method of measuring and/or assessing levels of chronicity and/or severity – or to assess levels of risk – that take into account the heterogeneous, pervasive and continuous nature of neglect in this highly vulnerable age group;
- the ecological nature of a needs-based operational definition means that the commonly reported parental and ecological factors inherent in the problem of neglect are able to be identified whilst retaining the focus on the child.

Study Two Findings

Characteristics of the Subject Group of Families

The Subject Group of families (N=14) resided in urban and rural areas with SEIFA relative socio-economic disadvantage scores ranging from 799 to 991, with the mean score of 906 being below the average IRSD (961) for Tasmania[44] and the Australian national average (1000). Homelessness and/or transience were a common experience for the majority of the families, with numerous moves occurring within and between those general urban and rural areas throughout the study period: 10 families resided within various urban areas, 2 families moved within rural areas, and 2 families moved from rural to urban areas in the middle of the period. All but one of the families experienced homelessness, inadequate housing and/or financial difficulties at some time during the

[44] Tasmania has the second lowest SEIFA Index of Relative Socio-economic Disadvantage (IRSD) scores after the Northern Territory, with IRSD for metropolitan and non-metropolitan Tasmania of 982 and 948 respectively.

period, which required ongoing support from family, women's shelters or community services. There were several reports claiming that parents were having or planning to have children as a way of solving their financial difficulties, via the baby bonus, with many custody disputes reportedly being more to do with the child welfare payments than the child's welfare.

Most of the families were reported to be living in financially and socially disadvantaged circumstances. Housing problems were reported for 85% of families, including transience homelessness, inadequate sleeping arrangements – such as six or more children, from toddlers to teenagers, sharing beds or mattresses in one bedroom; and mothers, toddlers and babies co-sleeping and/or sleeping in lounge rooms on unsafe makeshift bedding on the floor – and often with no electricity for cooking, hot water or heating (in the middle of a Tasmanian winter). Almost 80% of the families were reported to have unhygienic living conditions that were endangering the children's health; and 64% of the families were reported to have inadequate food and/or clothing (also in the cold Winter months). A high level of transience and/or residential instability for most of the families was evidenced by the number of reported residential changes during the notification period.

Primary caregivers

The primary caregiver was the biological mother for all of the subject infants (and co-residing children) during the notification period up until the time the Department intervened and/or the subject children were permanently or temporarily removed from her care, with the exception of two families in which each of the fathers fought for and was eventually granted custody of a subject child in the second year of the notification period, one prior to and one immediately following departmental intervention for another (younger) infant in the mother's care. Child protection intervention resulted in the temporary removal – involving brief periods for assessment purposes or longer periods of 12 months or more with re-unification in mind – or permanent removal of at least one SI from their mothers' care into Departmental foster or kinship care in 12 of the fourteen families at some point during the study period.

Table 6.1 Characteristics of the Subject Group of Families (SFG)

Family	All Chldrn[a]	Co-res. Chldrn[b]	Subject Infants[c]	All Ntfns 03-09	SI Ntfns 03-09	Family Type[d]	Mat. age < 20[e]	Biol. Fs[f]	Urban/ Rural[g]	SEIFA IRSD[h]
Family 1	2	1	2	11	11	1	No	2	R	918
Family 2	4	4	4	10	10	1	No	2	U	900
Family 3	3	2	2	13	13	2	No	2	U	918
Family 4	9	9	5	28	16	1.25	No	1	U	861
Family 5	1	1	1	6	6	1	No	1	R	909
Family 6	7	5	5	23	20	1	Yes	3	U	861
Family 7	4	4	2	5	5	1	Yes	1	U	799
Family 8	2	2	2	6	6	1.66	–	1	U	861
Family 9	3	1	1	20	20	1.5	No	1	U	991
Family10	8	8	4	19	14	2	No	1	U	861
Family11	6	3	3	18	18	1.33	Yes	2	R-U	991
Family12	4	3	4	19	19	1.66	No	3	R-U	956
Family13	5	1	2	22	22	1	Yes	3	U	932
Family14	2	2	2	9	9	1	No	2	U	932
Totals	60	46	39	209	189	-	-	25		Ave: 906

a. ‘Total Children’ refers to all biological children of the primary caregiver born prior to 2009, including those who are deceased or permanently in the care of the other parent, family member, or the Department. (In all of the cases presented here, the biological mother is the caregiver of all of the children throughout the notification period, except for one family where the biological father was granted full-time custody of one of the children, and the mother had part-time custody only)

b. ‘Co-residing children’ refers to the number of children in the family who were residing with the primary caregiver during the study period (2003–2009); it incudes the children who died while in their parents’ care. One SI who was stillborn and another 2 who went into their fathers’ care during the period are not included.

c. ‘Subject Infants’ includes all children in the Subject Group of families (SFG2) who were under the age of 48 months during the study period (2005–2009). (See Methods section for detailed description)

d. ’Family Type’ refers to the number of co-residing biological parents in the family during the notification period; that is, 1 = single parent; 2 = 2 parents. In families where the parents have separated during the period, or where some or all of the children have different fathers, the number reflects the proportion of time that one of the biological fathers spent residing with the family; for example, 1.5 means a biological father of at least one child was residing in the home for half of the period during which the family was being notified. (See Methods)

e. ‘Maternal age (<20)’ refers to whether or not (Yes/No/Unknown) the mother was less than 20 years old when her first child was born.

f.. Number of ‘Biological Fathers’ refers to the fathers of all children born to the mother (co-residing or not)

g. ‘Rural’ and ‘Urban’ classifications are explained in the Methods section of Study 1 in Chapter 3; the ‘R-U’ designation refers to the fact that a family has moved from a rural area to an urban area approximately halfway through the notification period.

h. ‘IRSD’ refers to the SEIFA Index of Relative Socio-Economic Disadvantage scores for the postal areas in which the families most recently resided (the lower the scores the greater the level of disadvantage). The average IRSD across Australia is 1000.

The 14 mothers in the SFG had given birth to a total of 60 children, 46 of whom were primarily in their mothers' care, while the remaining 14 children from five of the families were residing in the permanent care of the maternal or paternal grandparents or in the primary care of their fathers. In some cases it was difficult to ascertain the exact extent to which children were being cared for by extended family members, especially grandparents, and particularly those living in close proximity to the children. Four of the mothers were less than 20 years old when their first child was born; however, none of the children born to the mothers at that age had remained in their care. The number of co-residing children in each family in Sub-sample 1, including those who died, ranged from 1 to 9, and the number of Subject Infants ranged from 1 to5. In Sub-sample 2, the total number of children ranged from 1 to 8, and the number of Subject Infants ranged from 1 to 4.

Twelve of the fourteen households were single-parent families for varying lengths of time during the study period:[45] half of the SFG (n=7) were single-parent households throughout the period of their involvement, while the remaining five families (n=5) were single parents off and on for periods ranging from 75 % to 33% of the time during which they were involved with the department. This is very much higher than the proportion of single parent families in the general population in Tasmania which was at a level of 23.1% in the 2005–2006 period (Jacob & Fanning, 2006). There were only 2 families in which the biological father of the children was residing in the family home for the majority of the period, although one or more of the 25 different biological fathers resided with their respective families for varying periods of time. The foregoing timeframes are used to describe the family status (number of parents) included in the family characteristics for the SFG presented in Table 6.1.

A total of 209 notifications were identified for the co-residing children in the Subject Group of families for the period (2003 – 2009) covered by the study, and an additional 28 reports made in relation to any or all children of the primary caregiver between 1998 and mid-2003 were identified from an earlier database which covered that period. The number of notifications for the co-residing children in each of the families in the

[45] The length of time during which the families were involved with the Department, referred to as the notification period, may have been longer or shorter than the study period. The time period referred to here is the period during which the family was notified to the Department within the timeframe of the study (the study period).

Subject Group during the study period ranged from a minimum of 5 reports for Family 7, to a maximum of 28 reports for Family 4. The low number of referrals for Family 7, for whom there were some very serious concerns, could be at least partially accounted for by the fact that the family as a whole and the older (non-SI) children in particular appear to have resided with or near the maternal grandparents for much of the study period.

Parental and family risk factors

Substance abuse, mental health problems, intellectual disability, family violence and criminal activity did not exist as single issues of concern for the primary caregivers in any of the families; they were found to occur in various combinations of two or more which served to perpetuate one another in an ongoing cycle. In seven of the fourteen families, the primary caregiver was reported on at least one occasion to have either abandoned or been unable to provide care for the child(ren) – for a range of reasons such as having to serve a term of imprisonment, admission to hospital or other institution for mental or other illness, inability to cope, or for undisclosed reasons. Although the primary focus of the current study is on the children's experience of neglect rather than the caregivers' behaviours, the parental issues are relevant not just in the immediate effects on their capacity to provide adequate basic care but insofar as they are symptomatic of serious underlying concerns to do with their own early childhood experiences which have shaped their psycho-emotional development and fundamental capacity to meet their children's basic attachment and emotional needs.

Drug and alcohol problems[46]

Chronic drug mis-use was reported for every primary caregiver in Sub-Sample 1 and all but one of the primary caregivers (the mothers) in Sub-Sample 2, to the extent that it had a serious impact on their emotional availability and capacity to meet the care and protection needs of the children. Alcohol misuse or dependence was also reported for all of the primary caregivers in Sub-sample 1 and all but two of the primary caregivers in the SFG. The one family that had not been reported for either drug or alcohol misuse

[46] Only chronic or problematic alcohol and/or drug use reported to be having a negative impact on the children's health, development and/or wellbeing was regarded as placing the SIs 'at risk' of not having their needs met. (701.1-2).

nevertheless had one child who was assessed as having some features of Foetal Alcohol Syndrome and there was other evidence to suggest that alcohol and possibly drug mis-use may have been a problem for the mother as well as the father, who was reportedly known in the community to be involved in drug-related criminal activity.

As findings in relation to prenatal neglect below show, maternal mis-use of legal drugs, such as methadone and anti-depressant medication, was as problematic as illegal drug use. Problems arising from maternal drug use, and parental drug use in general, were far-reaching in their effects, including:

- maternal mental and physical health problems and cognitive capacity which (further) affected their ability to meet the developmental needs of the children;
- they were less able to meet the special needs of their infants who were more likely to be born prematurely and/or with low birth weight, neonatal abstinence syndrome and congenital and other health problems;
- financial difficulties which substantially affected their ability to provide basic necessities such as adequate food, clothing, heating, medical care, and housing;
- an increased likelihood that violent and/or drug-dependent fathers/partners would be allowed (back) into the home or the relationship;
- and social and lifestyle problems such as criminal activity and drug debts which physically endangered themselves as well as their families, and left them at continual risk of incarceration and loss of or separation from their children at a crucial stage of their development.

Mental health problems

Mental health problems were reported for 10 (70%) of the 14 mothers. Substance dependence or addiction is explored separately and is not included as a mental health disorder per se, although the harmful and/or exacerbating effects of chronic drug or alcohol misuse on the mental health of some caregivers and/or their partners, and ultimately the subject infants, was apparent. The reported mental health concerns included an array of disorders with varying degrees of severity, such as agoraphobia, obsessive compulsive disorder, depression, bi-polar disorder and personality disorders. The more serious psychiatric illnesses such as chronic depression and personality disorders are known to have a substantial impact on the mothers' ability to meet infants'

physical and psychological developmental and attachment needs – which often stemmed from their own experience of neglect and abuse as children.

Infants were exposed to the effects of the primary caregivers' and their partners' mental health problems, either in the form of prenatal or postnatal exposure to mis-use of drugs and/or alcohol, with exposure in one case to extreme psychotic episodes and violence. The mother of one baby who subsequently died unexpectedly had attempted suicide on several occasions, including while she was pregnant, with a cocktail of legal and illegal drugs and alcohol. The capacity of mothers diagnosed with serious personality disorders and depression and who were misusing alcohol and other drugs as well was never questioned.

The existence of domestic violence in every family in the sample lends further support to the suggestion that co-existing mental health problems were likely to exist for at least one adult partner in every family. The male partners suspected of assaulting two infants and a toddler, two of whom died and one resulted in brain damage had histories of extreme violent behaviour, and one was known to have a range of untreated serious mental health problems. The combined issues of mental illness and drug and/or alcohol dependence were factors that were present compromise the safety of a large proportion of the infants who died or were physically harmed in circumstances where their safety needs had not been met both prenatally and in infancy and early childhood. The family characteristics for the Subject Family Group (SFG2) are presented in Table 6.1.

Intellectual disability and/or capacity to parent

There were three primary caregivers and two secondary caregivers across the sample whose intellectual capacity to care was reported to be a concern. However, only one of the primary caregivers had undergone any formal assessment, and had been registered as having a mild intellectual disability some years earlier – this mother was later assessed for child protection purposes as having a 'very low' level of cognitive functioning, and the (mainly) previously co-residing father in the same family was assessed as having below average cognitive functioning. Two of the cases relating to the primary caregivers' intellectual impairment were directly associated with substance

mis-use, in that substance abuse was reported to cause or exacerbate the mothers' low level of cognitive functioning and capacity to parent.

Family violence

Exposure to family violence between two parents and/or partners was reported in relation to every family except one (N=13) – although there were no reports of domestic violence per se for this one family, the children were reportedly subjected to violent treatment by the father who resided in the home for the majority of the study period. Family violence to which the SIG were exposed, apart from the incidence of different forms of child abuse, included violence perpetrated by the father or male partner towards the mother, by the mother against the father or male partner, by older male siblings against the younger children including the SIG (2 families); and physical and/or emotional abuse by other adults in the home. While reports of violent behaviour or threats of violence were more commonly made in relation to males, the mother was a perpetrator of violent assaults against the father in four of the families – including a serious stabbing incident in one family and threats to have the father killed by criminal associates in another.

Exposure to the violent and/or anti-social behaviour of the older male siblings in two families was observed to have potential wide-ranging effects on the physical and emotional wellbeing of the infants and toddlers in the younger age group. In one of the families, the behaviour of one child was observed to worsen over the period from the age of eight to twelve years, by which time he was beyond the control of the single mother or the school staff. Another older sibling was reported to have repeatedly punched one of the mothers in the stomach when she was pregnant. By the time they reached school age, the subject children in these families were reported to be developing the same violent and aggressive behaviours as their older siblings. To exacerbate the problem even further, the children and their families were often ostracised within the school and local community.

For those families who were residing in rural areas, domestic violence incidents were found to have been unreported particularly during the early stages of the implementation of the 2004 Act. There was further evidence of domestic violence incidents going

unreported for some families living in rural areas throughout the study period. The question arises as to whether the death of at least one young child in the sample would have been prevented if the family had been residing in a less isolated area at the time. The lack of visibility of preschool age children in highly transient families moving through rural areas seeking temporary and/or cheap accommodation was apparent in readings of the notification reports – two families in the study were.

Criminal Activity

The involvement of primary caregivers in criminal activity in 12 out of the 14 families (86%) was noteworthy, with the number of reports for each of those families ranging from 1 to 8 (average of 4.25). Records of criminal offences and/or convictions relating to both parties involved in the incident accompany the police reports of domestic violence, which included violent assault and the use of weapons such as guns and knives, aggravated burglary; stealing; possession of stolen property, unlawful possession, breach of bail, traffic offences (such as unsafe driving practices), threaten or obstruct police, dishonesty, drunkenness; and possession of an illicit substance.

The impact of parents' criminal activity was not restricted to the children's moral development, it meant that they were likely to face periods of imprisonment – which would normally place the attachment relationship between some mothers and infants at risk – which resulted in family and residential instability. Criminal activity added to the likelihood of further social exclusion in the community, in addition to that resulting from co-existing lifestyle issues. At least three older siblings from three different families, who were between the ages of 8 and fifteen years old, were reported to have been in conflict with the law for offences such as assault, causing harm to person and/or property, threatening to harm person and/or property, stealing and illicit drug use. In some instances, the primary caregiver had involved the child in their own criminal activity.

The Subject Infant Group (SIG)

The Subject Infant Group (SIG) (N=39) in the Negative Outcome Sample consisted of 25 male and 14 female infants and toddlers, or 1.8 times as many boys as girls overall. There were twice as many boys as girls in Sub-sample 1 and approximately 1.6 times as

many boys as girls in Sub-sample 2. The children's ages ranged from 0 (unborn) to 38 months at the time of their first notification to the Department, with the majority of the SIs (75 %) less than 12 months old at the time, and the SIs in this age group fairly evenly spread across the two Sub-samples:

- 10 (26%) of the subject infants were notified either before or immediately after they were born – 3 infants in each sub-sample were notified before they were born (n=6), and 2 infants in each sub-sample (n=4) were notified by the hospital at the time of their birth;
- 19 infants (49%), 9 in Sub-sample 1 and ten in Sub-sample 2, were notified before the age of 12 months;
- 4 SIs (10%), two in each sub-sample, were first notified when they were 12 to 24 months of age;
- and six SIs (15%), 4 in Sub-sample 1 and 2 in Sub-sample 2, were between 24 and 38 months of age (see Table 6.2).

There were 189 notifications identified for the Subject Infants during the study period, with the number per SI family group during the period ranging from a minimum of 5 to a maximum of 22 notifications. The number of notifications for each family during the period covered by the study is provided in Table 6.1, and the notification history, including maltreatment type and priority classifications and timelines, for each of the families during the period is presented in Figure A6.2 (in Appendix E).

Information about the number of substantiations of notified concerns was not included primarily because substantiation of neglect in particular has been found to be somewhat less than meaningful generally (see, e.g. Hussey et al. 2005; Kohl et al. 2009). The other reason being that notifications of neglect during this period were often not substantiated because they had not received any further investigation or they had not been investigated within a reasonable timeframe – due to the overloaded state of the system at the time. Even the highest priority notifications could remain on the unallocated list for extended periods at that time, while priority two notifications had little chance of being investigated within a 12-month period, if at all.

Table 6.2. Age of Subject Infants (SIs/C) in the Negative Outcome Sample at first report and known negative outcomes of referent and non-referent SIs

Family	C1	C2	C3	C4	C5	Referent SI (-ve outcome)	Non-ref SI (-ve outcome)
Family 1	30 mos	unborn				C2	C1
Family 2	26 mos	15 mos	1 day	6 mos.		C3	C1, 2
Family 3	2 days	unborn				C1	C2
Family 4	6.5 mos	4 mos	8 wks	4 mos	4 mos	C1	C2, 3
Family 5	32 mos					C1	
Family 6	20 mos	7 mos	unborn	2 mos	3 wks	C5	C1-4
Family 7	26 mos	8 mos				C2	C1
Family 8	24 mos	9 mos				C1 C2	
Family 9	7 days					C1	
Family 10	38 mos	5 wks	24 mos	12 mos		C1–4	
Family 11	7 mos	5 wks	unborn			C3	C1, 2
Family 12	34 mos	4 wks	6 mos	1 day		C2	C1,3,4
Family 13	7 mos	unborn				C2	C1
Family 14	10 mos	unborn				C2	C1

Most of the subject infants in the sample, including referent and non-referent children, were found to have suffered a range of developmental and other forms of harm. The only 3 infants who were not reported to have suffered some form of harm were the youngest members of the family who had all been born at the end of the study period, after the deaths of their older siblings. The findings indicated that all of the Subject Infants in each family were subject to the same chronically neglectful experience, and were at similar risk of harm throughout the period. And since the concerns being notified were usually for the children as a group, and just as likely to be focused on the caregiver as the child(ren) being notified, it was deemed appropriate to explore the neglect experience for the subject infants as a family group, rather than restrict the information to one particular Subject Infant. While all notifications were used as a source of information about the infants' experience of neglect, only the information that applied specifically to subject infants was coded and quantified to provide measures of frequency.

Sub-sample 1: Child outcomes

Sub-sample 1 (S1) (n=21) includes six infants who were between 0 and 18 months of age and a young child who was four years old when they died (n=7 – 2 females and 5 males), and the fourteen siblings (n=14 – 5 females and 9 males) from six of those families, whose ages ranged from 0 (unborn) to 30 months at the time they were first notified to the Department. (Figure A6.2 in Appendix E shows the notification history for the families during the study period.) Two of the children who died were the only children residing in the family at the time of their death, whereas the other five infants all had older siblings, including 8 other Subject Infants. Eighteen of the 21 SIs in Sub-sample 1 were identified as having suffered a total of 34 negative outcomes among them, which gives an occurrence rate among those negatively affected of almost 2 (1.9) negative outcomes per child.

The youngest infant in the group of children who died was stillborn as a result of prenatal exposure to a drug overdose. The deaths of three infants aged between 2 weeks and six months were classified as Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected/Unexplained Death of an Infant (SUDI). Multiple risk factors were present in each of the cases, which had been reported a number of times previously, but the existence of personal or community service support in two families was deemed sufficient to ensure the infants' safety. All of the referent infants and most of their SI siblings were likely to have experienced a lack of emotionally sensitive and responsive care as a result of serious maternal drug and/or alcohol mis-use, combined with unsafe sleeping arrangements or unsafe bedding. The reports referred to previously together with the findings reported here reinforce the view that the deaths of all four infants were preventable.

The exact circumstances surrounding the deaths of three children which required further police investigation remains unclear as the three mothers, one father and two male partners who were present at the time provided conflicting accounts and/or claimed no knowledge of how the infants died or the circumstances surrounding their deaths. The initial findings relating to the death of an infant (between 12 and 18 months of age) were that it was the result of an unintentional drug overdose; the exact circumstances of which are unclear due to differing versions of events provided by the parents and the

lack of conclusive evidence. The information gleaned from notifications reported by Police and later from the Court proceedings that the deaths of (at least) two of the children involved both abuse and neglect.

One of the infants was found to have suffered severe and extensive non-accidental trauma, but the coroner's findings were that the death was directly caused by the attempts that were made to cover up the physical signs of injury and the failure to provide timely medical care. The death of a four-year-old child was found to be due to the lack of medical attention for a head injury: the Coroner believed the injury would not have caused the child's death if the medical treatment that was obviously required for this and other suspicious older injuries that the child had suffered had been provided. (This child had already been subjected to physical abuse allegedly caused by the mother's previous partners.) The Coroner believed that the child's very poor state of health at the time contributed to his death.[47] The Coroners' findings in all of these cases are limited by what can be established with regard to the facts of the matters before the Court – it is a disturbing fact that in the majority of the cases, the accounts of what occurred were conflicting; neither the witnesses (parents, partners and extended family members) nor the evidence they provided were considered to be reliable.

Eleven of the fourteen non-referent Subject Infants in Sub-Sample 1 – that is, the siblings of those who died – were also reported to have suffered a wide range of negative outcomes associated with neglect in the prenatal and early childhood stages of their development. Negative outcomes, other than fatalities, which were reported for SIs in each of the seven families (in no particular order) in Sub-sample 1 included:

1. One SI was born with a congenital disorder associated with prenatal exposure to drug and/or alcohol misuse, was diagnosed with developmental delays, and suffered a serious burn injury resulting from unsafe sleeping arrangements; another SI suffered numerous non-accidental injuries including burns, cuts and bruising. Two of the SIs were reported to have attachment disorders.
2. One SI was born with several life-threatening congenital anomalies and health problems which were associated with prenatal exposure to drugs and alcohol. The referent SI was also born suffering from NASD and a serious congenital defect.

[47] The Coroner's findings for this case had not been finalised at the time the data was collected.

3. Two non-referent SIs were reported to have cognitive development / learning difficulties and behavioural problems involving aggression and violence;
4. A non-referent SI was reported to have a range of emotional and mental health problems – including attachment difficulties, suspected Post-Traumatic Stress Disorder, anxiety, sleeping difficulties and aggressive, violent and anti-social behaviours;
5. A referent SI was found to be severely malnourished and had multiple untreated suspicious injuries.
6. A non-referent SI suffered a serious brain injury as a result of lack of supervision, anxiety and sleep disorders, and was reportedly being treated for behavioural and anger management problems; the referent Subject Infant in the family was found to have multiple non-accidental injuries.
7. Two non-referent SIs exhibited 'disturbing', violent' and 'aggressive' behaviour.

The only three SI siblings with no reported harm were all born later in the period – subsequent to the intervention that occurred in response to the infants' deaths – and there was little information reported or known about their wellbeing or otherwise. The negative developmental and health outcomes identified for the Subject Infants in Sub-sample 1 (neonatal and paediatric deaths) and Sub-sample 2 (neglected) are summarised in Table 6.4.

Sub-sample 2: Infant and child outcomes

The Subject Infants in Sub-sample 2 (S2) (n=18), consisting of 11 referent SIs and their 7 SI siblings. The referent group of infants consisted of all of the Subject Infants in three of the families (n=7), the second of four SIs in one family, the youngest of three infants in one family, and the youngest of two infants in two families (n=3). The negative outcomes which formed the basis of the referent infants' selection were found to be accompanied by a wide range of developmental and other harms. The amount of information relating to the outcomes for each of the subject children was very variable, the occurrence of harm reported here would therefore be considered to be an underestimate of the true incidence of harm. As with the cases in Sub-sample 1, the exact circumstances in which suspicious physical injuries occurred is often unknown

due to the lack of available evidence. Regardless of who caused the injuries, the infants basic needs were not met before, during and/or after the fact – in terms of timely medical care, sensitive and responsive (loving) care, or by providing safe alternative primary care for a highly vulnerable infant suffering from NAS.

Family 8. Both of the infants in Family 8 were hospitalised with severe malnutrition, they were both below the lowest percentile for their height/weight, and there was no evidence of any illness or disorder found that was able to explain their emaciated state. The children were described by hospital staff as very withdrawn, particularly when their mother was present, but not with their grandmother. There were earlier reported concerns about the children's developmental delays and suspected attachment problems, which they were to undergo further assessment for.

Family 9. The health, wellbeing and development of the subject infant in this family had been jeopardised from the prenatal period and throughout his early years: prenatal exposure to drugs resulted in the newborn infant requiring resuscitation at birth, placing him at increased risk of neuro-developmental impairment, and resulting in a lengthy recovery period in the Neonatal Intensive Care Unit where he was treated for NASD.

At the age of five years this little boy was suffering from serious psycho-emotional and behavioural problems, with symptoms of separation anxiety and attachment difficulties. The breadth of this child's mental health and psychological development generally are unknown, as he had received no professional assessment at that stage. But it was clear from the reports that these aspects of development were in jeopardy: in a notification from the mother asking for respite from the child's 'nasty' and violent behaviour, the mother reports that she "screams at child but he won't listen; child allegedly goes into a 'trance' ... Child's mother reports that he needs to see a specialist so that he can be tested to ascertain if he has epilepsy" [SIC].

The psychologist was concerned that the child has autism. He was reported by the school to have delayed speech and language, and cognitive development – he has "difficulty following the simplest directions", and requires one-to-one assistance in the classroom in order to carry out the simplest tasks. No medical assessment had been conducted at the time of the most recent notification; however, the school reported

serious developmental and mental health concerns for the child which required treatment by allied health professionals, and the child had been referred by the school psychologist for further assessment. The possibility that the child may have Foetal Alcohol Syndrome (FAS) was also raised.

Family 10. All four of the Subject Infants in Family 10 were assessed at the end of the study period, when their ages ranged from 2 to seven years. They were diagnosed with delays of varying severity in every sphere of development, including delayed language development and cognitive deficits, fine motor developmental deficits, socio-emotional developmental delay, personal hygiene and self-care skill development (such as toileting and bathing), social skills, and behavioural problems. All of the subject children bore scars on their faces, bodies and extremities from burns, cuts, grazes and scratches from old and recent injuries.

The second youngest subject infant (a toddler aged 3 at the time) was the most severely affected. He was diagnosed with Failure to Thrive, 'probable' attachment difficulties, and Global Developmental Delay, 'probably due to lack of stimulation and poor nutrition'. He had severe language and speech delay – he had no words and did not babble or shake his head for 'no' (development equivalent to that of a seven-month-old infant) – his fine motor development was delayed (to the level of a 14 month-old), and his 'personal/socio-emotional development' was delayed (to the level of a 20 month-old) – he did not seem aware of whether his nappy was wet or dirty. There were a number of old scars on the child's body, including two healed burns, one of which required hospitalisation. When he first went into care, this young toddler needed to be held all the time by anyone, he slept wherever he happened to drop and he disliked being bathed.

The youngest infant (aged 2 at the time) was also assessed as having global developmental delay, "probably due to lack of stimulation", and the infant's observed behaviour suggested that attachment problems were likely. His carer described him as 'not keen on cuddles or affection' and he did not attempt to seek comfort when upset or frightened. There were specific findings which included severe speech and language delays similar to his older sibling – he had no words at all either, he grunted or shouted for attention, and did not shake his head for no. He also had delayed social development

and self-care skills – he could not handle a cup, for instance, and was unaware if his nappy was wet or dirty; and delayed fine motor development. When he first came into care, his carers found that he had no sleep routine and was similarly used to falling asleep 'wherever he dropped', and he was afraid of water and baths. Although this infant's growth was normal, there were signs of iron deficiency anaemia.

The second eldest referent SI's developmental assessment (aged 4 at the time) found that he suffered Global Developmental Delay, 'probably due to lack of stimulation'; which included delays in speech and language/cognitive development, fine motor development, and personal and social development. (Cognitive aspects of development appeared to be included in the language and speech developmental assessment.) The results of the child's physical assessment included poor growth and nutrition, multiple scars on his head, face and body. He was also reported to have some dysmorphic facial features (although the question of Foetal Alcohol Syndrome was not raised).

The eldest referent subject child (aged seven years at the time) was found to have developmental delays in the areas of speech and language, personal and social skills, poor school performance, and problems with aggressive behaviour. The report stated that further testing was required to assess this child's cognitive development, with regard to his poor school performance and behaviour.

Family 11. The referent infant in family 11 suffered preventable brain damage as a result of the special medical, dietary and health care requirements for treating the particular condition not being met. The resultant harm that eventuated were exacerbated by suspected falsification of the blood samples being sent for testing, in what appeared to be an attempt to conceal the true state of the infant's health from the medical professions involved. Little is known about the health and developmental outcomes of the non-referent SIs, as the younger infant was the focus of the investigations that occurred.

The second youngest SI was described as a 'high risk / high needs' infant – as a result of a premature birth at 30weeks gestation, low birth weight and prenatal exposure to drugs – whose needs for follow-up medical checks were reportedly unmet. The infant was reported to be in continual poor health, suffering from asthma and chronic URTIs

which required hospitalisation on a number of occasions. The older SI had been removed from the mother's care by child protection in another state, where this young child was reported in relation to suspected delayed development and an 'unexplained' injury, which had resulted in the grandparents taking both of the non-referent SIs into their care for a time.

Family 12. The referent infant in this family was brought to hospital by his paternal grandmother at 7 months of age and was diagnosed with non-organic Failure to Thrive. A child health nurse had examined the baby and found that he had regressed developmentally; his weight had dropped since the last visit, he was no longer smiling, and no longer able to roll over on his own. On admission to the hospital, the infant was reported to be severely underweight, and suffering from a fungal skin infection, sunburnt lower limbs, and a bruise on the scalp. A paediatric examination found that the baby was hyper-alert, very anxious and agitated, and had a voracious appetite. The infant's severe nappy rash, scaly skin and a rash down the side of his body was believed to be consistent with being left in urine-soaked clothes and bedding for extended periods. The baby was described as "quite stiff – very neglected"; the paediatrician expressed concern about the infant's mental health. When this child was four years old – and had been back in the mother's care for 12 months after period in Departmental care – he was receiving psychological treatment for what was believed to be Pos-Traumatic Stress Disorder (which was reported to be the result of witnessing violent incidents in the home). The older (non-referent) Subject Infant (then aged 4) was also reported to be losing weight and showing signs of cognitive developmental delay at the time his sibling was hospitalised, and had been placed in the father's care at the time. The only information relating to the outcomes for the subsequent SIs was that the youngest was born with a low birth weight and the other infant required intensive neonatal care – together with reports of the mother's continuing drug and alcohol issues, and concerns reported at the time of the youngest infant's birth that the 1 year-old was being left lying in his cot all day.

Family 13. The referent infant in this family was 12 months of age when he was brought into hospital by child protection workers and found to have suffered several non-accidental injuries, including a broken leg, bruising around his head, as well as a severely bruised and infected penis, and what appeared to be cigarette burns. This baby

had been born prematurely and drug dependent, and was small for gestational age. He had been assessed by a child health nurse as developmentally delayed, as he was not sitting or crawling at the age of 11 months.

Family 14. The referent infant in this family had been prenatally exposed to multiple drug use including methadone and amphetamines, which resulted in this baby being born drug affected to the extent that he required resuscitation when he was born and continued to suffer from symptoms of NASD for an extensive period. When he was four weeks old, an allied health professional had reported concerns that he appeared to be very small and failing to gain weight (and that the mother continually appeared heavily under the influence of drugs). The baby was brought into the hospital at 12 weeks of age with bruising on his face and body and a brain injury.

Table 6.3. Negative outcomes associated with infant neglect identified for the Subject Infants in each sub-sample

Child Outcomes (neglect-related)	***Incidence (Number of children affected)***		
	Sub-Sample1 (n=21)	Sub-Sample2 (n=18)	Total (N=39)
1. Fatality	7		7
2. Failure To Thrive	1	5	6
3. Malnutrition	1	6	7
4. Global Developmental Delay	1	5	6
5. Psycho-emotional Development (inc. attachment probs)	6	10	16
6. Cognitive Development	2	8	10
7. Language Development	1	8	9
8. Psycho-social Development: Behavioural	6	6	12
9. Psycho-social Development: Autonomy1 (self-care)		4	4
10. Psycho-social Development: Autonomy2 (toileting)		4	4
11. Gross motor development		3	3
12. Fine motor development		3	3
13. Medical / Health problems (neglect-related)	1	8	9
14. Dental disease	1		1
15. Accidental injuries*	4	4	8
16. Non-accidental injuries*	3	2	5
Total number of outcomes	34	76	110
Ave no. of outcomes per SI/C	1.6	4.2	2.8

*Neglect-related accidental and non-accidental injuries other than those associated with fatal injuries

The Nature of the Neglect Experience

Every SI family group was found to have experienced at least six sub-types of neglect – which always included 'basic physical needs' (100), psycho-emotional and physical needs 1 (200: provision), psycho-emotional and physical needs 2 (300: protection)), and general neglect (700) – with the majority experiencing one or more unmet need constructs in all eight neglect sub-types. The total 'aggregated frequency score' (AFS) for the families in Sub-sample 2 (AFS=858) was greater than the total for Sub-sample 1 (AFS=662). Sub-sample 2 had higher total frequency scores in every sub-type with the exception of the 800 category, 'protection from prenatal harm' (AFS=52), and one of the 300 sub-categories, 'protection from physical and psychological abuse/harm' (301, AFS=72), which were both higher for the families in Sub-sample 1 (child death sample).

The aggregated frequency of need constructs for each neglect sub-type per family ranged from a minimum of 1 to a maximum of 53. The total AFS for individual families ranged from a minimum of 44 for Family 5 (with 1 co-residing SI) to a maximum of 181 for Family 9 (also with one co-residing infant). The families with more than four co-residing and/or subject infants (Families 4, 6 and 10) were among those with the next highest overall counts. The three families with the lowest total frequency scores (and number notifications) were Family 5 (FS=44) and Family 7 (FS=48) from Sub-sample 1, and Family 8 from Sub-sample 2 (FS=57). Despite the low number of notifications for these three families, one or more of the SIs in Families 5 and 7 were reported to have experienced every sub-type or category of neglect except prenatal neglect, and for Family 8, unmet need in every neglect sub-type except exposure to criminal activity and prenatal neglect.

In terms of the proportional distribution of the frequency scores for each family, the two sub-types which take into account those fundamental needs that relate most specifically to infants and very young children, 'provision of psycho-emotional and physical needs' (200) and 'protection from physical and psychological harm' (300), received the greatest proportion of scores, 27% and 26% respectively, making up more than half of the scores across all categories. They also had the two highest total aggregated

frequency scores (421 and 400 respectively) of all the sub-types. Although the greater number of constructs in the 'protection from harm' (300) sub-type would explain the higher frequency scores in that category, the provision of 'psycho-emotional and physical needs' (200), has one less construct than 'basic physical needs' (100), which had the next highest score, followed closely by the 'general/unspecified basic care and protection' (700) category (AFS=) (see Table 6.6b).

When the frequency data were normalised into scores for the presence or absence of constructs within each sub-types (see Table 6.5), the families in Sub-sample 1 were also found to have a greater number of need constructs present for 'prenatal neglect' than the families in Sub-sample 2, and Sub-sample 2 continued to have a greater or equal presence scores in every other category, with the most noticeable disparity between the two sub-samples occurring in the 'Basic physical needs' (100) and 'cognitive and language developmental needs' (400) sub-types. The aggregated frequency scores and proportional distributions for all neglect sub-types for each sub-sample are summarised in Tables 6.6a and 6.6b respectively.

Considering also that the incidence of negative outcomes for the SIs in Sub-sample 2 (n=76) was more than twice that of those in Sub-sample 1 (n=34), there was further reason to look at the question of whether or not the two sub-samples are different. The outcome findings for the entire SI group also provided an opportunity to assess the operationality of the research definitions.

Relationship matters and questions of difference

Although there are not enough cases to infer a cause and effect relationship between the neglect sub-types, or need constructs, and the occurrence of negative outcomes, it is possible to test the existence of relationships without reference to their specific forms. In order to find out, firstly, whether it is possible to infer that the constructs are useful for predicting the developmental and health outcomes, and secondly, whether the two sub-samples are indeed different, the following questions were addressed:

1. Is there a relationship between the sets of identified need constructs (or risk factors) and the child outcomes for the SIs in each family?

2. Do the need constructs identified per family in Sub-sample 1 differ from those identified for the families in Sub-sample 2?
3. Does the number of negative outcomes identified for the SIs in Sub-sample 1 differ from those in Sub-sample 2?

Question 1. The Mantel test was selected for the purpose of testing for the existence of a generic relationship between the need constructs and the child outcomes. The counts for the sets of need constructs and the harmful outcomes are influenced by the numbers of SIs per family. This has a confounding effect on any relationship that may exist between constructs and outcomes. To mitigate the confounding effects, the data were cast into presence/absence form or, in one case, converted into rates per SI. The Mantel is a test of the correlation between the difference measures calculated for each of the pairs of families – based on the 39 construct variables and the 16 child outcomes. Figure 6.1 below is a scatter plot of the differences between families based on presence or absence of need constructs against the differences between them based on the child outcome rates per SI. Table 6.4 shows the p-values for two of the more informative Mantel tests on the differences between the constructs and outcomes.

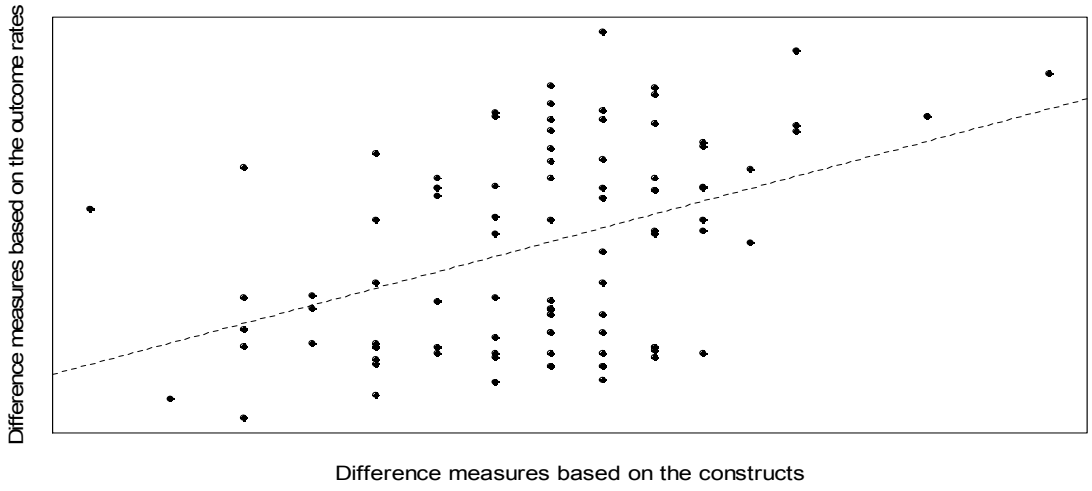


Figure 6.1. Scatter plot of inter-family difference measures based on outcome rates per SI against the presence/absence of need constructs

The test revealed significant p-values for both the presence/absence data (p=0.021) and the per-child data (0.015). It is therefore possible to conclude that there is a relationship between the need constructs and the negative outcomes identified as absent/present

within the subject group of infants, and to conclude even more confidently, that a relationship between the presence/absence data for the need constructs and the data for per-SI outcomes.

Table 6.4. Results of Mantel test of need constructs and child outcomes.

Data type for Need Constructs	Data type for outcomes	p-value
Presence/ absence	Presence/ absence	0.021
Presence/ absence	Rates per SI	0.015

Question 2. To address the question of whether there was any difference in the patterns of neglect identified within the families in Sub-sample one from those in Sub-sample 2, the frequency scores were converted to presence/absence data to mitigate the confounding effects. A non-parametric or 'distribution free' method of analysis of variance was applied, instead of the classic MANOVA tests which in this instance are not applicable.[48] The test results showed that the set of 39 need construct variables are generally different for the two groups of families, with the test showing a reasonable level of significance with a p-value of 0.0221. Although the presence/absence data on which the tests are based do not take into account the dimensions of frequency, and/or levels of severity or chronicity of the neglect experience, it does indicate that the pattern of neglect in the two groups of families is different. And although it was not possible to assess levels of difference in frequency, the findings described below indicate that there is evidence of both strong similarities and differences in the frequency measures.

Question 3. The difference between the incidence of negative outcomes for the Subject Infants in Sub-sample 1 (child death cases) and those in Sub-sample 2 (neglect cases) was tested using Fisher's exact test on a 2x2 table. The difference was found to be significant (p=0.011). The test was conducted to provide an *indication only* that the two groups are somehow different – it is important to acknowledge that it was not within the scope of this study to identify all the factors that may have contributed to the difference.

[48] The classical MANOVA tests were not applicable because the number of variables exceeds the number of cases and the data cannot be assumed to be normally distributed. A distribution-free or non-parametric analysis of variance gets around both of these problems.

(See Table 6.3 for a summary of the findings relating to the negative outcomes for the Subject Infants in each Sub-sample.)

Table 6.5. Presence/absence counts of the need constructs for sub-types/categories of neglect per family in each Sub-sample

Sub-sample 1	Presence/absence counts of constructs for neglect sub-types								
Family	Basic	Psych/ Phys.1	Psych/ Phys 2	Cog./ Lang.	Psycho -Soc.	Socio- Moral	General	Prenatal	Totals
	100	200	300	400	500	600	700	800	
Family 1	4	5	9	2	2	1	3	5	31
Family 2	1	5	7	2	1	0	3	4	23
Family 3	2	5	7	0	0	1	4	5	24
Family 4	6	5	9	1	1	1	3	2	28
Family 5	2	4	5	2	1	1	3	0	18
Family 6	6	5	8	3	1	1	3	5	32
Family 7	4	5	8	1	1	1	3	0	23
S/Total	25	34	53	11	7	6	22	21	179
Sub-sample 2									
Family 8	6	5	5	3	1	0	2	0	22
Family 9	5	5	7	3	2	1	4	4	31
Family10	6	5	8	3	2	1	2	0	27
Family11	5	5	11	2	1	1	3	3	31
Family12	5	5	7	3	2	1	5	3	30
Family13	6	5	7	3	1	1	4	3	30
Family14	5	5	9	3	1	1	4	3	31
	38	35	54	20	10	6	24	16	202

Table 6.6a. Aggregated frequency scores for the need constructs identified within the neglect sub-type groupings per family in each sub-sample

Frequency scores for neglect sub-type groupings per family

Family	No. Sibs	No. of SIs	No. of Not'ns	100s	201-2	203-4	301s	302-5	400s	500s	601	700s	800s	Total
Family1	1	2	11	10	6	19	13	15	3	7	8	15	14	110
Family 2	4	4	10	3	14	16	2	22	2	2	0	19	4	84
Family 3	2	2	13	6	12	8	5	16	0	0	4	15	17	83
Family 4	9	5	28	20	9	20	25	22	1	2	4	8	6	117
Family 5	1	1	6	3	6	10	8	5	3	3	1	5	0	44
Family 6	5	5	23	43	20	22	13	32	6	2	3	24	11	176
Family 7	4	2	5	6	5	13	6	8	1	1	3	5	0	48
Sub-total	26	21	96	91	72	108	72	120	16	17	23	91	52	662
Family 8	2	2	6	13	9	8	5	10	5	2	0	5	0	57
Family 9	1	1	20	24	27	26	10	25	22	12	6	25	4	181
Family 10	8	4	19	39	12	9	8	30	11	10	5	4	0	128
Family 11	3	3	18	10	10	29	14	18	4	1	6	11	8	111
Family 12	3	4	19	25	16	21	14	19	9	2	1	27	6	140
Family 13	1	2	22	27	19	29	10	24	11	4	6	26	9	165
Family 14	2	2	9	6	7	19	7	14	3	2	4	9	5	76
Sub-total	20	18	113	144	100	141	68	140	65	33	28	107	32	858
Total	46	39	209	235	172	249	140	260	81	50	51	198	84	1520

100. Provision: basic physical needs: food, medical care, clothing, hygiene, shelter

200. Provision of physical and psychological developmental needs:

201-2. Sensitive and responsive care

202-4. Secure and stable relationships, and residential stability

300. Protection from physical and psychological/emotional harm

301.1-2. Safety needs specific to newborn infants;

302.3-4. Safety needs for all < 4 yrs]

400. Provision: cognitive, language and motor developmental needs:

500. Provision: Socio-emotional developmental needs: Behaviour, self-regulation autonomy (self-care skill)

600. Provision and protection: Moral guidance / social inclusion and protection from conflict with the Law

700. Unspecified/general physical and psychological needs not met or 'at risk' of not being met – due to caregiver drug/alcohol dependence/ mental health problems; intellectual disability

800. Protection from harm: Pre- and peri-natal health, development and wellbeing

Table 6.6b. Proportional distribution of frequency scores for the need constructs identified within the neglect sub-type groupings per family

Frequency Proportions (%) for Neglect Sub-type Groupings per Family

Family	No. of SIs	No. of Notns	Basic needs 100s	Psych/ Phys 1 201-2	Psych/ Phys 1 203-4	Psych/. Phys.2 301s	Psych/ Phys.2 302-5	Cog./ Lang. 400s	Psych/ Social 500s	Socio-Moral 601	General 700s	Prenatal 800s	Total
Family 1	2	11	9	5	17	12	14	3	6	7	14	13	100
Family 2	4	10	4	17	19	2	26	2	2	0	23	5	100
Family 3	2	13	7	14	10	6	19	0	0	5	18	20	100
Family 4	5	28	17	8	17	21	19	1	2	3	7	5	100
Family 5	1	6	7	14	23	18	11	7	7	2	11	0	100
Family 6	5	23	24	11	13	7	18	3	1	2	14	6	100
Family 7	2	5	13	10	27	13	17	2	2	6	10	0	100
Family 8	2	6	23	16	14	9	18	9	4	0	9	0	100
Family 9	1	20	13	15	14	6	14	12	7	3	14	2	100
Family 10	4	19	30	9	7	6	23	9	8	4	3	0	100
Family 11	3	19	9	9	26	13	16	4	1	5	10	7	100
Family 12	4	18	18	11	15	10	13	6	1	1	20	4	100
Family 13	2	22	16	12	18	6	15	7	2	4	16	5	100
Family 14	2	9	8	9	25	9	18	4	3	5	12	7	100
All	39	209	15	11	16	9	17	5	3	3	13	6	100

Table 6.6c. Proportional distribution of scores for neglect sub-type categories across all families in the sample (percentages)

Proportion (%) of Neglect Sub-types across all Families

Family	No. of SIs	% of Total Ns	Basic needs 100s	Psych/ Phys 1 201-2	Psych/ Phys 1 203-4	Psych/. Phys.2 301s	Psych/ Phys.2 302-5	Cog./ Lang. 400s	Psych/ Social 500s	Socio-Moral 601	General 700s	Prenatal 800s
Family 1	2	5	4	3	8	9	6	4	14	16	8	17
Family 2	4	5	1	8	6	1	8	2	4	0	10	5
Family 3	2	6	3	7	3	4	6	0	0	8	8	20
Family 4	5	14	9	5	8	18	8	1	4	8	4	7
Family 5	1	3	1	3	4	6	2	4	6	2	3	0
Family 6	5	11	18	12	9	9	12	7	4	6	12	13
Family 7	2	2	3	3	5	4	3	1	2	6	3	0
Family 8	2	3	6	5	3	4	4	6	4	0	3	0
Family 9	1	9	10	16	10	7	10	27	24	12	13	5
Family 10	4	9	17	7	4	6	12	14	20	10	2	0
Family 11	3	9	4	6	12	10	7	5	2	12	6	10
Family 12	4	9	11	9	8	10	7	11	4	2	14	7
Family 13	2	10	11	11	12	7	9	14	8	12	13	11
Family 14	2	4	3	4	8	5	5	4	4	8	5	6
All Families	39	100	100	100	100	100	100	100	100	100	100	100

The neglect experience: Sub-types, severity and chronicity

Provision of basic physical care needs (100)

Provision of basic physical needs was included in its standard form as a sub-type mainly because neglect is commonly conceptualised in these terms by the general public and professionals alike. It was expected that the five basic needs would be found to be among the more commonly identified concerns; it was interesting to find that, for this age group, although the constructs were relatively commonly reported and/or identified – the third highest frequency score overall – they only made up 15% (AFS = 235) of the total frequency scores across all sub-types (Total AFS = 1520).

The SIs in Sub-sample 2 had a higher total aggregated frequency score (144) for each sub-sample (91, 144) and the presence counts for constructs of need (25 and 38) indicate that the Infants in Sub-sample 2 experienced a greater degree of severity and chronicity (144) across a wider range of constructs (38) for unmet physical care needs than the Infants in Sub-sample 1 (91 and 25 respectively). The frequency and proportional distribution of the scores for the complete range of sub-types and for each of the constructs of basic physical needs (100) are presented in Table 6.6a, Table 6.6b and Table 6.6c respectively.

'Unmet basic physical needs' 101. 'Unmet basic food/nutritional needs' (101) was coded when children were reportedly not being provided with adequate food to meet their nutritional needs – this sub-type does not include circumstances relating to special dietary or health care needs of infants (302.2, 302.4), nor does it include lack of responsiveness to infants cries of hunger (i.e. sensitive and responsive physical care – 202.2). In general, lack of food or adequate nutrition – and, similarly, lack of power for cooking, washing and heating – was repeatedly reported in terms of families having no money for food because 'the parents had spent it all on drugs'. Families were regularly reported to have exceeded their quota from non-government organisations and their relatives' willingness to continue to meet the shortfalls. Grandparents and other relatives appeared to provide a great deal of support to the younger group of caregivers, but they themselves were not generally in a position to continue providing assistance on a long-term basis, and because the children were usually suffering from other forms of neglect and or illness as well, they would report their concerns to the Department.

The larger families in particular were most likely to be reported for not being provided with adequate food. Although the largest family in the sample – who were also the only family not 'reported' for drug or alcohol misuse – were notified nine times in relation to problems to do with inadequate nutrition and provision of food, with reports from the school that the children are always hungry and there was no food in the cupboards, and six reports of children of all ages raiding the neighbours' rubbish bins and skips and eating whatever they found – two of the SIs in this family were diagnosed with nutritional deficiencies (as well as suffering substantial developmental delays).

The father of one of the young children in the family with the second-highest score repeatedly reported his concerns about the mother's ability to meet the toddler's basic needs, including food, in seven notifications over a period of 12 months. There was no further investigation of any of those reports. Eventually, the father managed to gain custody of the child through the courts, although ongoing contact with the mother resulted in ongoing notifications for this child.

The SIs in another family in the higher frequency range were reported by shelter workers as 'simply not being fed' when 'Mum is not doing well' – which appeared to be code for when she is misusing drugs and alcohol. Again there was a high degree of normalisation of drug misuse, in the discourse of support workers and child protection workers. The concerns were that the SIs coming to day-care with bottles of curdled milk, and children not being fed as a result of financial problems. Lack of food and financial problems were also notified by a supported housing worker from an NGO who reported that there was no food in the house despite the receipt of a fortnightly payment of $1600. The 4-weeks premature newborn infant with NASD in this family was reported to be primarily being fed 'cheap long-life milk' instead of formula, as well as breast milk which was exposing the infant to drugs such as speed, morphine and/or diazepam and alcohol. [In which case there are additional concerns regarding the lack of protection for this already vulnerable infant's health and wellbeing.(302.2)]

'Unmet basic physical needs' 102. 'Unmet medical care needs' (102) was the only construct in the 100 classification that was identified for every family in the sample, and it had the second highest frequency rate (f = 60). In the present study this construct refers only to the

provision of professional medical or allied health care. Regular engagement with Child and Family Health Centres was only considered to be a basic care need in situations where the health and wellbeing of the infant were considered to be at risk and had obviously been referred to Child Health Services for follow up. Among the most commonly reported issues for the SIs across all ages was the lack of follow-up for medical or health concerns which required ongoing treatment or monitoring. The other group of concerns relating more to newborn and younger infants included lack of developmental and health checks required for babies with special needs – such as those born prematurely, with low birth weight and/or suffering from NASD or other health or congenital problems – lack of engagement with the child health service in cases where an infant was deemed to be at risk as a result of concerns relating to previous children, and/or it is a condition upon which the mother is able to keep the baby in her care.

> *Example (Notification 3: 18.0 – no further action).* Child Health Nurse (CHN) reported that she had made several attempts to contact a mother living in a small rural township, after the mother had cancelled an appointment and failed to return her calls to arrange a visit. The visit was needed to check on the newborn infant who was "quite small and needed an eye kept on". The infant's grandmother had told the CHN that the mother had been quite sick and that they too were very worried about the baby – the grandmother was afraid to go and visit because of the dangerous dogs that the father breeds and which live in the house. When the CHN visited the home she was met at the gate by the father with a crossbow in his hands, which the caller thought he may simply have been cleaning, but who "was not very pleased to see the caller". The mother and father said it was not a good time as they were on their way out – the infant was sick with the flu and the mother was obviously quite ill and had been sick for some time. Meanwhile, the CHN reported that the father was behaving in an unusual and highly agitated fashion, swearing and taking clothes on and off – which, according to the mother, was because his methadone dosage had recently been changed. On further enquiry, the Drug and Alcohol GP informed the CPW that the father must have been taking other drugs to be behaving that way, and that the father had violent outbursts and poor impulse control, to the extent that he required a special management plan and that other services refused to deal with him. The grandmother later requested that the caller (CHN) contact the police, but the caller did not want to damage the rapport that had been established with the mother. The father was later arrested on being found naked wielding a knife in the local rural township – the notifier reported the grandmother's concerns that the mother had been drinking a lot lately, which was also confirmed by mum's GP. In a follow-up call from the notifier (CHN), she said she had spoken with the mother on two occasions since then, stating that "mum presented cagey and difficult to obtain information from. Caller suspects this may be alcohol related." The caller agreed that Child Health would keep monitoring the situation. [This notification was classified as 'physical/emotional abuse – presumably of the CHN]

Many of the families with newborn babies appeared to engage with the CHN, often by phone, in the very early weeks after the birth, and then contacts were either non-existent or only at the instigation of the CHN after that. Concerned grandmothers were often able to take the SIs for health checks when they were left in their care, and commonly reported their concerns to

the Department and to the CHN who referred those concerns on. Interestingly, there were a number of mothers who stated a preference for seeing their GP in relation to infant health concerns rather than the child health nurse – possibly because of past experience and/or that of their friends – of being more likely to be reported to the department by the CHN than the GP, or it was possibly not true that they were seeing their GP. Yet, as the example above highlights, the CHNs also often found themselves in the difficult position of being forced to choose between maintaining trust and rapport with the mother and reporting their concerns about the health and wellbeing of the infant to the police as well as to child protection.

The medical and health care needs identified in relation to the SIs in the older age group included speech problems, assessment of cognitive and behavioural developmental problems, and/or mental health concerns, and dental disease. Dental health concerns in this age group were suspected to be under-reported, with reports of dental care not being provided for one child only among the group. The field of infant mental health is a new and expanding area of child development and psychiatry which is highly relevant to this group of infants; yet despite reported concerns of anxiety, and behavioural and attachment problems, there were no reports from professionals in the field of the unmet need for this treatment of failure to provide medical or health care for problems of this type. On the other hand, the mental health and wellbeing of the parents was a frequently reported and much discussed problem.

A number of infants and young children had chronic illnesses or congenital problems that could become life threatening or cause permanent harm if left unmonitored and/or untreated – ranging from asthma to Phenylketonuria (PKU) through to congenital heart defects – which were not receiving the specialist treatment and monitoring that was needed. Only one of the referent children who had fatal or life-threatening injuries or illness had received appropriate medical care in a timely fashion. Two children suffering from severe malnutrition and another toddler who was malnourished and had a broken leg, for instance, only received medical help as a result of eventually being allowed a visit with one of the grandparents. In all of the foregoing, the provision of unmet medical care (102) was inter-related with the lack of protection from harm to health and wellbeing (302.2 and 302.4). Reports that related simply to provision of medical or allied health care were classified within the 100 category, while more complex cases involving lack of protection from harm to the children's health or lack of safety for their physical wellbeing were included in the 300 sub-type.

'Unmet basic physical needs' 103. The issue of inappropriate clothing (103) has higher relevance in Tasmania than it does in many regions of Australia because of the colder climate, although this particular unmet need was one of the two least identified, with a frequency score of 27. The reports were highest again for the two larger sized families, Families 6 and 10 – the children of all ages in Family 10 were constantly being reported for being sent outside in the cold during the day and at night, sometimes until midnight, inadequately clothed and often naked, and not allowed inside in spite of their cries to be allowed in (see child protection histories in Appendix E for the level of response to the reports for this family over a number of years; see also the developmental outcomes above). The SI in Family 9, also, was reported to be suffering from illness and cold, and wearing only a singlet in the middle of winter in a household unable to pay the power bills to provide heating for the home.

'Unmet basic physical needs' 104. Hygiene (104) was divided into two different constructs, personal hygiene and environmental hygiene. Personal hygiene (104.1) was reported as a concern in 9 families, with the highest frequency scores (9, 8) being for the same two families who had the highest frequency for unmet food/dietary needs. Lack of hygiene was more commonly reported and identified for families in Sub-sample 2 (6 families; AFS= 26) than those in Sub-sample 1 (3 families; AFS=11). As expected, there was some overlap between meeting babies' personal hygiene needs and responding to their physical needs (202) and protecting their physical/health wellbeing (302). Unmet personal hygiene needs (104.1) were coded when it was a straightforward report that children were dirty or unwashed or that babies and toddlers' nappies were not regularly changed, whereas reports of infants being left lying in urine-soaked or dirty nappies and/or beds for extended periods, were regarded as a lack of responsive physical care (202), and cases involving lack of hygiene and care of health problems such as fungal infections, head lice, burns and injuries was classified as unmet health care needs (protection from harm to infants' health 302.2 and 302.4).

As with personal hygiene, lack of environmental hygiene was coded in straightforward cases reporting dirty unkempt homes. The more extreme cases of lack of hygiene which posed a direct risk to the health of infants were coded as unmet protection or needs (Category 302). Environmental hygiene (104.2) and appropriate clothing (103) were the two least commonly identified of the basic physical needs for both sub-samples (AFS=27), although lack of hygiene in the home was experienced in eleven of the 14 families. Concerns about personal

hygiene and appropriate clothing were the least reported concern across both sub-samples (AFS=27).

Again, the issue of inadequate housing was most commonly reported for 2 of the larger families, this time Families 4 and 6 – as well as for the single SI in Family 13 – who both had inadequate housing which resulted in unhealthy if not dangerous sleeping arrangements. In Family 4, for instance, six or seven children shared a single bedroom, top-and-tailing on mattresses on the floor, with some of the younger SIs sharing the mother's bed. The lack of adequate housing and homeless ness were major issues for the majority of families in both sub-samples.

Provision of Psycho-emotional and Physical needs (Sub-type 200)

The five need constructs for the provision of 'psycho-emotional and physical needs' were based on the fundamental developmental need in infancy and early childhood for secure and stable primary attachment and family relationships, which in turn have been shown to be dependent on the provision of sensitive and responsive emotional care (201), sensitive and responsive physical care (202), caregiver security and stability (203), and family and residential stability (204.1-2). The needs in this category of neglect were deemed to be fundamental to the development, health and wellbeing of all infants.

Unmet psycho-emotional and physical needs made up 27% (FS=421) of the total AFS across the eight sub-type groupings, which does not bode well for this group of children – and that is reflected in the number of children whose physical and psychological development and wellbeing were affected. All of the constructs of unmet need were identified more than once in every family across the Sample, except in the case of 'caregiver stability' (203) which was not identified for the SI in Family 5. In other words, there was very little difference between the two sub-samples in terms of the range of need constructs experienced by the SI (total presence/ absence score; P/AS = 34, 35) for this particular sub-type. Frequency scores and proportional distributions for each family in the overall sample are presented in Tables 6.7a and 6.7b.

The following notification identifies several constructs of need within the current neglect sub-type (provision of sensitivity, responsiveness and stability) and across the wider range of sub-

types of neglect – such as lack of sensitive and responsive emotional and physical care (emotional unavailability, inability to prioritise the needs of the child), lack of stimulation, unmet supervisory needs, and residential instability:

Example: Infant 10 months old (Notification 19):

> The notifier reported that the MOC and baby arrived at the shelter [3 months ago] owing to homelessness. MOC was apparently evicted from her home and then temporarily assisted by [NGO] before coming to the shelter.
>
> The notifier reported that the Women's Shelter evicted MOC yesterday due to her ongoing abusive behaviour to staff and other residents. The notifier is currently concerned about the welfare and safety of the 10 month old.
>
> The notifier reported that MOC slammed doors and yelled abusively at staff (e.g. You don't fu##in help me!) with the baby in her arms.
>
> The notifier reported that she [MOC] would not attend appointments arranged for her and wanted to sleep all day.
>
> The notifier reported MOC was yelling at C1 'all the time', e.g., "stop crying" "shut up you fu##in …… I'm tired"
>
> The notifier reported that MOC disclosed she was still on Drugs (pot) which is why she is so moody.
>
> The notifier reported that MOC tries to get C1 to sleep as much as she does and as a result he is being fed inappropriately and lacks any routine and stimulation. MOC relayed an occasion when she had gone out on the drink and slept between 4.00pm and 5.00 am and had the "best sleep". When the notifier asked her about C1 she merely stated "Oh he's all right".
>
> The notifer reported that C1 does not appear to be meeting his developmental milestones and notes a distinct lack of baby babble and is not sitting up on his own or crawling.
>
> The notifier is concerned that MOC uses "sunshine" milk powder rather than proper baby milk with beneficial nutrients.
>
> The notifier reported that the staff felt intimidated by MOC.
>
> The notifier was unable to identify any parenting strengths.
>
> The notifier reported that MOC stated she was going to live in her car. The notifier does not have the registration number of the car.

Table 6.7a. Frequency scores and proportional frequencies for constructs of basic physical care needs per family in the Negative Outcome Sample

Frequency scores for constructs of basic care needs

Family	Co-res. Chldrn	Total Notfns	101	102	103	104.1	104.2	105	Total
Family1	1	11	2	4	0	0	1	3	10
Family2	4	10	0	3	0	0	0	0	3
Family3	2	13	0	5	0	0	0	1	6
Family 4	9	28	7	3	1	2	2	5	20
Family 5	1	6	0	1	0	0	0	2	3
Family 6	5	23	8	9	7	8	4	7	43
Family 7	4	5	0	2	0	1	1	2	6
	26		17	27	8	11	8	20	
Family 8	2	6	4	4	1	2	1	1	13
Family 9	1	20	6	7	3	5	3	0	24
Family 10	8	19	10	2	10	9	5	3	39
Family 11	3	18	1	5	1	0	1	2	10
Family 12	3	19	3	10	0	4	6	2	25
Family 13	1	22	9	3	3	5	2	5	27
Family 14	2	9	0	2	1	1	1	1	6
	20		33	33	19	26	19	14	
Total	46	209	50	60	27	37	27	34	235

Proportional distribution (%) of need constructs

Family	Co-res. Chldrn	Total Notfns	101	102	103	104.1	104.2	105	Total
Family1	1	11	20	40	0	0	10	30	100
Family2	4	10	0	100	0	0	0	0	100
Family3	2	13	0	83	0	0	0	17	100
Family 4	9	28	35	15	5	10	10	25	100
Family 5	1	6	0	33	0	0	0	67	100
Family 6	5	23	19	21	16	19	9	16	100
Family 7	4	5	0	33	0	17	17	33	100
Family 8	2	6	31	31	8	15	8	8	100
Family 9	1	20	25	29	13	21	13	0	100
Family 10	8	19	26	5	26	23	13	8	100
Family 11	3	18	10	50	10	0	10	20	100
Family 12	3	19	12	40	0	16	24	8	100
Family 13	1	22	33	11	11	19	7	19	100
Family 14	2	9	0	33	17	17	17	17	100
Total	46	209	21	26	11	16	11	14	100

Table 6.7b. Frequency scores for unmet constructs of need – sensitivity and responsiveness (201-2) and stability and security (203-5) – within the sub-type of 'provision of psycho-emotional and physical needs'

	Frequency scores for unmet need constructs							
Family	Cores. Chldrn	Reports (03–09)	201	202	203	204.1	204.2	Total score
Family 1	1	11	3	3	4	9	6	25
Family 2	4	10	7	7	5	4	7	30
Family 3	2	13	5	7	3	1	4	20
Family 4	9	28	3	6	4	14	2	29
Family 5	1	6	4	2	0	3	7	16
Family 6	5	23	10	10	2	11	9	42
Family 7	4	5	3	2	3	6	4	18
Sub-total	26	96	35	37	21	48	39	180
Family 8	2	6	5	4	2	4	2	17
Family 9	1	20	16	11	9	8	9	53
Family 10	8	19	4	8	2	5	2	21
Family 11	3	18	4	6	7	10	12	39
Family 12	3	19	9	7	3	11	7	37
Family 13	1	22	10	9	7	8	14	48
Family 14	2	9	4	3	7	4	8	26
Sub-total	20	113	52	48	37	50	54	241
Total	46	209	87	85	58	98	93	421

Table 6.8. Proportional distribution of unmet constructs of need – sensitivity and responsiveness (201-2) and stability and security (203-5) – within the sub-type of 'provision of psycho-emotional and physical needs'

Proportions (%) of need constructs per family

Family	Reports (2003–09)	201	202	203	204.1	204.2	Total
Family 1	11	12	12	16	36	24	100
Family 2	10	23	23	17	13	23	100
Family 3	13	25	35	15	5	20	100
Family 4	28	10	21	14	48	7	100
Family 5	6	25	13	0	19	44	100
Family 6	23	24	24	5	26	21	100
Family 7	5	17	11	17	33	22	100
Family 8	6	29	24	12	24	12	100
Family 9	20	30	21	17	15	17	100
Family 10	19	19	38	10	24	10	100
Family 11	18	10	15	18	26	31	100
Family 12	19	24	19	8	30	19	100
Family 13	22	21	19	15	17	29	100
Family 14	9	15	12	27	15	31	100
Total	209	21	20	14	23	22	100

'Psycho-emotional and physical needs' 201, 202. The SI in Family 9 had the highest individual frequency scores (16, 11) for the constructs of sensitive and responsive emotional and physical care (201, 202), which again is sadly reflected in the reports of attachment disorder and other developmental, emotional and psychological problems that this little boy is undergoing assessment for. The following is an extract from two notifications 18 months apart which exemplifies the type of concerns, and unmet needs, reported for this child, and the child protection response to the those concerns:

Example: (Notification 17b) Concerns:

> Caller is concerned about neglect and well being of child.
> Child is allegedly lethargic, does not eat, parents do not pick child off floor.

Poor hygiene, dirty house and child. Not always food in the house.

Child allegedly has 'school sores' – like chickenpox – infectious – picked up from other children at school [pre-school].

Concerns regarding parents alleged drug use (amphetamines) and alcohol (3rd hand information) – known to Police.

Caller has nothing to do with parents; third hand information from children's paternal uncle.

Example: (Notification 14, 18 months later) (17b) Current Concerns:

Child's mother is currently in prison and soon to be released.

Current carer does not have legal right to keep the child in her care when mother is released.

4 year old child appears to have little social skills and is very aggressive and angry. So much so that 3X staff have difficulty handling him – child – throws blocks around and a danger to other children.

Notifier does not think grandmother is able to cope with his behaviour

Notifier has heard 2nd hand but reliable sources that grandmother has alcohol issues.

Subject child appears to have major trust issues, fear of abandonment, perhaps deficient in attention and cannot focus on any activity for more than one minute. Child's way of interacting with other children is to destroy their activity. Carers felt he was dangerous for other children to be near.

Notifier unsure as to carer's motives for wanting to access family support via [NGO].

Psycho-emotional developmental issues were rarely conceptualised in terms of harmful outcomes and rarely acknowledged to be child-protection concerns. Response to cases of chronic neglect of SIs most fundamental care needs usually resulted in some form of support for the mother; intervention and treatment for the child were provided when they were physically or sexually harmed, and later when they were considered to have been emotionally harmed (usually considered to be due to exposure to family violence). Intervention for chronic neglect issues were usually precipitated by a SI sibling's death or suspicious injury.

Emotional unavailability and lack of sensitive and responsive care, in 13 out of 14 cases, went hand-in-hand with mis-use of both legal and illegal drugs, which was often combined with alcohol misuse and accompanied by mental health issues and/or underlying psychological problems. The unexpected loss of an infant for the three caregivers who were already suffering from a range of mental health and family problems was accompanied by substantial increase in the primary caregiver's level of drug and/or alcohol use, which led to even greater emotional unavailability and inability to meet the care and protection needs of the other children. There were increased reports of children being uncared for, unfed and unsupervised – a young toddler in one family was hit by a bus while playing out on the road – with the older children's behavioural problems increasing and the younger children displaying signs of anxiety and distress. The physical abuse of two SIs in one family during this period led to the

removal of the children from the mother's care. This family had one of the frequency scores for the need constructs of sensitive and responsive care, with the reported outcomes for the four surviving SIs including an attachment disorder for Child 1, and suspected attachment problems for Child 4, developmental delay for Child 2, and numerous accidental and non-accidental injuries for all four children.

'Psycho-emotional and physical needs' 203. Transitions Index scores for lack of caregiver stability (203) were established by counting the number of separations from the primary caregiver which exceeded 1 week. However it was apparent that some newborn and very young infants were being left in the care of a wide range of people on a daily basis and often at weekends on a weekly basis. Information about whose care the infant had been in and for how long was usually unavailable. Consequently the transitions index (TI-CS = 58) relating to caregiver stability did not accurately reflect the apparent lack of caregiver stability. The SI in Family 9 again had the highest Transitions Index, with nine (9) known caregiver changes during the notification period – the mother had to serve at least two prison sentences, the child was abandoned at one point and taken into care, he was in respite care on at least two occasions, and placed in the care of his grandmother and his father on several occasions for extensive periods of time.

'Psycho-emotional and physical needs' 204. Transitions Index scores were also established for family and residential stability (204.1-2) which had the highest scores (98 and 93 respectively) within the 200 sub-type. The number of family changes the SIs experienced ranged from a minimum of 1 for the SI in Family 3, to a maximum of 14 changes for Family 4. The number of changes and disruptions for Family 4 was due to a combination of complex factors resulting in a continuous cycle of domestic violence and chaos, financial difficulties from drug misuse, inability to cope with the eldest child's violent and uncontrollable behaviour, broken anti-violence Restraining Order(s), with the father regularly returning home at the mother's request, and short-term stays in women's shelters, and a new baby every year.

As with the caregiver transitions, it was difficult to establish the actual number of residential changes that occurred for this highly transient population, particularly when current addresses were not always known and the last known address was generally used.. The first notification for the SI in Family 5, for instance, reported that the 2½-year-old toddler and his mother had

moved 12 times in the previous 5 months (which figure was not counted because it was outside the notification period). The scores do provide a good indication, nonetheless, of the highly transient and unstable lifestyle of the majority of the families in both sub-samples, with the least number of reported or identified changes (2) for the three more stable, larger families with older children, and between 4 and 14 known changes for the remaining 11 families. Given the unreliable nature of the information provided and/or recorded – which was very much dependent on the number and regularity of the notifications – this would be a minimum number of changes that occurred. The mean residential transition index across the subject family group (SFG) of 6.64 (SD=3.67). The family with the highest transitions index for residential stability was Family 13.

Lack of physical care of infants and toddlers was usually considered strictly in terms of physical neglect and risk of physical harm rather than being understood in relation to its psychological impact on the SIs in the sample. Even reports of drug use during the early part of the period elicited concerns about needle-stick injuries for young children rather than the more potentially harmful lack of sensitive and responsive care. One of the young children who was hospitalised with 'severe malnutrition' and diagnosed with Failure to Thrive, and suspected attachment problems, was reported some years later by the treating psychologist to have been suffering from Post-traumatic Stress Disorder as a result of exposure to domestic violence at that time. Which is not to deny or minimise the harmful effects of exposure to domestic violence, but, rather, to highlight the lack of acknowledgement or understanding of infants' basic need for emotionally engaged, sensitive and responsive care.

The relationships between lack of sensitive and responsive physical and emotional care was apparent in circumstances involving newborn infants and young children having to be hospitalised, and parents extremely reluctant to remain with the childrenwith the mother of one infant stating that she would not be returning until the following afternoon because she needed to sleep in the next morning, and another mother who was refusing to stay with the children overnight having to be 'strongly advised' to stay by a child protection worker. The provision of sensitive and responsive care and stability and security, together with following sub-type of protection from physical and psychological harm illuminates the way in which neglect can be seen to exist as an underlying concern for all forms of maltreatment.

Protection from Physical and Psychological Harm (300)

This category was divided into constructs relating to the protection needs of infants in this age group, in order to ensure their physical and psycho-emotional health, safety and wellbeing. The first group (301.1-3) includes protection from the three different types of abuse (physical, emotional and sexual) and/or physical or emotional harm – which were coded only in those circumstances where such exposure was preventable. The second set of constructs (302.1-5) include the protection and safety needs that are specific to infants and toddlers; the first two constructs, protection from physical or environmental harm (302.1) and protection from harm to health and wellbeing (302.2) refer to the specific safety and health needs of newborns and infants and who are less than 12 months old; and the second set, protection from harm in the home environment (302.3); protection of health and wellbeing (302.4); and protection from harm / ensure safety outside the home (302.5) refers to the specific safety needs of all infants less than 48 months old. The latter constructs arose out of an in-depth analysis of the circumstances surrounding the deaths and occurrences of harm to the Subject Infants in the study.

Constructs relating to lack of supervision (303-04) are in line with the traditional concept of supervisory requirements of infants/toddlers in this age group, and the need for safety in the care of an alternative primary caregiver (305) refers to circumstances in which a child is at risk if left in the care of an unsuitable alternative primary caregiver (e.g., if the infant is left in the care of a parent/grandparent who is known to be violent or incapable of meeting their safety needs). This was the second highest scoring sub-type for the families in both sub-samples, and only slightly less than the previous sub-type (200), with an overall frequency score of 400. The presence counts for the identified constructs of need show little difference between the two sub-samples. (Detailed summaries of the individual constructs are summarised in Table 5.5 in Chapter 5, as well as in the content analysis instrument in Appendix E). The aggregated frequency scores for 'protection from physical and psychological harm' (300) are summarised in Table 6.9 below.

Protection from abuse and harm (301.1-3). The first three need constructs (301.1-3) are very much about the need for protection from both the physical and psychological effects of violence and abuse. One of the most disturbing aspects of the present findings relating to suspicious or non-accidental injuries for children in both sub-samples was the fact that the

children were knowingly and continually exposed to the risk of *further* abuse at the hands of a partner or partners, and that the caregivers were unwilling or unable to prioritise their children's needs over their own and, even more sadly, their partners' needs. The SIs in ten out of the 14 families were exposed to or unprotected from harm on at least one occasion. Interestingly, the data shows a marked difference in the frequencies of exposure to physical harm (301.1) and exposure to psychological harm (301.2), which indicates that either exposure to domestic violence did not necessarily expose the SIs to risk of physical harm or that DV incident reports were unable to provide information about whether or not the children were at risk of physical harm because the facts were either not known or were concealed due to awareness of the seriousness with which DV incidents were viewed at this time.

Family 4 had the highest frequency score for exposure to both physical and emotional abuse and or harm – the main source of which was the father who was continually being found back in the home when the mother was unable to cope on her own, either financially or with the uncontrollable behaviour of the not so very old older sibling. Exposure to the violent and aggressive behaviour of the older children in the same family was classified as exposure to harm in the environment, rather than as an unmet need for protection from physical harm.

The SIs in Family 1 and 11, including one highly vulnerable premature infant at the time, were exposed to physical and emotional harm and accidental injury as a result of exposure to violence and involvement with criminal activity within the community and/or in the extended family. SIs in both families were subjected to threats to kill and/or harm – which in one instance involved a threat with a knife, and exposure to the mother's ongoing violent attacks on the father, and in another incident, involved an attack on the home where the family was residing. The SIs in Family 12, also including a very young infant, were similarly exposed to incidents involving dangerous weapons, and violent outbursts, with two of the SIs reported to be physically abused by the mother's partner, with the mother reported to be unable to provide adequate protection for these children. (Section 900, below, provides further details about the incidence of abuse in relation to neglect.)

Protection from psycho-emotional harm or abuse (301.2). The SI Family groups had the highest frequency score (FS =100) for the construct of lack of protection from psycho-emotional harm or abuse (301.2). Given that the police are mandated to report all family violence incidents or domestic disputes to which a child has been exposed – and the

increasing notification rate for family violence (usually classified in Australia as emotional abuse) – the high frequency score for this construct is not surprising. The score provides a fairly accurate indication of the incidence of exposure to family violence, although lack of protection from all forms of emotional harm or abuse was included. The SIs in one family, for instance, were exposed to a number of suicide attempts by their mother (and quite possibly the successful suicide of their father).

The SI siblings of four of the infants who died unexpectedly, including those just referred to, were all witness to the deaths of their infant siblings. The older SIs were also reported to have been exposed to some highly disturbing and erratic behaviour, including overdoses, by caregivers, partners and other adults abusing adult drug use which resulted in drug dealing and parents under the influence of various substances. Of the three cases in which abuse of a sexual nature was thought to have occurred, one child was not protected from further exposure to the suspected perpetrator, and although the facts of the other two cases are unclear, serious drug and alcohol problems were believed to have been a contributing factor (see Section 900 below).

Protection from harm – safety and health (302.1-5). The second grouping of need constructs within this sub-type relates to the specific protection needs of infants and toddlers which ensure their safety, health and wellbeing. The need constructs relating to the protection from harm (PFH) to health and wellbeing of infants in both age groups (302.2 and 302.4) had higher frequencies overall (AFS=55, 62) than the two 'protection from environmental harm / physical safety' (302.1 and 302.3) for both age groups (AFS=29, 37). The two sub-samples were found to have similar presence-absence scores for this set of need constructs, although sub-Sample 1 was unusually very slightly higher with a count of 24 constructs identified, against the 22 constructs identified for Sub-sample 2.

Unmet environmental protection needs were reported for 4 families in Sub-sample 1 and five families in Sub-sample 2; however the frequency scores – and/or severity and chronicity levels – were greater for the families in Sub-sample 1 (AFS=17) than the Sub-sample 2 families (12). The main types of unmet environmental protection and safety needs identified for newborn and younger infants whose deaths were unexplained or unexpected involved unsafe sleeping practices and unsafe bedding when the caregiver was under the influence of drugs, including prescribed drugs, and/or alcohol. Unsafe sleeping practices included

newborns sleeping with the mother (and other young children); and unsafe sleeping arrangements and bedding, including makeshift bedding made up of cushions and soft pillows, which the infant can get lodged between and suffocate, and/or doonas under which the infant can overheat and also suffocate. Adults sleeping with their babies while heavily drug-affected or intoxicated run the risk of inadvertently rolling onto and suffocating or crushing them, or inadvertently pushing them out of the bed onto the floor. There were two families with the highest frequency score (AFS=7) for unmet protection and environmental safety needs, including one family in Sub-sample 1 in which an infant had died suddenly and unexpectedly and a family in Sub-sample 2 in which the referent infant suffered developmental and attachment problems and severe non-accidental injuries.

A primary concern with regard to unmet environmental safety needs for newborns and young infants included being cared for by caregivers who are heavily drug-affected (or under the influence of alcohol) and likely to fall asleep or into an unconscious state with the baby in their arms. A newborn infant in one family, who later died unexpectedly, had been discovered by nursing staff lying on the floor and suffering from hypothermia, having fallen onto the floor for the second time while being fed by the mother, who was so heavily sedated by medically prescribed (and perhaps un-prescribed) drugs that she kept losing consciousness. The same infant was reported for ongoing concerns about unsafe sleeping arrangements, which the mother had been warned about – on one occasion the grandmother had heard the infant's continuing crying and had found him in bed with the mother asleep beside him, with an electric blanket on and his head partly covered by bedclothes, in extreme distress and overheated. A newborn infant in another family was found by that grandmother wedged between the mother and the sofa cushions, and with the mother unconscious, and again, on a subsequent occasion, with the baby falling off her lap.

Unmet needs identified for young infants from both sub-samples included several reports of lack of suitable bedding, and unsafe sleeping and bedding arrangements (as above), unsafe feeding arrangements (for example in bed when drug- or alcohol-affected – regarding which there was a great deal of reluctance to heed advice); lack of protection from environmental hazards such as heaters, dangerous dogs, drugs and alcohol. Homelessness was also identified for one premature newborn infant – who was reported to be underweight and unwell with chronic upper respiratory tract infections – whose family were reportedly residing in a holiday shack with no proper bedding, and no power, telephone or running water. Extremely

unhygienic homes were sometimes considered hazardous for infants, including one report of sheltered accommodation being left in the worst condition ever experienced by the support worker – who described the floor being covered with items such as cigarette butts, condoms and mouldy food – and generally so filthy as to require industrial cleaning. A ten-month-old baby was reported by the GP and the day-carer worker to have suffered a serious gash-like burn to the head, having rolled off a makeshift bed on the floor onto a heater during the night, which the mother reportedly did not know about or respond to until the following morning.

While some of the constructs of need, such as safe sleeping arrangements, were applicable to infants and toddlers across the age range, the infants under 12 months were considered to be more vulnerable and at greater potential risk of SIDS. The concerns reported in relation to the older group were more to do with general safety issues. Several infants and toddlers suffered burns and injuries from lack of attention to the children's general health and safety. The older sibling of the infant who rolled onto a heater was sleeping on bedding on the floor The subject children in this group were also reported to be sleeping on wet, mouldy and mice infested bedding, or being exposed to dangerous dogs, such as Pit-bull terriers and Rottweilers that being bred and living inside one house. Toddlers and infants were residing in homes that were so heavily cluttered, unhygienic and chaotic that they were dangerous. The home of a family with four SIs, including two babies, was described by police on two separate occasions as follows:

> *Example. Notification 15.* The house was exceptionally filthy and uncared for and smelt strongly of animal urine. The back yard is crammed full of rusty old cars, car parts, rubbish and junk. The condition of the house is simply appalling and the house and the yard are both health hazards and very unsafe environment for a young child.
>
> The occupants use two large kitchen knives to secure the back door and both displayed a high level of paranoia by stating they often carry knives with them inside the house for self defence (in case there is a break in)and even sleep with a knife close by. Both occupants were polite and cooperative with police but there appeared to be no discernable reason for the occupants to act this way.

> *Notification 17.*... Police were aware that there were a number of young children present at the residence including two babies. The dwelling was unsuitable for human habitation described by the following: Rotting carpet on the floor, significant dirt on the floor. The lino in the kitchen had been ripped up in several places and there was significant dirt and filth build up on the kitchen floor and benches. No evidence of food in the kitchen cupboards or the fridge. No evidence of recent food consumption in the residence apart from a fryer with rancid fat in it. Food remains on the floor with evidence of mould. Animal waste on the floor in bedrooms. Mattresses that were filthy and wet. Toilet was filthy and containing faeces and there were a number of dirty nappies laying nearby. The children were poorly dressed for the time of year and filthy. The baby that was present was filthy and underweight. He had an obviously dirty nappy on that looked dirty enough not to have

been changed for many hours. In the reporting officers opinion it is one of the most filthy houses been entered and searched in many years.

The SIs in a number of families were reported to be exposed to parents' drugs, drug paraphernalia and dirty needles – one toddler was reported to be seen walking round with an uncapped needle used belonging to one of the mothers who had been infected with Hepatitis C. One toddler died as a result of a methadone overdose in circumstances that remain unknown due to conflicting versions of the events at the time. There were reports of exposure to knives, guns and other weapons, with one young child exposed to a hand grenade which the caregiver knew was kept in the partner's car.

The total frequency score for 'protection from harm to health and wellbeing' for both newborns and all SIs (302.2, 302.4) were lower for the SI families in Sub-sample 1 (AFS=23, 27) than for families in Sub-sample 2 (AFS 32, 35). The presence/absence scores for constructs in both sub-samples were similar with one more construct identified for the families in Sub-sample 1. The aggregated frequency score does indicate a relatively high level of severity and chronicity for this set of need constructs, as it does for this sub-type as a whole. Families 6, 12 and 13 had the highest frequency of unmet need for newborns and Families 9, 10 and 6 (again) had the highest level of severity for all SIs.

One of the most common concerns reported in relation to protecting the health and wellbeing of newborns is of babies being exposed to a range of drugs which are known to pose risks to the infant, or the safety of which is yet to be established. the safety of which has not been established drugs such as methadone and alcohol and/or prescribed medications which are less than suitable, such as Prozac, or in the following case, Citalopram, an SSRI anti-depressant medication not recommended during the last trimester of pregnancy or while breastfeeding, and a high dosage of diazepam which was suspected to have been mis-used.

Example. This newborn infant was exposed to anti-depressant and anti-anxiety medications which carry risk of withdrawal symptoms, at the very least, and are transmitted through breast milk. At the time of the baby's birth the infant was being subjected to an already very high dose of diazepam (30 mg per day; average dose is 15–20 mg) – which is not recommended for breastfeeding – and which according to the treating doctor the mother was increasing by 'doctor shopping'. The mother refused to lower the dose as advised by the treating doctors – on the grounds that it was placing the baby at risk – and requested more medication for pain, for which she was given Oxycodone

(Oxycodone Hypochloride), an opioid-based analgesic. The maternal grandmother reported that when the mother came home she was using 'uppers and downers' as well .[49]

There were a number of cases in which it was reported that both infants and toddlers – including the siblings of the infant in the scenario above, and the baby referred to earlier in the extract of the notification for Family 13 above – were being given medication or drugs, including methadone, to keep them asleep or sedated and/or to calm their behaviour. There were two instances of family relatives reporting that they have observed or been told by the mother that babies are given methadone in their bottle as a sedative or to 'keep them calm'. The family in which an unexplained death occurred was among those with the highest frequency scores for these two types of unmet need.

The following summaries of notifications were for an infant who had to be taken into care some six months later when he was not provided with timely and appropriate medical care for non-accidental injuries including cigarette burns and a broken a leg.

N17 (18.0 'no further action'). Notifier suspects that M puts drugs / panadol in SI's milk to make him sleep; SI never cries and sleeps all the time, day and night. M is a drug user and sleeps day and night; CHN is also concerned about the number of young men visiting the house smoking (including cones) near infant and drinking ...

N18. Infant aged eight months – described as being "about 2 months of age" – exposed to M and lots of other men in the house all smoking near him (including 'cones'); the house was recently raided by police who found ecstasy tablets in the house, with needles in the bathroom which infant could get hold of "when he learns to crawl"– SI (8 mos) just sleeps "most of the time" – "they give him this horrible milk stuff". Notifier has "never seen a baby so skinny". M never takes infant outside for fresh air ...

N19. SI has inappropriate eating sleeping routine; because he is made to sleep all the time he is not being adequately fed. M uses cheaper milk powder instead of formula; ongoing lack of engagement with CHN; C1 exposed to M's marijuana use/smoke ... the baby is 11 mos old and is not babbling or crawling

The last notification was sent for further assessment of the mother and child's homelessness and the infant's developmental status; however there was no follow-up for the concerns

[49] There is evidence of concern among mid-wives and medical practitioners about the ready availability of this drug for mothers, who are routinely offered it after Caesarean section and forceps deliveries despite manufacturer's advice that "because of the possibility of adverse effects in breastfed infants (sedation, respiratory depression, withdrawal symptoms upon cessation of maternal administration), oxycodone is not recommended for breastfeeding mothers unless the expected benefits outweigh the potential risk"; furthermore, "it should be used only with caution and in reduced dosage during concomitant administration of other narcotic analgesics" (brochure down http://www.aspenpharma.com.au/product_info/pi/PI_Endone.pdf

relating to inappropriate administration of drugs in the first notification "due to lack of notifier credibility – a 'male neighbour' – and lack of evidence to substantiate the concerns. The second notification was still being investigated almost nine months later when the infant had already been taken into Departmental care as a result of the nature of and lack of medical care for his physical injuries.

There was some normalisation of drug dependent babies being breastfed as a means of weaning them off the drug and/or to keep them sedated, which carries the danger of making mothers think it is acceptable for infants to be given drugs like methadone in bottles to keep them sedated. There was little acknowledgement of the fact that Methadone can have a negative impact on infant development and it prolongs the period of dependence and withdrawal. Some of the infants were also regularly fed breast milk which was likely to have high concentrations of alcohol, also harmful to the health and development of the infant.

Exposure to cigarette and marijuana smoke inside the home and in the bedroom is another commonly reported health risk for all young children – also mentioned in the Coroner's report into the SIDS deaths of three infants (discussed earlier). It is of even greater concern for the more vulnerable infants who were born prematurely or unwell and who are highly susceptible to infection and breathing problems. In cases where the health of an infant has been harmed, it is almost alway exacerbated by attempts to conceal the situation which results in further and, as in the two child death cases described above. Accidental and non-accidental injuries did not receive timely medical attention, and serious health condition did not receive preventive care. The infant who had rolled off some pillows onto a heater was not only left in an unsafe environment, medical treatment was delayed, and even after it was provided, the baby was not brought back to have the dressings changed, and the wound became infected, taking months to heal, and the child was left with a large unsightly scar. This child was also born with a congenital defect that requires regular specialist care, which he was reported to be not receiving, which places the child at risk of kidney damage.

Infants who were born prematurely or with NAS or other health and/or congenital problems had special care needs, such as routine check-ups and regular monitoring of progress with the hospital or infant health, which were regularly reported to be unmet.

Example. One of the referent infants in Sub-sample 2 was born with a serious health condition, for which it was vital to have regular medical care and monitoring and a special diet which, if adhered to, would prevent the infant from suffering permanent brain damage – the special care needs of this baby were not met – despite extraordinary efforts made by the Children's Hospital staff –and he did suffer permanent brain damage. In order to conceal the fact that the infant was not being fed the special (and freely supplied) diet, the medical specialist suspected that some of the blood samples that were sent must have been taken form another child – presumably in an attempt to conceal the fact that the infant was not receiving an appropriate diet and his health was in jeopardy.

As the SIs proceeded through the early years, a wide range of harmful outcomes such as Failure to Thrive, malnutrition, accidental injuries and other neglect-related medical and health problems were identified for a substantial number of the SIs – lower level health concerns reported, such as chronic colds and/or flu and general ill-health and problems such as infections and urine burns resulting from infants being left with nappies unchanged for extended periods, were not included among the outcomes. Mental health concerns were a concern for infants of all ages, although they are a specialised field and are rarely reported or recognised in very young infants. In the older age group, though, toddlers and SIs who were reaching school age were displaying behaviours that were indicative of serious psychiatric / mental health problems such as anxiety, PTSD and in one case, in particular, symptoms of a dissociative disorder.

The most worrying aspect of the reports about these concerns was the tendency of both school personnel and caregivers to attribute the concerns to problems such as ADHD or autism, and to have the children sent for diagnosis and treatment with drugs, such as Ritalin. The case files revealed that there were infants in this state as young as 2 years old who were being prescribed Ritalin – which is not tested or recommended for infants – in order to help the parent cope with the child's behaviour.

More often than not, the health of most of the infants and toddlers is at risk well before they are born; it continues to be at risk as a result of various forms of pervasive chronic neglect in every aspect of their lives from inadequate diet, sleep, medical care and hygiene to poverty and exposure to unhealthy environments and chaotic unstable lifestyles. There were a number of environmental safety concerns identified for newborn and very young infants who had unexpectedly died or had suffered accidental injuries such as burns; the majority of the circumstances in which the SIs protection and safety needs were unmet were associated with misuse of drugs or alcohol.

There were surprisingly few reports (AFS=9) of unmet needs relating to safety outside the home (202.5), especially in relation to car safety; although police report minor domestic arguments in the presence of children, they do not appear to report instances of driving under the influence or dangerous driving with children in the car, or failure to provide safety restraints. The majority of concerns were in relation to parents driving under the influence of drugs and alcohol. There were some reports by relatives of unmet safety needs in vehicles, as well as not wearing a safety helmet while riding bicycles on the road.

Every family except one was notified for 'Lack of Supervision 1' (LOS by Caregiver) (303), with a frequency score of 36, and six families were notified for LOS 2 (Inappropriate substitute care), with a frequency score of 12. The SIs in Family 10 had the highest frequency for LOS (AFS= 8). They were reported on several occasions for not being kept inside the secure backyard and playing on the road, with a SI on one occasion having to be removed from the road by the bus driver as the children themselves fail to move to avoid being hit by cars – reportedly having no road sense at all or concern about their safety needs – with buses and cars having to swerve to avoid hitting them. The police reported that the mother appeared unconcerned and seemed to think it was perfectly acceptable for the children to play on the road, and on top of sheds, and in garbage tips, and in waste transfer stations.

There was further evidence of lack of supervision in the form of numerous scars, abrasions, cuts and burns – one of which was received when the 32 month-old toddler was preparing food for himself by pouring boiling water onto some cereal. It was considered necessary to hospitalise the child due to the evident unlikelihood that the mother would be able provide adequate hygiene and care of the wound – given the level of neglect that was apparent at the time. Two children from two different families were involved in accidents while playing on the street unsupervised, one child was hit by a bus, with unknown consequences, and the other child was hit by a car and received a serious head injury.

The features of LOS for the younger infants in the sample inevitably involved one or several of the parental risk factors, particularly substance abuse – except for one family in which the caregiver had an intellectual disability, and whose drug or substance mis-use problems were suspected but unconfirmed. The story of mothers being found passed out on the floor or on the couch with an infant falling off their lap, or babies left in their beds all day while the

mother sleeps off the previous three days of 'partying', appeared again and again. Several mothers were reported to have lost consciousness or 'dosed off on buses with babies, in the middle of shopping centres, and even in the middle of a conversation. Two mothers were reported to have recounted occasions when they were 'out to it' for over 12 hours, as a result of drug and/or alcohol mis-use, with infants and toddlers in their sole care – in one such incident, one mother told the notifier that she had 'passed out' for fifteen hours straight, and awoke to find all the doors left open, and the toddler lying on the sofa beside her. Other reports were of instances of parents leaving SIs alone and unsupervised for extended periods of time while going out to visit friends or shopping.

The risks resulting from lack of supervision were heightened by the chaotic and unhygienic state of many of the houses, and by the general lack of environmental safety existing in the homes. There were numerous reports of children in the care of parents with chronic substance abuse problems, in which no specific neglect concern were specified, which are included in the general or unspecified neglect category (700). The effects of the different drugs varied; ranging from the abuse of alcohol, anti-anxiety medication or methadone which had a strong sedative affect to the use of amphetamines use which resulted in periods of alertness followed by days of sleeping the drug off..

The SIs in six of the families in the sample were reported 12 times in relation to being left in the care of inappropriate carers (304). The younger SIs in Family 10 were left in the care of a then seven-year-old SI who was reported to be developmentally delayed; the SIs in the same family were also reported to be supervised by the older siblings who were incapable of ensuring their safety given that they themselves appeared to have no sense of road danger, or safety, and were violent towards the younger siblings. In relation to children being left at risk in the care of the alternative primary caregiver (305), the problem was usually to do with exposure to the alternative caregiver's violent behaviour and/or drug use. One of the subject infants suffered a head injury as a result of being left in the care of his father who was known to be violent, and was also believed to have sexually abused the older SI. There were grandparents who were effectively alternative primary caregivers who were reported to be unsuitable caregivers for very young infants either because they were ill and/or too old, or, in one case were reported to have a drinking problem.

Table 6.9. Frequency scores for need constructs within the sub-type of 'protection from physical and psychological harm' (300)

Family Sub-sample1	Co-res Cs	Total SIs	PFH :301.1	PFH :301.2	PFH: 301.3	PFH: 302.1	PFH: 302.2	PFH: 302.3	PFH: 302.4	PFH: 302.5	LOS1: 303	LOS2: 304	AltC: 305	Total
Family 1	1	2	1	1	0	0	1	1	1	1	1	1	1	9
Family 2	4	4	0	1	0	1	1	1	1	0	1	0	1	7
Family 3	2	2	0	1	0	1	1	1	1	0	1	0	1	7
Family 4	9	5	1	1	0	1	1	1	1	0	1	1	1	9
Family 5	1	1	1	1	0	0	0	1	1	0	1	0	0	5
Family 6	5	5	1	1	0	1	1	1	1	0	1	1	0	8
Family 7	4	2	1	1	0	0	1	1	1	0	1	1	1	8
Sub-sample 2	26	21	5	7	0	4	6	7	7	1	7	4	5	53
Family 8	2	2	1	1	0	0	1	0	1	0	1	0	0	5
Family 9	1	1	0	1	0	1	1	1	1	0	1	0	1	7
Family 10	8	4	1	1	0	0	0	1	1	1	1	1	1	8
Family 11	3	3	1	1	1	1	1	1	1	1	1	1	1	11
Family 12	3	4	1	1	0	1	1	1	1	0	0	0	1	7
Family 13	1	2	0	1	0	1	1	0	1	1	1	0	1	7
Family 14	2	2	1	1	1	1	1	1	0	1	1	0	1	9
	20	18	5	7	2	5	6	5	6	4	6	2	6	54

Cognitive and language and motor development (401-3). All of the SI family groups except Family 3 were reported for at least 1 construct of unmet need in the areas of cognitive, language and motor development. Cognitive and language developmental needs 1 (stimulation) had the highest frequency score (AFS=38), followed by 'cognitive and language development 2' (opportunity) (AFS= 29), and then the least commonly reported 'motor development' (opportunity and stimulation). Sub-sample 2 had a substantially higher total AFS (65) and frequency scores for each construct, compared to Sub-sample 1 (AFS=16).

According to the frequency scores for each family, the SI in Family 9, again, had the highest frequency score over all and for each construct. It is notable that this SI also had the highest severity score for the 200 subtype (sensitive and responsive care and emotional security and stability), also vital to the cognitive and language development of young children, and high levels of unmet needs across the wider developmental spectrum were reported across the notification period. This SI's notification history is typical of the way in which chronic neglect is neglected: this little boy had been reported to the Department continuously from the day he was born through to the time he started school, at which time the extent of the harm to the child's development was eventually recognised (see Table 6.10 for a summary of the frequency scores).

The lack of stimulation and opportunities for cognitive, language and motor development, again were basically to do with the lack of sensitivity and responsiveness in interactive care provided, whether it was due to the overwhelming sense of hopelessness apparent in many of the families where DV and poverty were a daily part of life or due to ongoing problems of substance mis-use or dependence, depression or intellectual impairment which are everywhere in the narratives of these young children's experience.

More generally, concerns about lack of stimulation and lack of opportunities for language and cognitive development for the older age group were couched in terms of families' lifestyle – for instance, lack of routine and opportunities for activities such as games and books, especially in families that were highly transient or homeless; or situations where the primary caregivers were reported to sleep during the day, ignoring infants and young children or getting them to sleep for extended periods as well. The

question of how infants and toddlers were kept asleep was never investigated; although there were some reports of mis-use of methadone and other adult medications. The primary caregiver in one family was reported to be selling the children's toys and books for drug money –Some homes were reportedly so cluttered and chaotic, and often unsafe, that the SIs had to be restricted to a tiny space because there was no room or safe place to crawl.

Infants, usually notified by extended family who see what is happening at close hand, are reported to be left in their beds or on floors, and not being provided with opportunities to play, were not only found to have language and cognitive delays, they were also unable to develop their fine and gross motor skills. The other main sources of notifications about developmental concerns were child health or community health centres and day-care centres. There were two cases where infants who were brought to the CHN by concerned grandparents to find that the babies' development had regressed; they had stopped smiling and were no longer able to roll over or to crawl. Cases such as these usually went hand in hand with lack of sensitive and responsive care and malnourishment.

Social isolation was a commonly reported concern for the toddler age group who were not attending a day-care program. The older group of SIs starting kindergarten/school were reported for irregular attendance, particularly when appointments for special needs such speech therapy were missed – often due to the difficulty of simply getting the child there, or lack of transport, or lack of food for lunches. (The older siblings in two families were regularly reported for absenteeism and behavioural and learning difficulties.)

Considering the severity and breadth of negative developmental outcomes for all of the Subject Infants in the sample, the aggregated frequency scores for the constructs of need that were reported say more about the types of concerns that do and do not get notified – and what is considered to be or not to be a child protection issue – than they do about the level of severity of the problem.

Table 6.10. Frequency scores for need constructs within neglect sub-type 400 (Cognitive, language, and motor development)

Frequency scores for need constructs

Families Sub-sample1	Total Ntfns	Cog./Lang Dev. 1 401	Cog./Lang Dev. 2 402	Motor Dev. 403	Total AFS
Family 1	11	1	2	0	3
Family 2	10	1	1	0	2
Family 3	13	0	0	0	0
Family 4	28	0	1	0	1
Family 5	6	2	1	0	3
Family 6	23	2	3	1	6
Family 7	5	0	1	0	1
Sub-total Sub-sample 2	96	6	9	1	16
Family 8	6	3	1	1	5
Family 9	20	11	8	3	22
Family 10	19	7	3	1	11
Family 11	18	1	3	0	4
Family 12	19	4	1	4	9
Family 13	22	5	3	3	11
Family 14	9	1	1	1	3
Sub-total	113	32	20	13	65
Total	209	38	29	14	81

Socio-emotional needs (501–3). Although this category was not so relevant to the youngest SIs, the longitudinal design allowed for an ever increasing group of older SIs in the sample for whom this category was considered to be relevant, based on the case file readings. The three spheres of socio-emotional development included inter-subjectivity / social skills, self-identity / self-care skills, and personal hygiene / toilet training. Again all families except Family 3 were identified with at least one area of unmet need – and it is probably worth pointing out that this SI died halfway through the notification period aged less than 18 months and the infant born subsequently was taken into care. There was again some disparity between total AFS for Sub-sample 1 (17) and Sub-sample 2 (33). The SI in family 9 yet again received the highest frequency score overall (AFS=12) followed by family 10(AFS=10) and then Family 1 (AFS=7). The

antisocial behaviour reported for al three of the families is reflected in the overall scores, with the score for self-care skills for Family 10 (3) indicative of the outcomes described for this family earlier. (Table 6.11 presents the frequency scores for unmet socio-emotional needs for each family.)

Behavioural problems were the most commonly reported concerns in this category for the older group of SIs, as well as for any older siblings in the families. Behavioural problems were considered to be both an outcome and a symptom of unmet need in this category and two alternative categories, unmet emotional needs (200) or protection from harm to children's socio-emotional development, health and wellbeing (300) or the present category relating to lack of parental guidance and/or appropriate role modelling behaviour. The 500 category was coded when children's behaviour was reported to be associated with learnt behaviour – such as aggressive and violent behaviour in interactions with adults or children or repeating verbal threats which are likely to have been modelled on a parent or older sibling. (As opposed to those associated with unwillingness to return to a parent's care, for example, or behaviours associated with psycho-emotional development or health problems). Children's behaviour was often reported and considered to be a cause of parenting problems, rather than as a result of unmet developmental and care needs.

Although there were several reports of lack of personal hygiene being provided by caregivers, this was rarely reported in terms of the children's development of personal self-care skills in relation to personal hygiene and toilet training – that is, as a noteworthy aspect of the development of autonomy and socio-emotional development generally – until the children were in a much older age group and were being (further) ostracised from their peers because of their lack of hygiene and their strong malodour. Lack of toilet training and poor personal hygiene was encountered often in the in-depth reading of a sample of cases, yet there was only one such need reported in the present sample – however again, it's a matter of what is or is not reported. The reports tended to focus on the particular issue that was regarded as a more serious problem – with issues such as poor hygiene no longer generally regarded by professionals especially as child protection concerns. Yet, they are very important aspects of children's psycho-social development – the development of autonomy, self-identity and inter-subjectivity – which starts from the very early years of childhood development.

Two of the older infants in Family 10, aged 3 and 4 years at the time, were assessed as having little by way of awareness of (or training in) personal hygiene, toileting needs or self-care skills when they were taken into care; and the youngest infant (aged 24 months) was also reported to be unaware of whether his nappy was dirty or not. However, there were no reports outlining concerns about these issues for this family or for many of the families in the sample, despite it being an often-reported for the older age group encountered in the case files for the cases that were read as grounding for the need constructs.

Table 6.11. Frequency scores for constructs of need for neglect sub-type 'socio-emotional development' (500)

	Frequency				
Family Code	Total Notifications.	501	502	503	Total
Family 1	11	6	1	0	7
Family 2	10	2	0	0	2
Family 3	13	0	0	0	0
Family 4	28	2	0	0	2
Family 5	6	3	0	0	3
Family 6	23	2	0	0	2
Family 7	5	1	0	0	1
Family 8	6	2	0	0	2
Family 9	20	11	1	0	12
Family 10	19	7	3	0	10
Family 11	18	1	0	0	1
Family 12	19	1	0	1	2
Family 13	22	4	0	0	4
Family 14	9	2	0	0	2
Total	209	44	5	1	50

Socio-moral development (600). The constructs for unmet socio-moral developmental needs included 'provision of moral guidance and/or protection from exposure to criminal activity' (601) and 'protection from conflict with the law' (602). This category was included because of the degree of criminal activity and behaviour among the families in the sample to which the children were exposed, and were quite literally

learning at their mothers' or fathers' knee. Older children were included in the construct of 'conflict with the law' (602), as they were more likely to be reported and they were also likely to include the younger siblings in this type of activity, in order to highlight the high risk of exposure in this small child protection population. The only family in which the SIs were engaged in activities that placed them at risk of conflict with the law, were the older SIs in Family 10 who were encouraged with their older siblings to harass and steal from local members of the community. The children in this family appeared to lack any guidance whatsoever with regard to road safety laws. (Domestic violence, illegal use of drugs, and abusive and neglectful parental actions were not included.).

Table 6.12. Frequency scores for constructs of need for the neglect sub-type 'socio-moral developmental needs' (600) for the Subject Infants and the older siblings per family

Frequency scores for unmet constructs of need

Family	Total Ntfns	Moral Guide/protn 601 (SIs)	Moral Guide/Protn 602 (older sibs)	Total AFS
Family 1	11	8	0	8
Family 2	10	0	0	0
Family 3	13	4	1	5
Family 4	28	4	7	11
Family 5	6	1	0	1
Family 6	23	3	2	5
Family 7	5	3	0	3
Family 8	6	0	0	0
Family 9	20	6	0	6
Family 10	19	5	4	9
Family 11	18	6	0	6
Family 12	19	1	0	1
Family 13	22	6	0	6
Family 14	9	4	0	4
Total	209	51	14	65

The socio-moral development of the Subject Infants appeared to be at substantial risk, given their exposure to criminal behaviour and activity within the families in both sub-samples. There was very little difference between the total AFS score for Sub-sample 1 (33) and Sub-sample 2 (32). Overall, including the older siblings, Family 4 (AFS=11),

Family 10 (AFS=9), and Family 1 (AFS=8) had the highest frequency scores. There were only 2 Families (Families 8 and Family 2) in which the SIs were not reported to be exposed to criminal activity – that is other than illegal drug use. The older siblings and half-siblings in two families were engaged in criminal activity, on their own and/or with the mother. There was one instance of a primary caregiver being arrested for shoplifting with a very young infant in her care. Table 6.12 below provides the frequency scores for unmet socio-moral needs.

Basic care and protection needs unable to be met or 'at risk' of being unmet (700)

Many of the concerns reported about the children in this age group were couched primarily in terms of parental behaviours and omissions of care, rather than in terms of the wide range of unmet developmental and care needs which the subject infant(s) being reported were likely to be experiencing – and if they were referred to it was usually restricted to, or reflected, what the caller considered to be child protection concerns. Inability or unwillingness to meet infants general or unspecified care needs was the fourth most frequently reported sub-type with a total AFS of 197. The SIs in every family across the sample had been reported to have had their basic care and protection needs not met as a result of the primary caregivers' inability or unwillingness to care due to the existence of at least 2 constructs or risk factors being present. The families in Sub-sample 1 had a minimum of three and a maximum of 4 constructs of need present, and those in sub-sample 2 had a minimum of 2 and a maximum of 4 present. The families in Sub-sample 1 had a lower frequency score for reports of drug mis-use than Sub-sample 2 (40, 58), but a higher frequency of reported alcohol abuse (35, 21). There was little difference between the frequency of reports of maternal mental health problems (13, 14), and S-S 1 had less reported concerns for intellectual disability than S-S2.

Maternal drug mis-use had a higher overall frequency score (98) than alcohol mis-use (56). Maternal substance abuse was reported for every family except Family 10, and alcohol abuse was reported for every family except Family 10 and Family 8. (However; information gleaned during the intervention process suggests that there were either drug or alcohol concerns for the primary caregiver in Family 10.) Concerns about maternal mental health problems had a frequency score of 27 and the frequency of reports in

relation to maternal intellectual disability was 7. Drug and alcohol dependence had far-reaching effects on the development and wellbeing of the Subject Infants in both samples. Drug and or alcohol abuse were *known* to be present in every case in which an infant or young child died and in the majority of cases of non-accidental injury.

The lack of response to or awareness of the developmental and protection needs of infants dependent on primary caregivers who are dependent on or mis-use drugs, and prescribed medication in particular, on the part of professionals across the field was evident in a number of cases. The following extract is from a notification regarding an infant who was born heavily affected by drugs and who later died of a methadone overdose:

Example. Referent infant in Sub-sample 1 (extract from Notification 2)

> "Presenting Problem as identified by caller (Drug and alcohol GP):
>
> The caller began by saying she was treating the mother. The caller said the mother and father have unstable drug use and by this she said [sic] they were injecting things other than the prescribed methadone – they were injecting anything they could get their hands on.
>
> The caller said the baby had a long withdrawal period after birth, as he was born drug dependent. The child was born premature.
>
> The caller said the father has a warrant out for his arrest – traffic offences – and the father is not giving himself up. The mother also reports that the father has bashed her – the doctor said there were bruises on the mother but the mother never sought medical intervention. The doctor only saw the mother a week after the alleged bashing and so no details about the bruises were available.
>
> The caller said the father is becoming increasing irritable.
>
> The caller said she had spoken to the mother about DV and the support that was available but she wasn't sure the mother would utilise this.
>
> The mother and the child are supposed to be attending the Aboriginal health service but the doctor didn't know if they actually were.
>
> The caller said she believed the child should never have been released from hospital to the parents. The caller said she had spoken to the RHH but they had released the child and the mother.
>
> The caller said that the mother had reported the baby not sleeping well and the mother had track marks up her arm and this was a recipe for disaster.
>
> The caller said she had heard from other drug users that the mother wasn't coping with the child. The caller said the methadone nurse ... also had concerns about this baby.
>
> The caller said the last time the baby was seen it was healthy and well dressed and clean.
>
> The caller was told that this information would be kept on record.

The CPAARS worker tried to ask the caller more questions about risk and the caller terminated the call saying this situation was a recipe for disaster and no more information was needed and should have to be provided.

Caller's expectations:

The caller wanted the department to remove the child from the disastrous situation.

Outcome of internal service check (includes previous & current protective involvement):

A CWIS and TRIM search shows that the department has a personal file and this case was referred to assessment in January 2004. CWIS and TRIM say that the case has not been finalised.

PC from assessment senior ... who said the case was closed after a case conference at the hospital. The mother and father were willing to engage with services for drug rehab and parenting – good beginnings and the parenting centre - and the child health nurse ... was going to do home visits."

Summary of subsequent events

A follow-up call to the CHN confirmed that she had been visiting the home and that the child (now 22 weeks old) was developing well, although he might be a bit unsettled at night as a result of his 'birth status'. The nurse reported that "dad is fantastic with the child and mum is OK". The nurse had concerns about the mother always being tired, but the mother said this is the way she is, and has denied taking any extra drugs. The nurse was going to continue conducting home visits every 3 weeks. The notification was classified as 18.0 – no further action necessary

Four weeks later: CHN Child Health clinic was ringing to inform the worker she had tried 12 times to make contact with the family and had no luck. On 5 July she visited the home and left a note and today she had tried calling but there had been no response. The caller just wanted to let the department know of this. Another call from the CHN 3 weeks later informed the Department that she had caught up with the family, and reported that they were "not going to parenting centre as they indicated they would, however things have improved" [Neither of the calls were written up as notifications]

The fifth notification was from the police reporting that the mother had been arrested for shoplifting and was under the influence of a substance and had the infant in her care at the time. A follow-up call to the CHN, who stated that the parents "are lovely and caring" towards the baby, but "they are a very chaotic family"; "it is not an ideal situation" but the child has continued to grow and develop, however "it is hard to say what happens when the family are at home". In a follow-up call to the hospital social worker, further concerns were reported in relation to the infant not attending regular appointments required for the heart problem identified at birth. No further action was able to be taken because the family had relocated interstate where there was a possibility of the father gaining employment (and avoiding a number of police matters that had not been finalised at the time).

The sixth notification to the Department approximately 12 months later was a report by Child Protection [inter-state] – where the family had gone to avoid a court appearance. It was reported that the parents had been 'doctor shopping' for extra methadone – which they were able to receive from 'a dodgy chemist' who was being investigated in relation to the matter. The Magistrate had denied a 'Protection by Apprehension' warrant to prevent the family from leaving the state; however, the drug test showed a positive result for methadone for both parents, as well as cannabis, benzodiazepines and amphetamines for the mother, which the doctor found "very concerning [and] given the level of drug use he would be gravely concerned about mother's ability to care" for the baby (Notification 6). As expected, the family failed to appear in Court on the due date, and had 'done a runner' back to Tasmania. The treating doctor from drug and alcohol services in this state

> provided a follow up notification to update the Department about the family's return to the state and her concerns for the wellbeing of the baby and the obvious drug-affected state of the mother. The notification was classified under Section 17(b) (no further action) as the case had already been sent to the assessment team for allocation to a worker. Following another call from Child Protection in [other state], a child protection worker was allocated to the case and the mother signed a Voluntary Agreement for Family Support, including an agreement to undergo random drug screening, one of which was (eventually) carried out. The case was transferred to the Tasmanian Aboriginal Centre who were going to be organising a case management plan for the family. The infant died of a methadone overdose within approximately four weeks of receipt of the notification stating that the family had returned to Tasmania.

The failure to take into account individual circumstances and responsibilities of mothers with young children who are being provided with prescribed medication was raised in the case of a referent infant in Sub-sample 2, in which case an allied health professional had raised concerns about the fact that the mother was able to get additional doses of methadone with few questions asked (see notification for this family). This notifier had stated that when she spoke to the practitioner concerned about the mother's apparent drug misuse, he showed little awareness or concern about the ramifications of methadone abuse in this case on the highly vulnerable newborn with NASD and a very young toddler in the mother's sole care. In the case of one of the infants who died unexpectedly, the mother was able to take higher doses of an already very high dose of Diazepam, for example, by 'doctor shopping'. Misuse of medications, and possibly non-prescribed drugs, caused the single mother's loss of consciousness on several occasions including in the hospital and at home – which one medical officer did express concern about. However following a period in hospital after a second suspected suicide attempt – reported by the mother's extended family – the discharging medical officer reportedly did not consider the mother's overuse of Diazepam at night, with a newborn infant and two toddlers under age of 3years in her care, "as a huge risk to children" (Notification 4). The MO had no knowledge, and had sought no information, about whether or not these three very young children would be in her care when she left the hospital.

The subject infants in all three families were believed to be safe in the care of their parents on the basis that they each had support from close relatives and support services who were theoretically able to ensure the infants' care and safety needs were being met. In all three families, support was extremely close at hand at the time, but it was not able to prevent two deaths and a serious brain injury from occurring.

Table 6.13. Frequency scores and presence/absence counts for constructs identified for general/unspecified care and protection needs reported to be unmet or 'at risk' due to parental risk factors (700)

Frequency scores for constructs per family

Families	No. of Ntfns	Drugs 701.1	Alchl 701.2	Cogn. 702	Ment. 703	Unable 704	Total AFS
Sub-sample 1							
Family 1	11	6	6	0	3	0	15
Family 2	10	9	6	0	4	0	19
Family 3	13	9	4	1	0	1	15
Family 4	28	2	4	0	2	0	8
Family 5	6	2	1	0	2	0	5
Family 6	23	10	12	0	2	0	24
Family 7	5	2	2	0	0	1	5
Sub-total	96	40	35	1	13	2	91
Sub-sample 2							
Family 8	6	3	0	2	0	0	5
Family 9	20	17	2	0	4	2	25
Family 10	19	0	0	3	0	0	3
Family 11	18	7	2	0	0	2	11
Family 12	19	10	10	0	5	2	27
Family 13	22	16	6	0	3	1	26
Family 14	9	5	1	0	1	2	9
Sub-total	113	58	21	5	13	9	106
Total	209	98	56	6	26	11	197

Presence/absence of constructs of unmet needs

Families	No. Ntfns	701.1	701.2	I702	703	704	Total
Sub-sample 1							
Family 1	11	1	1	0	1	0	3
Family 2	10	1	1	0	1	0	3
Family 3	13	1	1	1	0	1	4
Family 4	28	1	1	0	1	0	3
Family 5	6	1	1	0	1	0	3
Family 6	23	1	1	0	1	0	3
Family 7	5	1	1	0	0	1	3
Sub-total	96	7	7	1	5	2	22
Sub-sample 2							
Family 8	6	1	0	1	0	0	2
Family 9	20	1	1	0	1	1	4
Family 10	19	0	0	1	0	0	1
Family 11	18	1	1	0	0	1	3
Family 12	19	1	1	0	1	1	4
Family 13	22	1	1	0	1	1	4
Family 14	9	1	1	0	1	1	4
Sub-total	113	6	5	2	4	5	22
Total	209	13	12	3	9	7	44

Drug use on its own was generally considered not to be a child protection concern, despite being the sixteenth notification for a family in which an infant had died only 2 months previously. And despite the fact that there were two young toddlers (out of six children in all) still dependent on their mother's care, the following report received only a cursory examination of the family's previous history – which was simply (routinely) copied from earlier reports which did not include the infants SIDS death which was subject to further investigation due to the presence of risk factors for neglect – with no further investigation of any kind conducted (classified as a s.17 a):

Notification 16 (Sub-sample 1)

Caller advised

Concerned about the children living with the mother

Believes that the children deserve to have the chance of a good life

Does not believe that the mother is providing proper care for the children

Has not seen the children for a couple of weeks now

Had heard from someone that there had been drugs in the family car, and that the mother and a partner (caller unsure if the children's father) were using drugs and alcohol

Caller said that the children are involved with CP

Consult with Senior

Write up as 17(a) insufficient information to ascertain risk to children

There appeared to be a lack of understanding of the complex issues surrounding parental drug or alcohol dependence and acknowledgement of the low success rate of most rehabilitation programs. The assumption was that if parents agreed to engage with the CHN, support services and programs, then the risk would disappear; yet the subsequent histories attest to the fact that parents may engage with the CHN for the first few weeks – that is, they allow the visiting nurse into the home – then the nurse reports the difficulty she is having with broken appointments and/or making contact with the family, and when drug screening is put in place, they seem to occur with great irregularity. There also appeared to be little acknowledgement of the devastating impact that drug misuse was likely to have on the attachment relationship and children's physical and psychological development in particular, with investigations focusing more on the physical harm that might result from lack of supervision and/or access to dirty needles.

Cognitive impairment. Not unexpectedly, the number of reports of infants whose needs were (or were at risk of) not being met due to a primary caregiver's cognitive impairment was low – six reports in all made in relation to three families – compared to the number of parents reported to be dependent on drugs and alcohol. Only one of the primary caregivers was known to have been assessed as having an intellectual disability, with the father in this family also assessed as below average in cognitive functioning. Although this was one of the two two-parent families in the sample, the parents appeared to be living separately at times – for instance the father took one of the SIs to live on a property in a rural area for a short period with the birth of a new baby in the family – and appeared to be living separately on a more permanent basis at the end of the study period. The reports for this family suggest that the children were almost entirely left to fend for themselves and to run wild in the community and within the home as the outcomes for the SIs described above attest. One of the older children reported that their mother slept all day, which raises further questions of additional substance use issues.

It was evident from the informal reading of the case files that caregivers with intellectual impairments who were involved with child protection had a very strong desire to be left to manage their families on their own, without support/interference from others, and resented the intrusion of support services into their private lives. That being said, intellectual disability or impairment was less commonly observed in the case files to be a problem on its own, but rather, when it was associated with other risk factors such as substance misuse, domestic violence, and mental health problems.

There were two other caregivers whose intellectual capacity to provide adequate care was brought into question. A report from a medical practitioner raised concerns about a mother's ability to care for a newborn child who later died was questioned by a drug and alcohol medical practitioner, who stated that the "mother doesn't appear to be very bright even without the drugs ... [The doctor] believes mum would have difficulty knowing how to care for a baby and acquiring the knowledge to do this" (Notification 1). In the case of the second family, the notifier was primarily concerned about the parents' addiction to marijuana, reporting that both parents were always 'stoned' and that the "mother isn't mentally all there, neither is he". The Coroners report on one of the unexpected infant deaths paid particular attention to the fact that the mother, who

was on high doses of Diazepam in conjunction with other known and unknown substances, was provided with advice about the risks to her unborn and newborn infant and the need to reduce the number and amount of medications and the importance of safe sleeping practices, which advice was either not comprehended or not heeded. The mother was later described by a notifier as 'very slow', taking a long time to comprehend what she was being told – and was observed to be giving the two young toddlers what was believed to be adult medication.

On the other hand, concerns about caregivers' substance use either contributing to or causing impaired cognitive functioning did not appear to be a commonly recognised problem by notifiers and child protection workers in general. Cognitive impairment was found to be an important and under-recognised aspect of substance abuse which places infants who have already been prenatally affected by exposure to drugs and alcohol, and who consequently have an even greater need for sensitive and responsive care, at substantial risk of additional harm. It was a particular problem for infants who had serious health problems and whose continued health and wellbeing were totally dependent on parents' understanding of the importance of meeting their special needs, including the regular monitoring of their health and development and attention to their medicinal and dietary requirements.

Mental health problems. While depression was commonly recognised as a serious concern for mothers of newborn infants in particular, there was a range of mental health and psychological problems that were likely to impact on the capacity of some of the mothers to meet the needs of their newborn and older infants, especially in families where the mother was the sole caregiver. A single mother in Sub-sample 1 was reported to have made two suicide attempts – one while she was pregnant with her third child and another after the infant's birth – was diagnosed with a personality disorder and substance problems at the time of the initial admission to the Department of Psychological medicine. Given that some types within this group of disorders can have serious implications for the vital mother-child attachment relationship, it is very concerning to observe the number of single primary caregivers in the child protection population generally who may not be capable of providing affective sensitive and responsive care. The long-term ill-effects of many caregivers' own childhood experiences of abandonment and exposure to the same issues their own children are

experiencing, evidenced by their inability to prioritise the needs of their children over their own and their engagement in serial relationships with men who behave violently towards them and their children – even after the death or serious injury of a child – raises questions about their own psycho-emotional wellbeing – with or without the additional problem of substance abuse.

Unwilling or unable to care. This construct refers to caregivers who reported themselves to be unable to provide care or were reported to have abandoned or to have been unwilling or unable to provide care for SIs. Two primary caregivers in S-S 1 and five in S-S2 were either deemed to be or considered themselves to be unwilling or unable to care for the SIs. The primary caregiver/mother of an infant born with a range of congenital and special health care needs believed that a foster care situation was better able to meet the infants special care needs, and wished to place the infant in the permanent care of the Department. Caregivers reported themselves to be temporary unable to provide care in three families due to ill health; mental ill health and substance abuse problems in particular, including one case where both parents' mental health and drug dependence had reached crisis point, and they felt temporarily unable to care for the child.

A primary caregiver who had sought temporary respite for two SIs on a number of occasions was reported when she failed to return to pick them up as arranged and was unable to be located for an unknown period of time, and was considered to have temporarily abandoned the children. Three of the primary caregivers had to serve prison sentences, at which time the SIs in two families were able to be cared for by family members, however, two of the SIs had already been taken into departmental care for other reasons at the time.

Prenatal neglect (800)

As with all sub-types discussed above, it seems worth re-iterating that the constructs relating to protection from prenatal exposure to harm through substance abuse and domestic violence, and provision of prenatal care, are viewed form an ecological and child-centred perspective, and although the risk of mother blaming is heightened here and elsewhere, the fundamental issue is that the infant has not been protected from harm, regardless of questions about responsibility and blame. This is particularly

pertinent to the matter of exposure to violence, which often runs the risk of blaming the victim/mother – the view being taken in the present study is that child protection, social welfare, the police, medical professionals, family and the community as individuals and in general all share responsibility for ensuring the safety and wellbeing of unborn infants and children generally.

Prenatal exposure to drugs and alcohol (801.1-2). Although mandatory reporting of concerns about unborn children was not included in the Act until 2009, reports were made to the Department during the period and these were recorded as 'unborn enquiries'. The number of reports listed on the original database (from July 2003 to February 2008) for Tasmania increased from 30 reports made in relation to 23 unborn children, to approximately 89 reports for 69 children in 2006, with a similar number in 2007 at which time a new system was in place for liaising with the hospital.

Protection from harm from prenatal exposure to drugs was reported approximately twice as much (31) as prenatal exposure to alcohol (15). Exposure to drugs was reported for SIs in nine families in all; including 4 families in Sub-sample 1 and 5 families in Sub-sample 2 – which is not to say that the Subject Infants in the other families were not exposed to drugs before they were born, given that all of the families except one who were not reported for prenatal drug use were reported to be mis-using drugs while the SIs were in their care. (And given that notifications for unborn children were not mandatory and were not necessarily made to child protection during the early part of the study period.)

There was one case only in which the mother was reported to have started mis-using drugs only after the birth of her first child. There was reason to believe that the some SIs not notified for prenatal exposure to drugs were highly likely to have been given the existence of maternal drug (and alcohol) problems at that time. Maternal drug and alcohol mis-use were later discovered to be serious problem for the unborn children in one family in Sub-sample, which appeared to go unreported until the SIDS death of one infant, despite the intensive and close support being provided by a non-government organisation over a number of years.

Prescribed drugs such as methadone and diazepam and other legal and illegal substances were taken, in extremely high doses in some cases, as a form of pain management at the onset of labour – at least two mothers had slept through the births of their babies (and for much of the time subsequently). Both of these infants had to be resuscitated at birth and kept for extended period of time in neonatal intensive care while undergoing withdrawal treatment. The Subject Infants born with NASD had to be kept in hospital, often in the NICU, until their drug withdrawal (morphine) treatment was completed, which could take weeks and sometimes months – which is neither a good start in life nor a good start to the development of the vital attachment bond between the mother and the baby. As discussed in the previous category, the attachment relationship for both mother and baby is further impeded by the infants' NASD symptoms, which when maternal drug and/or alcohol addiction which at best is risky and at worst a fatal combination. Two unborn SIs were exposed to drug and/or alcohol overdoses: one was during a suicide attempt, and the other was an accidental methamphetamine overdose – one of the infants was stillborn and the other infant died unexpectedly some months later.

As Table 6.14 shows, unborn children in seven families were exposed to both drugs and alcohol, four of those infants died and one infant suffered a non-accidental brain injury Prenatal exposure to alcohol mis-use was reported for SIs in eight families in all; five families in Sub-sample 1 and 3 families in Sub-sample 2, which is also likely to be an underestimate of occurrence in the sample, given that alcohol mis-use was reported for all but two families with SIs in their care, and given that one of the unreported infants was observed to have some physical (and developmental) features of Foetal Alcohol Syndrome.

Again, the problem of drug and alcohol use led to further neglect of the unborn child, because a), mothers were reluctant to seek prenatal care, which could detect and treat developmental and other health problems, and b), the nutritional needs of the mother (and developing foetus) were also likely to be unmet as a side-effect of drug use. It's not within the realm of the present study to examine the reasons for this reluctance, but apart from the obvious fact that they do not wish to be reported to the Department, and risk having the baby removed, one mother was reported to have said that she did not seek prenatal health care for fear of discovering that the developing foetus had been

harmed. The number of newborn infants reported to be born drug-dependent or suffering from NASD and other outcomes associated with prenatal neglect are presented Table 6.15 below.

Unborn SIs were exposed to physical harm or 'risk of harm' from violence or other cause in 5 families in Sub-sample 1, and 2 families in Sub-sample 2. Ascertaining whether or not a violent assault on a pregnant mother caused foetal deaths or miscarriages is not always easy, particularly when the person who has been assaulted is afraid of the perpetrator and afraid of the consequences of providing factual information relating to the incident. Most cases involved risk of harm with reports of violence while the mother was pregnant, except for one case in which the mother was reportedly attacked with the intention of harming the unborn child. The mother of four SIs in sub-sample 1 was reported five times in relation to being assaulted while pregnant, including an assault by an older sibling, and on several occasions by the father. The loss of a twin of one SI was also believed to have been caused by another father's violent assault on the mother. There was one attempted suicide while the mother was pregnant with one of the referent SIs in Sub-sample 1.

Lack of antenatal care was reported as a concern for six families, in circumstances where antenatal care was considered advisable or necessary – such as those circumstances outlined in the preceding sections of this sub-type, in which the unborn SIs were considered to be at greater risk of developmental problems and prematurity compared to the general population.

Table 6.14. Frequency scores for need constructs within the sub-type 'prenatal neglect' (800)

Frequency scores for identified need constructs (prenatal neglect)

Family	Total Ntfns	Exp. Drugs 801.1	Exp. Alcohol. 801.2	Exp. DV 802	Antenatal. Hlth Care 803	OtherHlth/ W'being 804	Total
Family 1	11	3	3	2	4	2	14
Family 2	10	1	1	1	0	1	4
Family 3	13	6	2	1	4	4	17
Family 4	28	0	1	5	0	0	6
Family 5	6	0	0	0	0	0	0
Family 6	23	4	3	2	1	1	11
Family 7	5	0	0	0	0	0	0
Sub-Total	96	14	10	11	9	8	52
Family 8	6	0	0	0	0	0	0
Family 9	20	1	0	1	1	1	4
Family 10	19	0	0	0	0	0	0
Family 11	18	4	2	2	0	0	8
Family 12	19	3	2	0	1	0	6
Family 13	22	6	0	0	2	1	9
Family 14	9	3	1	0	0	1	5
Sub-total	113	17	5	3	4	3	32
Total	209	31	15	14	13	11	84

Neonatal outcomes

The number of subject infants who suffered negative outcomes at birth is summarised in Table 6.15. Only those SIs who suffered harm that was known to be associated with prenatal exposure to substances or situations, such as inadequate nutrition or exposure to violent partners which were known to place the infant at risk, were included. For example, an SI with low birth weight would only be included in the number of children affected if the outcome was associated with heavy drug or alcohol use and/or other lifestyle factors that might lead to poor foetal growth and development. Although the number of babies affected overall is in line with the number of infants in each sub-sample (i.e., 21 in S-S1 and 18 in S-S2), in fact, not all outcomes had been notified and some infants had more than one negative outcome. The two sub-samples had a similar

number of SIs affected overall, with the exception of a much larger number of infants born with neo-natal abstinence syndrome in Sub-sample 1 (n=9) than Sub-sample 2 (n=3); however five of the eight infants were from one family. There was little difference overall in the reported occurrence of prenatal substance misuse for the two sub-samples.

The stillbirth of one child was directly due to exposure to an overdose of amphetamines, and all three of the infants who had unexplained/unexpected deaths had been exposed to both legal and illegal drugs and alcohol before (and after) they were born. One infant had been prenatally exposed to a particularly high regular dose of diazepam, combined with Citalopram (a Selective Serotonin Re-uptake Inhibitor SSRI), alcohol, and occasional marijuana, as well as being subjected to an intentional overdose of prescribed medication. The newborn infant had further exposure to this medication as well as a strong painkiller requested by the mother – not recommended for breastfeeding newborn infants

Another of the infants was prenatally exposed to alcohol – in quantities of 'a carton daily' for a period of 2-3 months (when the mother was released from prison) – as well as Prozac and other unknown illegal drugs. The third infant was subsequently identified, during the enquiry into the baby's death, as having been prenatally exposed to alcohol.

The infants who were born with neonatal abstinence syndrome were at increased risk because they tend to be highly irritable, difficult to console, have sleeping difficulties and a very distinctive high-pitched cry, which would be difficult for any parent, but particularly for those who have substance dependence and mental health problems. One of the babies who suffered brain damage from being shaken, for example, had been left in the care of the father, who was known to be violent (and suspected of sexually abusive behaviour), because the mother was heavily dependent on, and misusing, methadone and was reportedly in no fit state to cope with the infant on her own.

There were 11 SIs, excluding the infant who was stillborn, reported to be born affected by and/or dependent on drugs, which required various levels of care and treatment with morphine, and extended periods of separation from their mother, all of which places strain on the already endangered attachment relationship. The neonatal drug dependency

status of some of the infants was not necessarily reported to the Department in the early part of the period especially when there were no guidelines in place for unborn children, even for those infants who were born drug-affected. The information relating to the newborn infants in some families appeared far from complete, especially for older SIs in the sample and those born interstate.

Ten premature births were reported among the subject group of infants, and five were reported to have low birth weights. The number of infants exposed to alcohol and/or drugs who were born with congenital disorders, such as heart, gut and other defects which required surgery, was concerning. Although there are no figures available with which to make a direct comparison, an estimated figure of 5% of congenital anomalies for all births and terminations (Abeywardana, Karim, Grayson & Sullivan 2007), and 3.1 % of women had given birth to an infant with a congenital anomaly in the 2002–2003 period (Abeywardana & Sullivan 2008). One of the subject infants exposed to heavy substance abuse was born with a number of congenital disorders including frontonasal dysplasia, a heart defect and two heterotopic masses in the brain, resulting in epilepsy and the need for ongoing medical and surgical treatment. The infant was described as suffering withdrawal symptoms at the high end of the scale for which he was treated with morphine for a lengthy period. After one year the baby was still showing ill-effects from exposure to drugs.

Two of the infants required resuscitation at birth – one needed to be revived with an injection of Narcan which in itself is believed to be highly risky – as a result of being exposed to drugs/methadone prenatally and subjected to an extraordinarily large dose at the time of their birth to prevent the pain of labour. One of the mothers was so heavily sedated with methadone that she slept through the birth. And although only 2 infants were reported as having some features of foetal alcohol syndrome, the diagnosis is reportedly rarely given in this state. (This is also the state in which 2 year-olds have been prescribed Ritalin for their behavioural or ‘hyperactivity’ disorders.)

Table 6.15. Negative neonatal outcomes associated with prenatal neglect identified for the SIs in each sub-sample of the NOS (number of children)

Neonatal Outcomes (neglect-related)	*Incidence (Number of children affected)*		
	Sub-Sample1	Sub-Sample2	Total
1. Stillbirth	1		1
2. Drug affected / NAS*	9	3	12
3. Prematurity	5	5	10
4. Low Birth Weight	1	4	5
5. Congenital disorder	4	1	5
6. Other medical / health problem	2	5	7
7. Foetal Alcohol Syndrome	1	1	2
Totals	23	19	42

*Neonatal Abstinence Syndrome

Abuse and neglect

There were a total of 48 reports of abuse concerns made in relation to the SIFGs, including 23 reports of physical abuse, 20 reports of emotional abuse (that is, an emotionally abusive act against the child), and 5 reports of sexual abuse.[50] The older siblings (n=8) living in the home in two of the three families with older children received 12 notifications for the full range of abuse sub-types – the third family who were thought o have been residing with grandparents much of the time did not receive any allegations of abuse although the younger SIs in the family were notified for serious abuse concerns when they were in the mother's care. The SIs in five of the seven families in Sub-sample 1 and in six of the seven families in Sub-sample 2 were notified for physical abuse at least once in the period, an equal number of families in each sub-sample were also notified for emotional abuse, and one family in Sub-sample 1 and three in Sub-sample 2 were notified in relation to sexual abuse of one or more SIs (see Table 6.8 for the frequency of notifications of physical, emotional and sexual abuse).

[50] The standard departmental definitions of physical and sexual abuse were applied in the present study, however, emotional abuse is defined strictly in terms of direct acts or commissions against the child which are emotionally or psychologically harmful (please refer to approach outlined in Chapters X1 and X2).

All physical abuse allegations for children in this age group would be considered serious; however, the abuse incidents reported for at least four of the Subject Infants in this particular sample were found to be extremely serious, indirectly resulting in the death of two children in Sub-sample 1 and causing serious harm requiring hospitalisation for two infants from two other families. The more extreme situations involving physical abuse and/or suspected non-accidental injuries were characterised by (a) substance abuse and/or mental health problems of the perpetrator and/or primary caregiver; (b) the failure to seek timely medical attention; (c) concealment of the facts about how the injuries occurred, and prioritising the primary caregivers' own and/or the partner's needs over those of the child; and (d) repeated exposure of the children to violent partners and dangerous situations. One case of abuse was reported for two children under the care of the Department (in kinship care). In every case of reported abuse within the family, non-accidental injuries occurred in situations where neglect either played a pivotal role – in terms of the basic care and protection needs of the infants not being met by the primary caregiver – or it was the major ongoing and underlying concern – in terms of basic care needs being unmet and/or a lack of emotional attachment and/or sensitivity and responsiveness to the needs of the child.

The experience of emotional abuse in this age group, as with all forms of abuse and neglect, is somewhat different to that experienced by the older age groups mainly because of the differences in developmental needs that exist throughout the course of childhood. The emotional abuse experienced by the SIs in this sample fell into the following three main categories: (a) most commonly, verbally abusive behaviours such as constant yelling at the child and derogatory name-calling, (b) victimisation and/or intimidation; (c) threats to kill or harm the child and/or the child's other parent or themselves; and (d) locking young children outside the home (at night), or in a shed or room.

The most extreme case of emotional abuse occurred when one toddler and his mother were held in a hostage situation for 48 hours by the mother's ex-partner. Emotional abuse most commonly occurred in situations where the main caregivers and/or their partners were known for violent and/or aggressive behaviour and/or had substance abuse problems, mental health concerns or intellectual disability. It was commonly in response to, or occurring with, an infant who is irritable or difficult to console – typical

of babies born with NASD – or toddlers and young children with problematic or uncontrollable behaviour.

Of the five notifications which included sexual abuse concerns, three contained allegations of sexual abuse involving two female and one male child, and two contained information relating to physical abuse of two male children which was of a sexual nature. In one case, the mother's partner was believed by the family and professionals involved to have engaged in sexual activity of some kind with a female toddler, which was substantiated despite being unable to have the allegation confirmed due to lack of evidence and the little girl's age. Two separate notifications were made by the mother in one family, one against the father and another against a member of the kinship carer's family, alleging that the two subject children, one boy and one girl, had been sexually interfered with – which were believed to be made in two separate attempts to regain custody of her children.

The other two cases involved two male infants who hade been subjected to physical abuse, which included bruising, inflammation and infection of their genitals. Again, there is a lack of factual information about how those injuries occurred; but both of the children were subsequently removed from their mothers' care. Alcohol abuse had become an increasingly serious problem for one of the mothers who had recently suffered the loss of a younger infant and the other mother was described as highly drug dependent and unable to prioritise the needs of her son over her own.

The number of notifications of physical, emotional and sexual abuse made in relation to the Subject Infants, and incidence of combined abuse types for the older co-residing siblings, are summarised in Table 6.16. (The notification history for the families in Figure 6.1 provides an overview of the types of maltreatment being reported.)

Table 6.16. Frequency of notifications for each abuse sub-type for the SIs and total notifications of abuse (all sub-types) for older co-residing siblings for each family

				Abuse sub-types				
Family	Ns 2003–09	No. of Co-res Cs	No. of SIs	Physical Abuse	Emotnl Abuse	Sexual Abuse	All abuse (Older Cs)	Total
Family 1	11	1	2	0	1	0	N/A	1
Family 2	10	4	4	1	0	0	N/A	1
Family 3	13	2	2	0	0	0	N/A	0
Family 4	28	9	5	1	0	0	4	5
Family 5	6	1	1	4	2	0	N/A	6
Family 6	23	5	5	2	2	1	N/A	5
Family 7	5	4	2	2	1	0	0	3
Family 8	6	2	2	2	1	0	N/A	3
Family 9	20	1	1	0	3	0	N/A	3
Family 10	19	8	4	4	2	0	8	14
Family 11	18	3	3	2	1	2	N/A	5
Family 12	19	3	4	3	1	1	N/A	5
Family 13	22	1	2	3	7	0	N/A	10
Family 14	9	2	2	1	0	1	N/A	2
Total	209	46	39	25	21	5	12	63

Summary and Discussion of Findings

The neglect experience

The infants in the sample experienced unmet need in its many and varied forms over extensive periods of time, and usually without intervention until a harm-related incident occurred. Although the significantly higher level of severity and chronicity for the infants in sub-sample one overall suggests that they were also at greater risk of developmental harm, all of the infants were at substantial risk of harm of one form or another, which was reflected in the range of outcomes identified for the referent and non-referent infants alike. 'Protection from physical and psychological harm' (300), 'provision of psycho-emotional and physical care' (200), 'provision of basic physical

needs' (100), and 'unspecified or generalised unmet basic needs' due to caregiver incapacity (700), were the sub-types with the highest proportions of concerns *reported* to be unmet for this age group.

These were very conservative findings. Although the notifications suggested that the wider range of developmental and health care needs of the children were highly unlikely to be being met, it was not always explicitly stated – and rarely further investigated. The category of 'generalised or unspecified unmet basic needs' (700) were included to take account of the problem, and the fact that notifications were very much focused on the parents' behaviours and actions, rather than the children's experience.

Reports from professional reporters were often couched in terms of parental problems, pathologies and behaviours, and very much founded on the notifier's stated concerns. Interpretation of the concerns and what they meant for the child was minimal – unless they were explicitly stated by the caller – the focus was strongly on the question of whether or not it was 'a child protection concern', the assessment of immediate risk and the presence of some form of support that would be deemed to ensure the infant's safety.

Considering that it was apparent in every single case of serious and fatal injury, the disappearance of 'protection from harm' from definitions of neglect is hard to comprehend. There was little sign of recognition – from child protection workers, support service providers or medical professionals – that babies need and have a human right to an emotionally available caregiver who can provide nurturing, sensitive and responsive care in order for their physical and psychological development to proceed effectively.

Prenatal neglect

Prenatal neglect was conceptualised in the definition proposed here in terms of the need for protection from harm and unmet health care needs of the developing foetus. The primary form of prenatal neglect was the lack of protection from maternal drug and alcohol mis-use. The use of methadone for pregnant women was found to be a cause of particular concern, given that mis-use was found to be widespread, and research

showing a range of harmful outcomes for the developing foetus and the children's ongoing development over time (e.g. Jansson, DiPietro & Elko 2005; Rosen & Johnson 1982). In light of the level of mis-use of prescribed medication generally, and research findings showing the harmful effects of these on the developing foetus, the tendency to put the mothers' needs and/or requests before those of the developing foetus is an issue that also requires further exploration (see, e.g., Carmichael, O'Connor & Fitzgerald 2001; Fried & Watkinson 1990; Hans & Jeremy 2001; Jacobson & Jacobson 2001).

Normalisation of drug affected, premature and under-nourished infants in the reports by hospital staff and child protection workers was very much in evidence, which may well contribute to the ongoing lack of protection from exposure to drugs in breast milk, and perhaps even in the bottled milk, of newborn drug-affected infants. The high rate of prenatal neglect and extremely poor outcomes for newborn infants exposed to substance mis-use points to an urgent need for definitions of neglect to include the period before they are born. The comparatively high rate of sudden infant deaths found in the child protection population generally and the findings presented here indicate a somewhat urgent need for greater protection of the developing foetus, within the system and the legislation – and not simply as a notifiable concern.

Parental risk factors

The majority of the infants were residing in situations involving high levels of residential and family instability and insecurity. There were only two families with both parents residing in the home for the majority of the study period. The findings relating to caregiver characteristics for this particular sample revealed the presence of well-known risk factors, such as parental substance mis-use, domestic violence, mental health problems, cognitive impairment and social disadvantage, as well as the presence of the less-explored exposure to the various risks to young children's wellbeing and development resulting from parental involvement in criminal activity.

The vast majority of the families were socially disadvantaged and many had very poor standards of living – although some were being provided with substantial and ongoing support from paternal and maternal grandparents – and problems of homelessness and/or transience in 85% of the families. The levels of legal and illegal drug

dependence/mis-use, alcohol dependence/mis-use, and family violence in this sample were extraordinarily high – each reportedly occurring in 13 out of 14 families. Co-existing mental health problems were reported for 10 of the 14 primary caregivers, and primary caregivers in 12 of the families engaged in criminal activity, apart from illegal drug use.

For single mothers in particular, criminal activity increased the risk of further disadvantage and social exclusion, and intermittent periods spent in prison contributed further to residential and family instability. Periods of separation from very young children placed additional strain on the development of healthy attachment relationships between mother and infant, at which time they were likely to be left in the care of alternative caregivers who, going by the incidence of drug problems and domestic violence were often less than suitable. Although four of the mothers (primary caregivers) were less than twenty years old when they gave birth to older siblings of the subject children, no longer in their mothers' permanent care, none of the mothers in this sample were teenagers at the time the infants in the subject group were born. By the time most of the subject children were born, poverty, homelessness, transience, substance abuse and criminal activity had become an entrenched part of the majority of the families' lifestyles. There were only two families with both biological parents co-residing for most of the study, and only one family by the end of the period, who no longer had children in their care.

The fundamental capacity of some of the primary caregivers to provide the type of loving and selfless care that infants require for their physical and psychological development to proceed in a normal fashion is questionable, with or without substance abuse issues. At least two of the primary caregivers were known to have had serious affective forms of mental illness and suicidal behaviour in combination with personality disorders and very serious substance dependencies.

The child death sample

The general pattern of neglect identified in the child death cases was found to be different to that of the neglect-related harm cases. There was a significantly lower incidence of harmful outcomes – particularly developmental harm – and there were

significantly fewer constructs of need present overall for the infants in families in which a child had died than there were for those in the neglect sample. But, and it is a very large but, the fact that the referent infants in Sub-sample Two were selected on the basis of neglect-related harm being known to have occurred, that a proportion of the infants died at an early age, that assessments had not been carried out on most of the children, and that developmental harm was not treated as a child protection concern, all meant that the actual outcomes and level of harm for all of the children was not known.

Nonetheless, families in which a child had died had higher levels of reported prenatal neglect than the 'neglect-related harm' families, and the outcomes for newborns reflected that. The number of infants born drug affected and with congenital disorders was approximately three times greater in the child death sample.

The overall frequency scores show that the level of severity and chronicity of neglect for the infants in the child death sample was lower than that for the infants in the 'neglect' sample. However, the second and probably more useful finding was that the unmet need for 'protection from harm' stood out as the one sub-type that reached the same severity levels as the neglect-related harm cases. This suggests that the differences in frequency scores may reflect the differences in the referral rates among the sample of families as a whole.

However, given the serious nature of the cases selected for the chronic neglect sample, and the overall small sample size, it is not possible to make any inferences from the findings. Given also that the frequency scores are still reliant to a large extent on the number of notifications received, the fact that the two families in which a child died in extremely tragic circumstances had low notification rates necessarily influences the frequency scores – notwithstanding the fact that the average rates for the two families overall were similar. It is worth noting, though, that two families (with older co-residing siblings) in the child death sample had a pattern of referral that was much more typical of the chronically neglectful families. The low notification rate for two families may well have been due to their high level of transience, socially isolated and drug dependent lifestyles, and the fact that both of these families were residing in rural areas at the time.

Parental risk factors were present to a much higher degree in this sub-sample compared to child deaths of children known to child protection in Victoria in 2006–07 – with parental characteristics including family violence, substance use and transience present in 100% of cases and mental health concerns reported to be present in approximately 70% of cases. The study highlighted the importance of gaining a broad picture of the neglect experience within the family as a whole, in order to ensure the safety of siblings and subsequent children. Every case provided ample evidence of unmet protection needs, if not for the infant in question, then for one of the siblings. Previous history of covering up abuse and lack of adequate care and protection from further harm was evident in most cases. Infants were repeatedly exposed to the source of harm, after child protection and family violence support services had been given assurances that would not happen.

The generally high numbers of re-referrals for many of the families across the population sample largely reflects the lack of child protection response to neglect concerns throughout the period, they are nonetheless able to indicate levels of chronicity and severity in terms of the ongoing nature of the concerns and the possibility of the cumulative effects on the particularly vulnerable infants in the group. The frequency scores in the present study are aimed at providing a measure of the severity and chronicity of 'neglect', or risk of harm, rather than the severity of the outcome.

The suggestion that accidental deaths should be in a different category to those that were related to chronic neglect was brought into question. There were some very serious accidents that may well have resulted in the death of a child, which were simply part of the everyday experience of chronic neglect. The findings also bring into question the suggestion in the DoCs (2006) report that deaths in circumstances involving chronic neglect are somehow different to those that are accidental.

Notification matters

Individual case histories confirm the important role of members of the extended family, especially grandparents, in providing basic support, notifying concerns and providing first-hand detailed and vital information about infants and toddlers in particular. On the other hand, and at other times, it was clear that the close involvement of extended

family and various types of community support resulted in the failure to report serious concerns. The fundamental importance of forming and maintaining a relationship of trust between the source of support and the caregiver is incompatible with the requirement to report concerns to child protection services – particularly for grandparents who know dare not risk losing contact with their grandchildren for the children's sake. Individual witnesses at the hearing for one of the children suggested that serious concerns had been unreported at the community level.

The issue of Non-Government Organisations receiving continued funding means they also have a vested interest in being seen to be successful in their supportive role, when research suggests that this particular combination of issues is by no means easily or quickly fixed. The lack of properly qualified or trained staff involved in supporting families and vulnerable infants with a range of serious and complex health and social problems is a serious concern.

The unwillingness of doctors to notify concerns is a well acknowledged fact within the research community and the child protection community alike, which leads to caregivers seeking help from their GPs and hospitals, rather than risk engaging with child health nurses who are more likely to report them.

Close relatives such as maternal and paternal grandparents were able to provide the most useful and detailed information. A bias against fathers was very apparent in the present study and in the case files, which commonly resulted in assumptions of the reported concerns being malicious or unfounded, with little or no further investigation being carried out. There was a very strong focus on establishing the veracity of the notified concern and the intent of the notifier, particularly if it was an ex-partner or non co-resident father. Unfortunately, within the mandatory reporting system, non-mandated reports are treated with some amount of scepticism, despite the fact that the notifiers are often placing themselves in physical danger by making the report. Given the important information provided by close relatives and neighbours, and evidence that important information was rejected on a number of occasions in the sample above, it is an issue that is worthy of further investigation.

Measures of frequency, severity and/or chronicity

There was an obvious advantage in being able to assess frequency – and levels of severity and chronicity – in terms of the constructs of need (the smaller risk factors) and subtypes (the larger risk factors), rather than simply in terms of the number of notifications of a particular 'incident' of some vague and undefined form of neglect. The results suggest that current methods of measuring frequency, severity and chronicity in maltreatment research which rely on the number of notifications over time need to be further refined – in light of the nature of neglect generally and in light of cases involving serious harm which for a variety of reasons go unreported.

While the frequency scores calculated for this study are dependent to a large extent on the number of notifications – and the length of time over which the family is reported before some form of intervention and/or critical event occurs – they are not the straightforward notification rates that are used in most neglect research. Factors such as the amount and quality of the information that was provided by the notifier and sought in the investigation process contribute to the number of constructs of need which are able to be identified for the SIs in the family.

Validity

Initial validity testing found a strong relationship between the constructs of need and the child outcomes; however, it was not possible to infer a cause and effect relationship between them due to the necessarily small number of cases. The higher levels of chronicity and severity – and accumulated risk – found in the chronic neglect sample was accompanied by a higher incidence of harm among the infants in Sub-sample 2, which lends further validity to the SCAN's potential use as a measurement system for research, and as an additional risk assessment tool for use in practice with infants and toddlers.

The results of the testing, and the aforementioned findings, infer that further testing and validation of the classification system with larger samples would be worthwhile. The validity of the system is enhanced by the fact that the constructs of needs deemed essential for normal development proposed within this study and those proposed by

Dubowitz et al. (2005) were based on empirical findings. The finding that the two groups of families were in fact different – in terms of outcomes and in terms of the relative proportions and presence of different sub-types of neglect – also validates the selection of these two particular sub-samples to develop the classification system for more general neglect research, as well as for use in professional practice as a risk assessment tool. However, further research and testing is needed, with larger samples and more detailed and accurate information regarding the outcomes and experiences of the children, in order to validate the constructs of need that have been identified for each of the neglect sub-types and the proposed method of measuring the various dimensions of the problem.

Conclusion: Clarifying the definitional issues

The foregoing research has demonstrated the multiple benefits of having broad, clearly spelt out operational definitions for research, as argued by several writers specialising in definitional issues and early childhood neglect research. The needs-based definitional approach used in the SCAN provides a range of basic needs as distinct sub-types of neglect which can be used to measure the dimensions of the neglect experience of the child, in terms of the severity and chronicity of the child's experience. The use of broad definitions such as this would help child protection workers and lawyers to provide better advice to the Courts and better evidence of the nature of the child's neglect experience.

Defining neglect in terms of basic care and protection needs is a simple answer to the problem of trying to establish what general or acceptable standards of care might be – care and protection needs essential to normal development, health and wellbeing are standards in themselves. Notions about what these needs are may change with cultural and social norms, but the fact that it is a right of children to have their basic needs met will not. There is a very strong argument to be made for simplifying the ever-growing forms of maltreatment and that abuse would be more suitably conceptualised as an unmet need for physical and emotional safety and security, as a form of neglect in fact.

This research was strongly founded upon the notion that defining neglect in terms of parental acts or omissions is more harmful than it is helpful for the reasons discussed

throughout the thesis. It is generally accepted that one way of differentiating between neglect and abuse is to describe the former as an omission of care, or failure to act, and the latter as an act against the child. Unfortunately, there is some confusion about what is and is not regarded as an action, especially with regard to emotional abuse, which brings the concept of 'parental intent' into the picture. The confusion arises from the fact that it is not always possible to differentiate between abuse and neglect on those grounds.

The question of whether definitions should be restricted to clear instances of physical harm is vitally important to neglect in general and neglect in this age group in particular. Hopefully, it has been demonstrated here that waiting for evidence of harm is the problem that most urgently needs to be addressed. It results in tragic loss of life and serious and permanent harm to the future health, development and well being of the infants and toddlers in this study and to many others like them.

CHAPTER 7

Conclusion

The research presented in the foregoing chapters leaves little room for doubt that the development, health and wellbeing of infants and young children continue to be jeopardised because their basic care and protection needs are not being met within the family or the wider community. The findings validate continuing concerns about the ever-widening gap that exists between the nature of the problem and the way it is conceptualised and defined in research and the way it is conceptualised, defined and responded to within child protection and multi-professional practice (e.g. Besharov 1981; Wolock & Horowitz 1984; Zuravin 2001). Considering the severity of the consequences of neglect in infancy, and the general findings of ever-increasing numbers of notified cases of neglect in this age group, this lack of alignment between the nature of the experience and the definitions currently being used to guide research and practice is a matter of fundamental importance for the children and for every aspect of the field.

The primary aim of this research was to gain a better understanding of the nature of neglect during this vital period of child development and to work towards the development of a conceptual definition that would help to close the existing gap between the problem and the multi-disciplinary response to it. The second aim of the research was to investigate neglect in this age group in terms of notification rates and patterns of referral and response, and to establish some reliable child protection data for this group in an Australian context. The main objectives of the research were to –

- investigate (a) the 'incidence', or yearly notification rate of abuse and neglect for all infants (< 48 months) notified to the Department in the 2005 calendar year in two child protection regions in Tasmania; (b) the general pattern of referral and response for infants notified during the 2005 calendar year; and (c) the pattern of referral for the infants and their sibling family groups over a period of four years;

- develop a classification and measurement system for the research, which provides conceptually sound operational definitions of neglect in infancy and early childhood that can be applied across the domains of research, practice and policy;
- explore the nature of the neglect experience in the early developmental period from before birth through infancy and early childhood (< 48 months of age) – in terms of unmet basic care and developmental needs – and identify any specific unmet needs relating to cases in which infants or young children have died;
- clarify the definitional issues that are currently impeding effective research, policy and practice, including the nature of the relationship between abuse and neglect.

In this chapter, the contributions of the research are summarised and discussed in light of the research aims and objectives and in relation to some of the main issues and concerns that have been raised in the thesis.

Referral patterns and rates for the 0-4 age group

Study One covered a period of particular turbulence in the annals of child protection in Tasmania which added another dimension to the findings of the study. Although some of the findings reflect the overloaded state of the system and the substantial systemic changes that were taking place during this period in Tasmania, and in Australia more generally, they are nonetheless able to provide a picture of the overall pattern of referral and response at a time when thresholds for what is considered to be a child protection concern have been raised. The main contributions of Study One were:

- the collation of reliable data relating to the referral and re-referral rates to child protection for children in the 0–4 age group in rural and urban communities in an Australian context;
- a description of the general patterns of reporting and response to abuse and neglect for children in this age group over a one year period, and an exploration of the referral pattern for infants and their sibling groups throughout a four-year period;
- identifying the unique characteristics of notifications of neglect and abuse relating to children aged 0–4 in the child protection population.

The study was able to confirm that infants less than 48 months of age were a unique group within the general child protection population in a number of ways. The pattern of referral for the group was found to differ from the general child protection population – neglect and 'emotional abuse' concerns were notified at a significantly higher rate, and physical and sexual abuse concerns were notified at a significantly lower rate in the younger age group. Within the group, the proportion of neglect compared to abuse was found to be significantly higher in the 0–1 age group, with the likelihood of physical abuse and sexual abuse increasing with age.

The findings confirmed the concerns expressed in a number of reports at the time that the basic care and protection needs of a large proportion of vulnerable infants and toddlers were not being met by their families, communities or the child protection system(s) (e.g. Jacob & Fanning 2006; Liddell et al. 2006). The extraordinarily high notification rates for abuse and neglect (15%; per-child rate of 6.9 %) were partly due to the high proportion (33%) of mandatory notifications of 'emotional abuse' (or exposure to domestic violence incidents) from the police, and the other systemic and procedural changes that were introduced during the period, but the high staff turnover and severe lack of resources were also more than likely to have had a negative impact on the quality of the initial assessments and the adequacy of the response that led to the re-notification of many infants, particularly those suffering from chronic neglect (see, e.g., Horwath 2005a, 2007; Jacob & Fanning 2006). Other unknown factors correlated with a high level of socio-economic disadvantage among the families would have contributed to the high notification rate.

The re-notification rate for the infant family groups in this child protection population was almost twice as high as re-referral rates reported elsewhere (see, e.g., Connell et al. 2007; Forrester 2007). While the re-referral rate indicates the poor level of effectiveness of the child protection system generally (e.g. Forrester 2007), the overall lower level of response to neglect compared to abuse points to the inadequacy of the response to neglect in particular. The high re-referral rate also points to the inherently chronic nature of maltreatment generally for this age group. The problem being that most of the maltreatment research refers to 'recurrences' of neglect and abuse, as if chronic neglect in infancy occurred in single incidents – as if it were abuse, in fact. It raises the important question of how the dimension of neglect 'chronicity' in infancy should be

defined. The continuous nature of child maltreatment in this age group, and the lack of response to it, was evident in the pattern of notifications for families who remained in the system over the three-year period. Interestingly, and unlike previous findings, increasing numbers of children in the family did not appear to lead to an increase in the number of notifications over time.

In confirmation of previous findings, neglect was the most frequently reported maltreatment type, and the least likely to be regarded as a child protection concern or to receive a high priority response. The low level of initial investigation and priority response classifications given to neglect (and emotional 'abuse') compared to physical abuse suggests that even in this age group, neglect is considered to be less serious or, more probably, less *immediately* harmful. It reflects the tendency of risk assessments to lead to a more incident-based response and to focus on immediate risk and harm. The findings further strengthen the argument for a different approach to the assessment of risk – as well as a different approach to conceptualising the problem.

Rural and urban differences

There was evidence to suggest under-reporting of concerns for infants in rural regions of the state. The study found a strong difference in the reporting patterns for infants in rural and urban areas, with rural areas showing significantly lower reporting levels than those found in urban regions. Furthermore, it was the most vulnerable age group of infants less than 12 months who were found to be less likely to receive a report than their urban counterparts. The differences in the source of notifications for children in this age group suggested further that they were likely to be less visible within the community. The level of socio-economic disadvantage for the families in the sample was also found to be greater for those residing in rural communities compared to those residing in urban areas.

Implications for policy and practice

The Study One findings reflect what happens to cases of neglect in particular when thresholds are raised. The shift to a support service approach to protecting (neglected) children assumes that child neglect and abuse are being over-reported, based on the fact that only a small percentage of cases end up being substantiated. These and the Study

Two findings relating to cases of death and serious developmental and other harm suggest that neglect in this vulnerable age group are more likely to be under-reported, and less likely to be either investigated or substantiated. The findings point to the danger of further under-reporting and lack of response to chronically neglectful families because of their involvement with support services.

The risk is that infants whose fundamental care and protection needs are not being met will slip through the 'Gateway' at one end of the system, simply to return to the front door of child protection once the harm has become evident. The findings of Study Two revealed that cases regarded as chronic 'lower level' concerns have serious consequences for infants in the child protection population. The accumulated findings here support those in the literature suggesting that thresholds for neglect are already too high; especially in those cases involving child deaths and serious injuries (e.g. Brandon et al. 2008; Howarth 2005a, 20). The lack of recognition of the serious and sometimes fatal consequences of neglect in early childhood on the part of child protection practitioners is an ongoing problem, with serious case reviews revealing that services fail to intervene at an early stage to prevent problems from worsening, and they were particularly poor at addressing the problems that had already occurred as a result of chronic neglect (Brandon et al. 2013).

One of the more concerning findings of Study 1 was that the chronicity or frequency of the reports for families who had lower notification rates in 2005 appeared to increase for these families over the subsequent years. The notifications for families with higher notification rates in 2005 also continued, but the average frequency rates appeared to reduce slightly over time – perhaps because they were more likely to have received some form of intervention or support. Considering the cumulative nature of the effects of chronic neglect in this age group, and the evidence of under-reporting, the practice of relying on the number of referrals to help assess levels of chronicity and/or risk is likely to be jeopardising the health and wellbeing of infants – some of the serious cases reviewed in Study 2 bear this out.

This study provides additional evidence that, for this age group, at least, rumours of over-reporting have been greatly exaggerated. There was a considerable amount of evidence in the Study Two sample to suggest that under-reporting is a problem –

especially within the support service system and in community health generally. A large proportion of cases in which infants died or suffered immediate and long-term physical and psychological harm may well have been prevented if the concerns had been reported – and responded to.

The classification system

In one way or another, each chapter in the thesis points to the need for a universally accepted definition of neglect that takes into account its heterogeneous and multi-dimensional nature. A unified eco-developmental approach to defining neglect based on infants' basic needs was considered to be most appropriate for that purpose, in light of the fact that each of the perspectives on the problem is considered to have something unique to offer. The study lends further support to the view that a systematic approach to the classification and measurement of neglect would lead to greater consistency and precision and better comparability of findings in research, and would serve as a useful guide to identifying and assessing neglect in practice (Barnett et al. 1993).

The main contributions of this aspect of the research were:

- the identification of empirically-based constructs of need and sub-types of neglect to further the development of a conceptual and operational definition of neglect based on the developmental and care needs of infants (<48 months);
- the design and development of a classification and measurement system (System for Classifying and Assessing Neglect – SCAN) using the operational definitions developed for the purpose; and
- a proposed new method of measuring and/or assessing neglect frequency, severity, chronicity, and/or accumulated risk for infants and young children in this vulnerable age group.

The needs-based approach employed here represents a radical, though sorely needed, departure from current methods of defining neglect based on parental behaviours and harm to the child. The particular advantages of this approach are that it draws the focus back onto the child – and away from the issue of parental blame and intent – and brings the definition into closer alignment with the neglect experience itself. To ensure an even

greater proximity between the two, the operational definitions were developed in tandem with the in-depth readings of case files and the exploration of neglect in Study Two.

Defining dimensions and measuring neglect

Research in the field of neglect is very much a matter of bridging the gaps and overcoming the definitional hurdles. Not only is there no generally accepted method of defining abuse and neglect to be had, there is no agreed-upon, or appropriate, definition of the dimensions in which it is measured. Current methods of measuring the dimensions of maltreatment fail to take into account the multi-dimensional and heterogeneous nature of the phenomenon during infancy and early childhood. This research proposes an innovative method of conceptualising and measuring the dimensions of frequency, and thence levels of severity and chronicity of neglect, which more adequately reflects its inherently chronic, continuous and diverse characteristics during the early stages of development. In the approach proposed here, frequency is conceptualised and measured in terms of the number of constructs of need at any one time and/or over time, rather than the number of notifications received.

The importance of identifying the full extent of the child's experience of neglect was noted in the Victorian Child Death Review Committee's (2006) report, with the recommendation that child protection practice take into account the cumulative effects of children's maltreatment experience, particularly the cumulative effects of co-occurring forms of neglect. It is exactly this sort of assessment that the SCAN aims to achieve. It is suggested further that this method would be easily adaptable for professional practice to provide a more specialised, precise and realistic assessment of risk. It would be of particular benefit in the assessment of cumulative risk for highly vulnerable babies who have additional health concerns such as those born dependent on or otherwise affected by exposure to drugs and alcohol, and/or who are premature and/or of low birth weight.

All in all, the benefits of the systematic approach for both research and practice are that it can be used as a guide to identify the wider range of unmet needs and as a tool to assess levels of risk. The particular usefulness of the system lies in its ability to (a)

focus on the child's broader maltreatment experience, from the perspective of the child (b) identify both the smaller risk factors (constructs of need) and the larger risk factors or issues (sub-types of neglect); and (c) summarise the risk factors to assess the accumulated risk that they pose to the child – both in terms of the combined effects of co-occurring risk factors as well as in terms of the experience of the past.

Implications for research and practice

In light of the findings of this study and the literature on neglect more generally, the research supports the following proposals –

- that the constructs of need and/or sub-types of neglect identified here be used to further the development of the definitions proposed by Dubowitz, Newton et al. (2005) and English, Thompson et al. (2005):
  - provision of physical and emotional care and nurture;
  - protection from harm and/or safety;
  - provision of psycho-social developmental needs;
  - protection from prenatal and perinatal harm and provision of prenatal care;
  - general (unspecified) unmet basic care and protection needs, due to parental incapacity.
- that the dimensions of the neglect experience itself be measured and assessed in terms of the frequency measures proposed here for the purposes of assessing levels of severity and chronicity for research and assessing levels of risk in professional practice.

The nature of neglect

The neglect experience of the infants and toddlers was explored using the conceptual definitions and constructs of need operationalised in the classification system. The main contributions of Study Two were:

- adding to current understandings of the nature of neglect during the prenatal and early years of child development to further the development of a needs-based definition of neglect;

- a demonstration of how the conceptual definition is operationalised within the system for classifying and measuring (or assessing) neglect in infancy and early childhood;
- improved understandings of neglect and its role in the preventable deaths of infants and young children known to child protection – with the identification of the unmet care and protection needs of infant whose deaths were unexpected (SIDS) and/or unexplained and those who died in circumstances involving both abuse and neglect; and
- findings relating to the characteristic features of and differences between families in which deaths have occurred and those in which children have suffered serious harm caused by or associated with neglect.

Study Two demonstrated the use of the classification and measurement system and its ability to identify and measure a wide range of unmet needs, and their varying levels of frequency, severity and chronicity, during the early years of development – regardless of the type of harm that was known to have occurred, regardless of the classification of the notification, and regardless of the number of notifications received. The findings confirmed that neglect during prenatal, infant and early childhood development is an inherently chronic, pervasive, heterogeneous, and multi-dimensional set of phenomena. Its multi-dimensional and heterogeneous aspect means that the problem is measurable in those terms – rather than in terms of the severity of the observable outcomes or the parental care. Its potentially harmful nature suggests further that the actual experience of neglect itself should be measured, rather than the harm that has almost certainly occurred but that may not yet be visible.

The experience of neglect within the sibling groups was diverse and multiple, with each family experiencing at least six sub-types of neglect, and with the majority experiencing all eight. The process of developing and applying the framework, and the findings of the study, confirmed the inter-relatedness of the psychological and physical aspects of neglect. Sensitivity and responsiveness to an infant's cries of hunger or discomfort (200), for example, has a range of physical and psycho-emotional aspects – as well as having a wide range of physical, neurological and psychological effects. Similarly, the

commonly unmet basic physical care needs such as food, hygiene and medical care had a strong psycho-emotional component in this age group.

'Protection from physical and psychological harm' (300) and the 'provision of physical and psychological care' (200) were the most commonly identified neglect subtypes. 'Protection from harm' was found very much at the heart of and inter-related with abuse and other forms of neglect relating to the protection of the infants' physical and psychological development, health and wellbeing. Unmet physical and emotional care and protection needs were found to be varied in form, pervasive, and continuous in nature – and intrinsically bound. Both of these sub-types are deemed to be an essential component of the definition of neglect – needs-based or otherwise. The findings point to the need for conceptual understandings and definitions that take into account the inter-relationship between neglect and abuse.

The basic developmental care and protection needs in particular were found to be of a continuous character rather than incident-based – the (known) harmful developmental and health outcomes testify to the persistent, continuous and cumulative, or chronic, nature of the problem. It is the degree of chronicity in infancy that may well help to distinguish an infant in need of care and protection and a family in need of support. The degree of chronicity is influenced by the number of different types of unmet need being experienced at any one time as well as the persistence of the problem over time.

The developmental stage at which neglect occurs is one of the most fundamentally important dimensions of neglect. It is central to the argument for a needs-based definition aimed specifically at this age group, and the importance of assessing the severity of the neglect rather than the severity of the harmful outcome. The severity and sub-type of neglect varied substantially according to the care and protection needs relevant to the particular phases of foetal, infant or early childhood development. And therein lies another danger of definitions based on caregiver behaviours – they fail to take into account either the variable nature of the experience or their less visible harmful effects.

Unmet psycho-emotional and physical care needs not only had a negative impact on children's ongoing development, they were also found to be closely associated with

unmet protection needs. Both types, in turn, were strongly related to the chronic substance abuse problems that were so prevalent among primary caregivers in this sample, and in the cases of neglect in this age group more generally. Drug and alcohol problems were exacerbated by the fact that most of the caregivers were single, and/or were in unstable and often violent relationships, which resulted in further instability for the infants and exposed them to further emotional trauma and extensive risk of harm.

The rate and serious nature of harmful outcomes for the newborn infants point to the need for greater protection of the developing foetus at the level of the individual and in multi-disciplinary practice. The primary form of prenatal neglect was exposure to maternal substance mis-use, in combinations of legally and illegally prescribed drugs and/or alcohol, including medication that are known to pose a risk to the developing foetus. The mis-use of methadone during pregnancy, and 'doctor shopping', was a serious concern, considering the serious outcomes for a number of infants who suffered outcomes such as those described in the literature, including harmful neurological and developmental effects, NASD, risk of prematurity and low birth weight.

Infants exposed to methadone and substance mis-use in general were found not only to have suffered ill-effects at the time but to suffer further neglect and a wide range of developmental and other harms. Considering that the full extent of the negative outcomes for newborn infants was not known, the reported rates of NASD, prematurity and congenital anomalies was unacceptably high. There is evidence to suggest that the medication needs (or demands) of mothers are being given precedence over those of their unborn child.

There was a certain amount of normalisation of drug affected, premature and under-nourished infants in the reports, with very little reference to the hidden and sometimes apparent developmental effects that had undoubtedly accompanied these external signs of harm. The acknowledged reticence of some medical professionals in this state to diagnose Foetal Alcohol Syndrome may protect parents from distress, but it does not help the infant in question or those subsequently born to mothers with alcohol dependency problems. There also appeared to be a veil of silence around the disturbingly high rate of congenital anomalies among infants exposed to legally and illegally prescribed drugs.

Neglect in cases involving the death of a child

The nature of the neglect experience of infants in families in which an infant or child had died was found to be significantly different from the experience of those infants who had suffered neglect-related harm. The differences were based on the presence-absence scores, rather than frequency scores, which means that this difference is not due to the number of notifications received. The families in which an infant or young child had died did have lower levels of severity and chronicity overall – however, it was not possible to test whether these differences were real or not in a sample of this size. The finding that the child death sample had a significantly lower incidence of harmful child outcomes overall than the cases of neglect-related harm did provides further support for the conclusion that the nature of the neglect being experienced was different for the two groups – on the whole. However, the child death sample had a slightly higher incidence of neonatal outcomes, which points to where the differences between the two sub-samples lie. There were two sub-types of neglect that did not follow the general pattern: 'protection from harm' and 'prenatal neglect' were unique in having higher levels of severity and chronicity than the 'neglect-related harm' sample.

These findings are not entirely consistent with the DoCS (2006) reported finding that "the characteristics of families in which neglect-related deaths occur are not distinguishable from the characteristics of families in which neglect is chronic" (p. 9). However, given that the cases selected for the neglect-related harm sample were at the more serious end of the severity scale as far as chronic neglect is concerned – and in light of the findings by Brandon et al (2008) that neglect-related deaths often do not meet the thresholds for child protection intervention – it is possible to conclude that families in which neglect-related deaths occur are more like the 'less severe' cases of chronic neglect reported to child protection services on a daily basis. However the specific features that were found in child death cases may serve to better identify infants at potential risk, and differentiate them from the less severe cases of chronic neglect in this age group. More research is needed to confirm these findings.

The number of infants born drug affected and with congenital disorders was approximately three times greater in the child death sample. The number of children

(five) in the sample who were born with congenital anomalies was particularly concerning – especially when compared to an estimated five congenital anomalies per one hundred births in the general population. It was also noteworthy that, proportionately, parental risk factors were present to a much higher degree in this sub-sample compared to child deaths of children known to child protection in Victoria in 2006–07 (VCDRC 2007). All three parental risk factors of family violence, substance use and transience were present in 100% of cases, with serious mental health concerns co-existing in approximately 70% of cases (VCDRC 2007, p. 31).

High levels of transience between rural and urban areas and apparent social isolation associated with a drug-dependent lifestyle resulted in the under-reporting of two child death cases. Under-reporting also occurred in situations that were considered safe due to the close involvement of a family member, support worker or other community service provider. The low number of notifications for the family in one of the most extreme cases of neglect and abuse highlights the importance of taking into account the information provided in each and every notification, especially non-mandated reports from fathers and family members who are in a position to provide vital information about the day-to-day circumstances of infants and toddlers. But it particularly emphasises the importance of thorough assessments, in which the wide range of past and present unmet needs are identified and the accumulated level of present and potential risk which that poses is assessed.

The single focus of risk assessments on immediate risk and harm and the overly optimistic reliance on safety factors proved to be inadequate if not dangerous in current child protection practice. There was ample evidence that the essential care and protection needs of every one of the infants in the sample who were known to child protection at the time would not have been being met on a continuous basis. This study confirms that infants and very young children die as a direct or indirect result of chronic neglect, whether deaths are deemed accidental or not. Professional expertise and guided assessment tools are needed to ensure thorough assessments that take into account the varied continuous and pervasive nature of the neglect within the family as a whole, in order to assess the aggregated level of severity and risk to the infant.

Measuring neglect and assessing risk

The capacity of the SCAN to measure levels of severity and chronicity of neglect and/or to assess the level of developmental risk for the purposes of research and practice has been demonstrated. This method provides a more appropriate and useful measure of frequency, chronicity and severity of neglect in infancy and early childhood than those currently used in research. It provides a similarly useful measure to assess the accumulated risk of developmental harm for the purposes professional practice. It is proposed further that, instead of measuring chronicity and severity in terms of unknown harmful outcomes or parental actions, severity and chronicity can and should be measured in terms of the neglect experience of the child.

Implications for research and practice

Ample support was provided for the proposal of a broad, concise needs-based definition of neglect for the purpose of identifying, classifying and measuring (or assessing) the experience of neglect prenatally and during infancy and early childhood for research. The study demonstrated the capacity of this systematic method of defining and measuring the dimensions of neglect to provide a more refined and accurate measure of levels of severity and chronicity which takes into account the heterogeneous, multi-dimensional and chronic nature of neglect. The potential value of this method for the purposes of assessing risk for very young and newborn infants in practice situations is that it identifies the various types of needs that are likely to be unmet – which has been shown to be of vital importance in cases of death and serious harm – and it is less dependent on the number of notifications and the duration of the experience.

Most importantly, identifying the unmet needs of children as soon as or even before they are born increases the likelihood of preventing the otherwise inevitable developmental harm from occurring. By the time children reach early childhood and school age, the neuronal damage has already been done and the nature of child development is such that the harms will accumulate throughout childhood and its effects will continue into adulthood (e.g. Belsky 1984, 1993; De Bellis 2005; Erickson & Egeland 2002; Perry 2002) – when the cycle will inevitably be repeated in the next generation.

The main implications of the research findings on the nature of neglect are as follows:

- More definitional research is needed to further develop a definition of neglect aimed specifically at infants during the early stages of their development (<48 months of age) with larger samples and a more extensive source of information about the nature of the child's actual experience and their developmental and other health outcomes.
- A new approach to defining and assessing neglect in infancy and early childhood is needed in multi-disciplinary policy and practice, which (a) is more conceptually and theoretically sound, (b) is more easily and consistently applied, (c) takes into account the care and protection needs essential to normal development, health and wellbeing, and (d) is better able to assess or determine levels of potential risk and harm.
- More research is needed on the nature of neglect and its involvement in cases of unexpected or unexplained deaths in particular and child death cases in general.
- It is time for a discussion about and a move towards the inclusion of neglect as a classifiable cause of infant death in child death review processes and reports more generally throughout Australia, in line with parts of the United States.
- In particular, findings relating to the child death cases point to the need for ongoing expert assessment of infants exposed to mis-use of legal and illegal drugs prior to their birth, and/or whose essential care and protection needs are at risk of being unmet after their birth due to a combination of risk factors that defy intervention or treatment.
- They also highlight the need for practitioners to actively seek out information from as many sources as possible – including in the notification history for the siblings as well as the child in question, from fathers and relatives, and from the research literature.
- The high incidence of neonatal harm points to the need for further research to explore the problem of neonatal exposure to drugs in an Australian context – in particular, the level of mis-use of methadone and other medications that pose substantial risk of neurological and other developmental harm to the foetus.

- The overall findings indicate a need for expertise and specialised assessment of the care and protection needs of infants (< 48 months) to be conducted at the first point of call in child protection practice.
- The findings point to the importance of assessing primary caregivers' ability to prioritise and meet the needs of their infants, and the need to consider parallel permanency planning at an early stage of the intervention process.

The reality of the situation is that the combination of drug and alcohol addiction and mental health problems and/or intellectual disability is neither readily nor easily fixed. It poses an unacceptably high risk of devastating harm to infants before and after they are born. The level of harm that was identified among this sample of infants, one after another in some families – together with the fact that many of the families were supposed to be or were engaged with a range of supports and support services at the time – indicates that it is time to rethink our family preservation policies in Australia. The evidence shows that the earlier that infants can be placed in a loving, secure and stress free environment, the greater the chance they will have to recoup the losses in neuronal brain development, and in their general physical and psycho-emotional and psycho-social development.

Babies need love. They need to experience it physically and emotionally, to know that they are loved – the sort of love babies need is in the doing and the giving of it, rather than just the idea of 'the thing called love'. And they need both to feel and to be safe and secure. Protection from harm is a vital 'need' and one that is essential to infants' health, safety and wellbeing. It is also considered to be a vital ingredient of any definition of neglect.

Towards a resolution of the definitional issues: Closing the gaps

This research responds to calls within the literature to work towards improved conceptual understandings of neglect during infancy and early childhood, in an effort to bring the nature of the experience of neglect into closer alignment with the way it is currently conceptualised and defined in research, policy and practice (e.g. Barnett, Manly & Cicchetti 1993; Belsky 1984; Besharov, 1981; Cicchetti & Manly 2001; De

Bellis 2005; Dubowitz, Black, Starr & Zuravin 1993; Goddard & Tucci 2008; Wolock & Horowitz 1984; Zuravin 2001). The development of a practical system for classifying and measuring (or assessing) neglect is a further attempt to close the gap between the serious nature of the problem and the way it is currently addressed in research and multi-professional practice (Barnett et al. 1993). The system addresses some of the main issues and difficulties that currently impede research and practice in the field.

Neglect is a noun as well as a verb. Defining neglect in infancy and early childhood in terms of the unmet care *and* protection needs that are essential to normal development, health and wellbeing addresses a range of issues and concerns that have been identified in the thesis as impediments to good quality research, policy and multi-disciplinary practice. The study lends support to the argument made by Dubowitz and his colleagues (1993), that a definition based on essential developmental needs fits within the ecological perspective and has the capacity to take into account the range of associated parental and social factors that need to be identified for the purpose of treatment and intervention. It is worth noting that the needs included here are only those that are considered 'essential' to 'normal' development and wellbeing, which goes some way towards addressing the question of what 'basic' care needs may or not include (Zuravin 1999).

Compared to the current approach, based on parental actions or inactions and harmful outcomes, a definition based on essential needs more easily addresses the question of minimal standards of care raised by Garbarino and Collins (1999), insofar as they can be readily adjusted to fit changing social norms and social problems over time, are less culturally bound, and take into greater account new knowledge about human development. It could be argued that the care and protection needs essential to normal development, health and wellbeing are standards in themselves. This approach brings the focus back onto the child and identifies the essential needs that are not being met, regardless of the cause – which is one of the main stumbling blocks in the current definitional debate as well as practice (e.g. Dubowitz 1993; Horwath 2011; Lawrence & Irvine 2004; Ofsted 2010; Zuravin 1999). It also diverts attention away from the issue of parental blame and intent – which appears to be well nigh impossible to determine anyway – while allowing the identification of parental risk factors, and thereby

increasing the likelihood of parental understanding, co-operation and engagement with supports.

It also takes into account the fact that the harm associated with neglect is not necessarily immediately observable or imminent. And the outcomes described in Study Two highlight the dangers of a definition and a risk assessment process that focuses on incident-based harm that is already evident – that is, it is visible and/or has already occurred – or is at risk of (re-)occurring in the near future.

Much of the confusion and debate stems from the fact that abuse and neglect and emotional maltreatment are defined in terms of parental acts that harm the child. The focus on abuse has directed the attention onto parental behaviours and harmful outcomes, which is incompatible with the nature of emotional maltreatment and neglect. Attempting to define emotional maltreatment in terms of what the person responsible does or does not do, intentionally or unintentionally, or the harm they may or may not incur is a self-defeating exercise. It may well apply to the problem of abuse, but it has little relevance to the nature of psychological, emotional or physical neglect.

The needs-based conceptual approach clarifies and takes into account the conceptual differences between abuse and neglect which will lead to better understandings of the problem. The vagaries and the confusion surrounding current definitions have led to an ever increasing number of overlapping forms of maltreatment which are not necessary and which decrease the likelihood of identifying their causes and providing appropriate treatment.

This definition of neglect takes a multidisciplinary approach to the problem, within which to attend to its heterogeneous and multi-dimensional nature. The broadness of the conceptual definition is more likely to make judges happy, the multi-disciplinary nature of the approach makes it useful within professional practice generally, and its concise terms can help to guide researchers and practitioners alike to identify, classify and more adequately measure and assess the problem.

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APPENDIX A

Box A2.1. The Definition of 'a neglected child' under the *Infants' Welfare Act 1935*

"Neglected child" means a child –

I. Who is found in a brothel or reputed brothel, or a place where opium or any preparation thereof is smoked, or who is known to associate with or be in the company of a person known to the police, to be, or reputed to be, a prostitute, whether such person is the mother of the child or not;

II. Who associates or dwells with any person known to the police, to be, or reputed to be, a thief or drunkard, or with any person who has no lawful means of support;

III. Who begs in any public place, or habitually wanders about ... or sleeps in the open air in any public place;

IV. Who is not provided with the necessary food, nursing, clothing, medical aid, and lodging, or who is neglected, ill-treated, or exposed by his parents or either of them;

V. Who, being of the compulsory school age, is an habitual truant from day school, or whose parent has been convicted at least twice of neglecting to cause such child to attend school;

VI. Who is illegitimate, and whose mother is dead, or is unable to maintain or take charge of such child;

VII. Who takes part in any public performance whereby the life or limb of such child is endangered;

VIII. Who being a female, solicits men, or otherwise behaves in an indecent, improper, or disorderly manner, or habitually wanders at night without sufficient cause;

IX. Under the age of fifteen years found doing any of the things referred to in division (a) of paragraph 1. of section 109 ... [relating to the employment of children]

X. Who is found by a children's court to be an uncontrollable child.

XI. Whose home, by reason of the neglect, cruelty, or depravity of his parents, or either of them, is an unfit place for such child; or

XII. Who dwells with, or in the same house as, any person known to the Director to be suffering from a venereal enthetic disease or from pulmonary consumption in conditions which a medical officer of health has certified to be dangerous to the health of such child. (Section 3, *Infants' Welfare Act 1935*)

Box A2.2. Guiding principles of the Act 1997 (Sections 8 and 9)

8. Principles to be observed in dealing with children

(1) The administration of this Act is to be founded on the following principles:
(a) the primary responsibility for a child's care and protection lies with the child's family;
(b) a high priority is to be given to supporting and assisting the family to carry out that primary responsibility in preference to commencing proceedings under Division 2 of Part 5 [Care and protection orders];
(c) if a family is not able to meet its responsibilities to the child and the child is at risk, the Secretary may accept those responsibilities.
(2) In any exercise of powers under this Act in relation to a child –
(a) the best interests of the child must be the paramount consideration; and
(b) serious consideration must be given to the desirability of –
(i) keeping the child within his or her family; and
(ii) preserving and strengthening family relationships between the child and the child's guardians and other family members, whether or not the child is to reside within his or her family; and
(iii) not withdrawing the child unnecessarily from the child's familiar environment, culture or neighbourhood; and
(iv) not interrupting unnecessarily the child's education or employment; and
(v) preserving and enhancing the child's sense of ethnic, religious or cultural identity, and making decisions that are consistent with ethnic traditions or religious or cultural values; and
(vi) preserving the child's name; and
(vii) not subjecting the child to unnecessary, intrusive or repeated assessments; and
(c) the powers, wherever practicable and reasonable, must be exercised in a manner that takes into account the views of all persons concerned with the welfare of the child.
(3) In any exercise of powers under this Act in relation to a child, if a child is able to form and express views as to his or her ongoing care and protection, those views must be sought and given serious consideration, taking into account the child's age and maturity.
(4) In any proceedings under this Act ... [the child's family and other interested persons must have an opportunity to present their views in respect of the child's wellbeing]
(5) In any proceedings under this Act ... [the child's family and other interested persons must be provided with sufficient information to enable them to participate fully in the proceedings]
(6) All proceedings under this Act must be dealt with expeditiously, with due regard to the degree of urgency of each particular case.

9. Principles relating to dealing with Aboriginal children

(1) A decision or order as to where or with whom an Aboriginal child will reside may not be made under this Act except where a recognised Aboriginal organisation has first been consulted.
(2) In making any decision or order under this Act in relation to an Aboriginal child, a person or the Court must, in addition to complying with the principles set out in Section 8 –
(a) have regard to any submission made by or on behalf of a recognised Aboriginal organisation consulted in relation to the child; and
(b) if a recognised Aboriginal organisation has not made any submissions, have regard to Aboriginal traditions and cultural values (including kinship rules) as generally held by the Aboriginal community; and
(c) have regard to the general principle that an Aboriginal child should remain within the Aboriginal community.
(*Children, Young Persons and Their Families Act 1997*, S 8 & 9)

Box A2.3: Mandated and non-mandated obligations to report (the Act 1997)

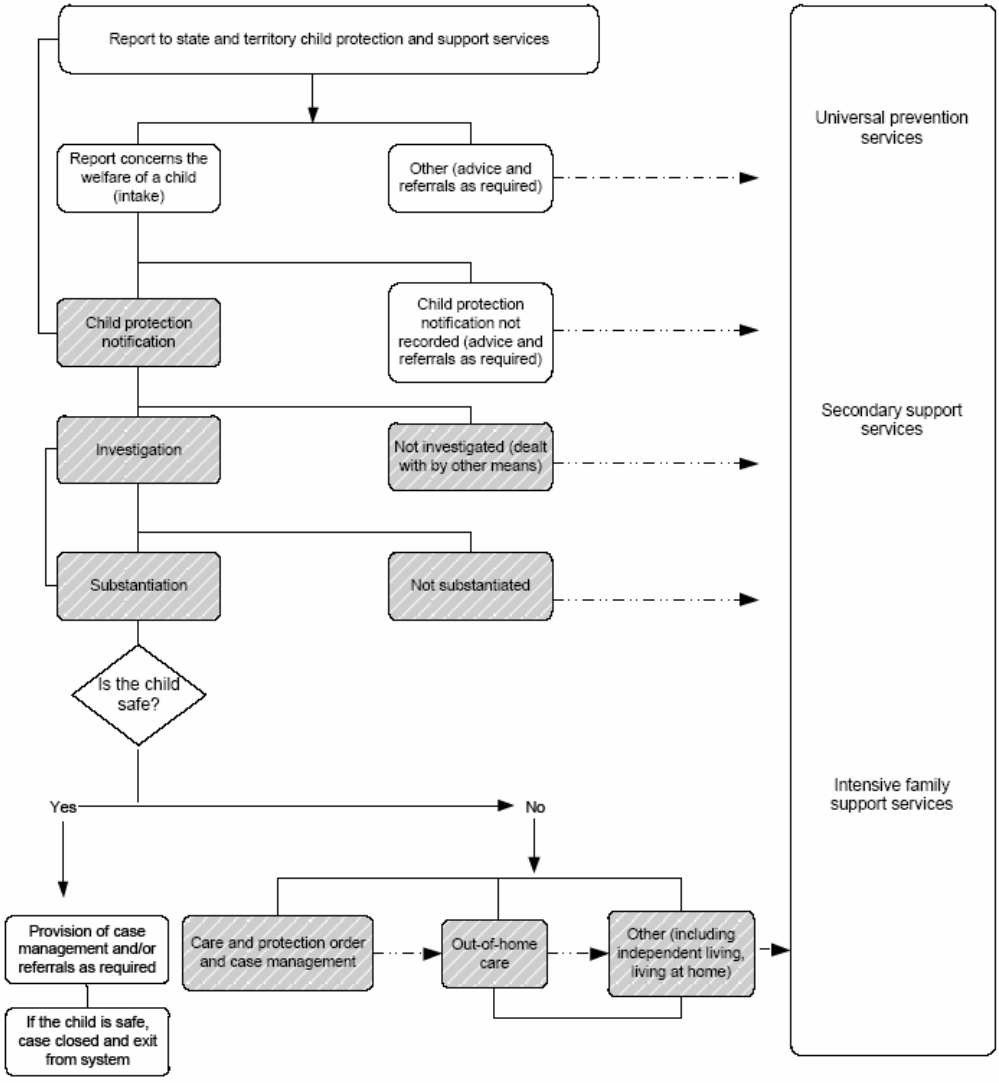
13. Responsibility to prevent abuse or neglect
(1) An adult who knows, or believes or suspects on reasonable grounds, that a child is suffering, has suffered or is likely to suffer abuse or neglect has a responsibility to take steps to prevent the occurrence or further occurrence of the abuse or neglect.
...

14. Informing of concern about abuse or neglect
(1) In this section, "**prescribed person**" means –
(a) a registered medical practitioner; and
(b) a nurse, within the meaning of the *Nursing Act 1995*; and
(c) a person who is registered as a dentist, dental therapist or dental hygienist under the *Dental Practitioners Registration Act 2001*; and
(d) a registered psychologist, within the meaning of the *psychologists Registration Act 2000*; and
(e) a police officer; and
(f) ... ;
(g) a probation officer appointed or employed under section 5 of the *Corrections Act 1997*; and
(h) a principal and a teacher in any educational institution (including a kindergarten; and
(i) a person who provides child care, or a child care service, for fee or reward; and
(j) a person concerned in the management of a child care service licensed under the *Child care Act 2001*; and
(k) any other person who is employed or engaged as an employee for, of or in, or who is a volunteer in –
(i) a Government Agency that provides health, welfare, education, child care or residential services wholly or partly for children; and
(ii) an organisation that receives any funding from the Crown for the provision of such services; and
(l) any other person of a class determined by the Minister by notice in the *Gazette* to be prescribed persons.

(2) If a prescribed person, in carrying out official duties or in the course of his or her work (whether paid or voluntary), believes, or suspects, on reasonable grounds, or knows –
(a) that a child has been is or is being abused or neglected or is an affected child within the meaning of the *Family Violence Act 2004*; or
(b) that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides –
the prescribed person must inform the Secretary of that belief, suspicion or knowledge as soon as practicable after he or she forms the belief or suspicion or gains the knowledge.
Penalty:
Fine not exceeding 20 penalty units.

Table A2.1. Child Protection Service Practice Framework (DHHS 2009)

	Engagement and Assessment	Seeking Solutions	Security and Belonging
Child* Centred (< 18yo)	•Are we thinking about the whole child: safety, security, health and well-being? • Have we thought enough about the vulnerability of the very young child? • Are we engaging and building a relationship with the child? • If moved from home, is the decision fully justified? • Has the child been consulted and informed about practice decisions? •Does the child have someone to talk to about their concerns?	• Has the child been actively involved in decision-making processes, e.g. FGC, Residential Plans? • Are decisions and plans supporting safety, stability and belonging? • Have systemic attachments been maintained, e.g. familial, cultural, social, educational? • Are decisions mindful of the child's timeframes? • Does the child have an advocate or someone they can talk to? • Are services directed toward the child's needs?	• Does this child feel like he or she belongs somewhere? • Does the plan for the child address care, safety, health and well-being? • If in care, have all health and educational checks been done? • Does the child understand about care decisions and what is happening? • Does the child have family mementos, e.g. photographs, life story book? • Is permanency a priority and is placement stability being closely monitored? • Are transitions from care fully planned and supported?
Family-Led and culturally Responsive	• Are we applying a family support response which strengthens the stability of the family? • Is all contact with the family respectful, fully informative and setting the scene for future work? • Has the social worker persevered with engaging the family even when resistance is encountered? • Are we encouraging family ownership of the issues and solutions? • Are we responding to the family's cultural needs?	• Is the family fully involved in the process of decision-making? • Are all family members having an opportunity to contribute? • Are decisions family-led? • Have cultural and broader support systems been mobilised around the family? • Is everyone clear about what the family (and the workers) need to do to make the solutions work?	• Is family reunification a practice priority? • Are family members having regular contact with the child? • Is the family at the centre of care decision-making? • Are we helping the family manage the tensions and dynamics that impact on the plan? • Are cultural support systems mobilised? • Are plans culturally responsive?
Strengths- and Evidence-Based	• Are we clear with the family about our role and power? • Are pro-social values modelled and abuse-supportive dynamics identified? • Is the tension between supporting the family and protecting the child being managed? • Are family decision-making processes being utilised early? • Is the family seen as a care and protection resource? • Are we working collaboratively with professionals involved with the family?	• Does the family have all the information necessary to make sound decisions? • Are decisions linked to family strengths and resources? • Are we addressing family violence dynamics? • Are people working together to support the family and is it clear who is doing what? • Are the right services being provided at the right time? • Does the worker have a relationship with the family that fosters change? • Is progress being reviewed and positive changes reinforced?	• Is permanency being secured for the child to prevent drift in care? • Are professional relationships working positively to support the child? • Are community and cross-sectoral services being mobilised? • Are services well coordinated and are workers getting together to support planning, monitoring and transitions? • Are services and plans being reviewed as agreed?



Notes:

1. Shaded boxes are items for which data are collected nationally.
2. Dashed lines indicate that clients may or may not receive these services, depending on need, service availability, and client willingness to participate in what are voluntary services.
3. Support services include family preservation and reunification services provided by government departments responsible for child protection and other agencies. Children and families move in and out of these services and the statutory child protection system, and might also be in the statutory child protection system while receiving support services.

Figure 1.1: The child protection process in Australia

Figure A2.1. Child protection intake processes in Australia (From AIFS 2013, *Child Protection Australia 2011–12*, p. 2.)

APPENDIX B

B3.1

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MEMORANDUM

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

UTAS

FULL COMMITTEE APPLICATION APPROVAL

22 May 2007

Dr Clarissa Hughes
Rural Health
Private Bag 103
Hobart

Ethics reference: H9269

Child neglect: In concept and practice'.

PhD Candidate: Alexandra Fitzpatrick

Dear Dr Hughes

The Tasmania Social Sciences HREC Ethics Committee approved the above project on 21 May 2007.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the *National Statement on the Ethical Conduct in Research involving Humans 1999* (NHMRC guidelines).

Therefore, the Chief Investigator's responsibility is to ensure that:

1) All researchers listed on the application comply with HREC approved application.
2) Modifications to the application do not proceed until approval is obtained in writing from the HREC.
3) The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
4) Clause 2.37 of the *National Statement* states:
   An HREC shall, as a condition of approval of each protocol, require that researchers immediately report anything which might warrant review of ethical approval of the protocol, including:
   a) *Serious or unexpected adverse effects on participants;*
   b) *Proposed changes in the application; and*
   c) *Unforeseen events that might affect continued ethical acceptability of the project.*

   The report must be lodged within 24 hours of the event to the Ethics Executive Officer who will report to the Chairs.

5) All participants must be provided with the current Information Sheet and Consent form as approved by the Ethics Committee.

6) The Committee is notified if any investigators are added to, or cease involvement with, the project.

7) This study has approval for four years contingent upon annual review. An *Annual Report* is to be provided on the anniversary date of your approval. Your first report is due [12 months from 'Ethics Committee Approval' date]. You will be sent a courtesy reminder by email closer to this due date.
Clause 2.35 of the National Statement states:
As a minimum an HREC must require at regular periods, at least annually, reports from principal researchers on matters including:
   a) *Progress to date or outcome in case of completed research;*
   b) *Maintenance and security of records;*
   c) *Compliance with the approved protocol, and*
   d) *Compliance with any conditions of approval.*

8) A *Final Report* and a copy of the published material, either in full or abstract, must be provided at the end of project.

Yours sincerely

M. Knott

for **Ethics Executive Officer**

B 3.2

CPAARS Notification Report

NOTIFICATION DATA COLLECTION

REGION:
NFA 17 (a)
NFA 17 (b)
NFA under s: 18
Dealt With By Other Means under s: 18
INVESTIGATION PRIORITY RATING (1, 2 or 3):
ALLEGED ABUSE TYPE:

NOTIFICATION DETAILS:
Date:
Time:
Entered by:

NOTIFIER DETAILS:
Name:
Address:
Contact numbers:
Source:

SUBJECT CHILD/REN: **CWIS ID** **Intake No:** **File No:**
Name/s / Sex:
Age/s – DOB:

Address:
Contact details:
Residing with:

PRIMARY CARER DETAILS (1):
Name/ details:
Address:
Contact number:
Relationship to child:
Family status:
CWIS ID:

PRIMARY CARER DETAILS (2):
Name/ details:
Address:
Contact number:
Relationship to child:
Family status:
CWIS ID:

natural / adoptive parent; single parent mother; single parent father; substitute; extended family; blended 2 parent; other

---

ABORIGINAL:

Yes /No /Unknown:

TORRES STRAIT ISLANDER:
Yes /No/ Unknown:

LANGUAGE OTHER THAN ENGLISH:
Yes /No /Unknown:

INTERPRETER NEEDED:
Yes/No/Unknown:

SUMMARY PROFILE

FAMILY PROFILE:
FAMILY AND INFORMAL NETWORK DETAILS **(Child/ren not at risk)**:

Name / Sex:
Age/s – DOB:
Relationship to Child:
Address:
Contact number:

Name / Sex:
Age/s – DOB:
Relationship to Child:
Address:
Contact number:

Name / Sex:
Age/s – DOB:
Relationship to Child:
Address:
Contact number:

FORMAL NETWORK DETAILS:
Name:
Profession:
Address:
Contact Details:

Name:
Profession:
Address:
Contact Details:

FAMILY COURT MATTERS:

ANY INFORMATION TO ALERT CARE & PROTECTION WORKERS:

DETAILS OF NOTIFICATION

INFORMATION GATHERED:

AGREEMENTS WITH NOTIFIER:

S4 RISK ALLEGATION AT NOTIFICATION (Sections of Act):

S4(a) Child has been, is being, or likely to be abused or neglected
S4b (i) Any person has threatened to kill or abuse or neglect
S4b (ii) Any person has killed or abused or neglected other child/adult + likely threat to a child
S4c (i) Guardians unable to maintain the child
S4c (ii) Guardians unable to exercise adequate supervision/control
S4c (iii) Guardians unwilling to maintain the child
S4c (iv) Guardians unwilling to exercise adequate supervision/control
S4c (v) Guardians dead/abandoned the child/cannot be found
S4c (vi) Guardians unwilling/unable to prevent child from abuse of neglect
S4(d) Chid is under 16yrs and does not attend school regularly

S3 ALLEGED ABUSE TYPE:

INTERNAL SEARCH/PREVIOUS HISTORY:

CASE NOTES

RISK FACTOR WARNING LIST (2002)

C= confirmed A = alleged NTK = need to know

Child and Young Person:

RISK

- Child under 2 years
- Evidence of physical abuse/shaking
- Born drug dependent
- Difficulty feeding, sleeping, cries a lot
- Currently underweight
- Premature
- Chronically ill child
- Developmental or other disability
- History of multiple separation/placements
- No stable day program
- No effective guardian/homeless
- Mental health issue
- Recent significant behaviour change
- Violent behaviour
- Offending
- Sexual offending
- Unsafe or age-inappropriate sexual activity, including prostitution
- Substance abuse problems
- History of self harm/suicide (talk or attempt)
- **SAFETY**

- Meets some/all development milestones
- Attending childcare/school
- Demonstrates some self-protective behaviours, eg tells someone about abuse, runs away
- Has positive self-esteem
- Has mentor/significant adult friend outside family
- Child able to seek assistance (emotional, physical) relative to age factors, functioning
- Made initial (even partial) disclosure
- Health monitored/assessed/treated
- Safe from responsible person's (harm) behaviour
- Coped with effects of disclosure/intervention
- **Confident further abuse will not happen**
- Discussing problems with agency
- Discussing with carer what problems are
- Is intelligent, has insight
- Has caring, responsible and protective carer
- Has extended periods where harm is not occurring
- Has support of siblings
- Has adequate finances/shelter
- Has own mobile phone
- Has long-term goals or aspirations
- Has positive peer group

Opportunity for Harm:

RISK

- Alleged perpetrator has access to child
- Imminent exposure to harm
- No protective adult present
- Young person not self-protecting

SAFETY

- **Person responsible for harm has left the home**
- **Person responsible has only supervised contact**
- Person responsible removes themselves from situations where she/he may be abusive
- **Person responsible has identified the catalysts to abuse**
- Person responsible is likely to be responsible and willing to act to demonstrate or build safety
- Family network taking responsibility to ensure person responsible is never alone with child/young person
- Family recognises danger person responsible poses for child/young person
- Protective parent available and clear about risk. Is clearly able to protect

Pattern and History:

RISK

- Any prior notifications
- Escalating concern or contact with child protection
- Other child removed, or died in parent(s)' care
- Carer(s) have physically abused any child (past/present)
- Carer(s) have a history of sexual assault of children
- Carer(s) have any history of violence

SAFETY

- History and pattern reveals periods of safety
- Exceptions: times when abuse could have occurred and didn't
- Exception periods (attending school, not suicidal, ceases substance abuse, etc)

Complicating Factors:

RISK

- Carer under 20 at birth of first child
- Carer under 20 now
- Carer(s) abused as child (ren)
- Carer(s) have poor health
- Carer(s) have current mental health issues
- Carer(s) have history of mental health issues
- Carer(s) have self esteem issues, depression
- Carer(s) have history of alcohol/drugs use
- Carer(s) have intellectual disability
- Carer not the biological parent
- Carer(s) have current alcohol/drugs use
- Carer(s) is/has been victim of domestic violence
- Carer is/has been perpetrator of domestic violence
- Carer(s) have history of sexual assault of adults
- Carer(s) transient/homeless
- Current financial difficulties

SAFETY

- Carer has positive self esteem
- Open relationship with protective practitioner/willing to work with agency
- Willing/capacity to do something to build on safety
- Meeting, understanding, responsive to child or young persons needs
- Has realisic view of building safety
- Has good problem solving skills
- Can seek assistance from services
- Has mentor or supportive friend outside of family
- Has successfully dealt with crisis in the past
- Is engaging in discussion about how to deal with problems and plans for dealing with the problems
- Seeking or is open to appropriate services for child
- Is providing child with emotional support
- Is functional at a level to provide adequtate care and support all of the time/most of the time/some of the time
- Is communicating with other family members about the concern.

Beliefs and Relationships:

RISK

- High criticism/low warmth family
- Carer(s) have poor understanding of needs of the infant/child
- Carer(s) use of excessive or inappropriate discipline
- Carer(s) describe or act toward child predominantly negatively
- Carer(s) failed to co-operate satisfactorily
- Carer views concerns less seriously than child protection
- **Young person views concerns less seriously than child protection**

SAFETY

- Caregivers able to understand the concerns
- Young person acknowledgement/partial acknowledgement of harm behaviour/placing at risk
- Carer recognises impact of abuse/neglect eg anger/violence scares child/young person
- Carer(s) loves/likes child/young person
- Has provided for essential or basic needs
- Acknowledges/has acknowledged abuse/concerns
- Can describe exceptions to the abuse/neglect and acknowledges limitations (even partially)
- Carer(s) can identify contributing factors
- Carer can describe positive interactions with the child
- Demonstrated clear commitment to the child
- Clear instances of good parenting skills

Isolation or Supports:

RISK

- Family is socially isolated
- Young person is socially isolated
- Family is chaotic
- Family is severely fragmented
- Family have not engaged with offered services in past
- Young person has not engaged with offered services in past

SAFETY

- Connected to cultural community that has positive view of children/young people
- Informal network know what has happened and willing to participate in planning for future safety
- Extended family has acknowledged harm and taking allegations seriously
- Has the capacity to protect child and is willing to take responsibility for the child
- Meeting needs: treatment, normalisation, financial, physical, emotional
- Have continued to support family through crisis
- Alternative carers/significant others are: open to scrutiny, encourages honesty, has strengths to cope with this stressful event/investigation, has good communication skills
- Informal network is willing to discuss concerns with agency
- Child/family having regular contact with other agencies (school, doctor, sport)
- Involved professional/agencies are collaborating, all understand concern and safety plan

- Involved professional/agencies report treatments, monitoring, assessments and working towards child/young person's/families goals. (not imposing own agenda)
- Agencies realistic about danger/harm, open to family as partners but not overrating strengths
- Achieved case plan with family that all involved understand/feel achievable
- Practitioner confident family will work on the plan
- Practitioner accurately records risk/safety/harm/injury

Assessment goals/decisions understood by family

- **ASSESSMENT AND RECOMMENDATION**

OUTCOME

CONCLUSION OF NOTIFICATION AT CPAARS:

Date:
Time:
Worker ID:

Outcome:
NFA *(No reasonable grounds, insufficient information, no action possible)* **17 (a):**
NFA *(Based on reasonable grounds, but being dealt with by other means)* **17 (b):**
NFA *(Further assessment conducted at CPAARS, now being dealt with by other means)* **s18:**

Rationale for decision:

Feedback Form:

Police Referral:

ASSESSMENT OUTCOME AND TRANSFER DETAILS AT S18:

Referral to SC for Investigation:

Priority:

Rationale for decision:

Feedback Form:

Police Referral:

Date:
Time:
Senior Worker ID:
Service Centre Contact:

Further actions to be considered:

HARM CONSEQUENCE:

Describe actual or believed harm: record harm + indicators, observations & opinions

Severity:

HARM PROBABILITY

Characteristics:

Opportunity:

Pattern and history:

Beliefs and relationships:

Complicating factors / Parenting Factors:

Supports:

SAFETY

Strengths:

Protections:

Safety statement:

HARM CONSEQUENCE
HARM PROBABILITY
IMMEDIATE SAFETY ISSUES
FUTURE RISK
WORKER'S RECOMMENDATIONS/ PLAN:

B 3.3

Child Protection Services Notification Record

Outcome Details

Outcome	Priority	Primary alleged abuse	Date approved	Senior Id

Notification Details

Intake No		Date received		Time		Worker Id	

Notifier Details

Name:
Address:
Contact number:
Email:
Source:
Service type:
Service Name:

1. Child or Young Person Details

Name	Age/DOB	Sex	Contact details	Residing with	File no

2. Carer Details *if primary caregiver

	Name	Age/DOB	Sex	Relationship to child	Contact details	File no
1						
2						

Current Family Court matters.

3. Family Profile

Is anyone in the family Aboriginal or Torres Strait Islander origin?

Do any of the above persons speak a language other than English at home?

Is the child or family a recent arrival to Australia

Recent arrival regionally or interstate (including New Zealand)

Child or caregiver with a disability

4. Family/Informal Network

	Name	Age/DOB	Sex	Relationship to child	Address & Phone No.	File no
3						
4						

5. Professional Network (agencies referred to/involved)

	Name	Relationship	Name of Service	Contact Details

6. Previous Notifications/Investigation

NN	Start/End	Last Phase	Subst	Abuse type

7. Notification Details

Date:		Time:		Entered by:	

Agreements made with the notifier (including any feedback):

8. Case note records

Date: By **Worker Id:**
Person contacted:

Date: By **Worker Id:**
Person contacted:
.

9. Persons believed responsible for the harm or risk
(please highlight the person identified as causing the most harm for CWIS and AIHW counting)

	Name	Relationship to child	Abuse/risk type	Confirmed: Y/N

10. Risk Analysis

Severity

Vulnerability
Child and Young Person

Opportunity for harm

Likelihood
Pattern and history

Complicating factors (care-parenting capacities that effect capacity to protect)

Beliefs and relationships

Safety
Strengths

Protection

Safety Statement

11. Initial Assessment

Date completed		Time		Worker Id	

Primary Abuse/Neglect: Secondary Abuse/Neglect:

Risk type:

Judgement

Harm Consequence:

Harm Probability:

Future Risk:

Immediate Safety:

Decision

Outcome Section of the Act Priority Referred to police

Recommendations/Advice:

APPENDIX C

Table A4.1b: Notification (Referral) frequencies for the Subject Group per SI (N=788) and per Infant Family Group (N=599) in 2005

Notifications per SI		Notifications per Infant Family Group			
No. of Notifications	No. of SIs	No. of Notifications	No. of Families	No. of Notifications.	No. of Families
1	423	1	260	17	1
2	154	2	145	18	0
3	80	3	53	19	0
4	53	4	47	20	1
5	27	5	17	21	0
6	19	6	26	22	0
7	15	7	9	23	0
8	7	8	9	24	0
9	1	9	5	25	0
10	4	10	8	26	1
11	1	11	5	27	0
12	0	12	2	28	0
13	0	13	2	29	1
14	1	14	3	30	0
15	1	15	3	31	0
16	2	16	0	32	1

Table A4.1d: Families classified according to numbers of notifications in 2005 x 2006 (numbers)

No. notificat-ions in 2005	Number of notifications in 2006									Total
	0	1	2	3	4	5	6	7	>7	
1	160	55	25	13	6	7	8	2	3	279
2	57	29	9	9	6	3	2	2	2	119
3	28	6	6	5	7	3	3	2	1	61
4	8	14	7	2	3	2	2	0	4	42
5	4	3	6	3	2	2	0	0	2	22
6	1	6	0	1	4	2	1	1	2	18
7	4	1	4	2	2	4	1	0	2	20
>7	1	3	4	1	3	2	1	5	7	27
Total	263	117	61	36	33	25	18	12	23	588

Table A4.1e: Families classified according to numbers of notifications in 2005 x 2007 (numbers)

No. ntfns in 2005	Number of notifications in 2007									Total
	0	1	2	3	4	5	6	7	>7	
1	187	41	14	14	7	5	4	0	7	279
2	74	24	7	3	3	3	2	1	2	119
3	26	12	5	4	5	2	3	0	4	61
4	18	7	4	5	1	4	1	0	2	42
5	6	6	2	1	2	0	2	0	3	22
6	9	2	0	1	0	3	1	0	2	18
7	7	4	1	1	2	2	1	0	2	20
>7	5	5	1	4	3	2	0	0	7	27
Total	332	101	34	33	23	21	14	1	29	588

Table A4.2d: Calculated Confidence Intervals (95%) for the difference in proportions of maltreatment type between the SG and the CP populations for 2004-05 and 2005-06

Maltreatment Type	Interval Points	SG-CP05 (Lower)	SG-CP05 (Upper)	SG-CP06 (Lower)	SG-CP06 (Upper)	CP05-06 (Lower)	CP05-06 (Upper)
Neglect	Estimate	0.059		0.061		0.002	
	Bounds	0.022	0.097	0.023	0.099	-0.018	0.022
Emotional abuse	Estimate	0.101		0.066		-0.035	
	Bounds	0.065	0.137	0.029	0.103	-0.054	-0.016
Physical Abuse	Estimate	-0.083		-0.066		0.017	
	Bounds	-0.108	-0.058	-0.092	-0.041	0.001	0.033
Sexual Abuse	Estimate	-0.077		-0.061		0.017	
	Bounds	-0.095	-0.06	-0.078	-0.043	0.003	0.03

1. The Estimate is the best estimate of the difference and should be approximately half-way between the lower and upper bounds of the confidence interval.
2. The shaded cells are intervals which exclude zero – therefore the corresponding difference can be claimed to be truly a difference at the 5% significance level.

Table A4.2h: Calculated confidence intervals (95%) for the differences in proportions of maltreatment type between pairs of age groups

		Differenced age range pairs					
Maltreatment Type	Interval Points	(0 to 1) – (1 to 2)	(0 to 1) – (2 to 3)	(0 to 1) – (3 to 4)	(1 to 2) – (2 to 3)	(1 to 2) – (3 to 4)	(2 to 3) – (3 to 4)
Neglect	Estimate	0.055	0.091	0.130	0.036	0.074	0.039
	Bounds	-0.05 0.161	-0.014 0.196	0.029 0.23	-0.076 0.147	-0.033 0.181	-0.059 0.136
Emotional abuse	Estimate	-0.058	-0.017	-0.041	0.041	0.017	-0.024
	Bounds	-0.161 0.045	-0.119 0.085	-0.139 0.058	-0.069 0.15	-0.089 0.123	-0.133 0.085
Physical Abuse	Estimate	0.007	-0.025	-0.023	-0.031	-0.030	0.002
	Bounds	-0.058 0.071	-0.094 0.044	-0.089 0.043	-0.103 0.04	-0.099 0.039	-0.074 0.077
Sexual Abuse	Estimate	-0.005	-0.050	-0.066	-0.045	-0.061	-0.016
	Bounds	-0.034 0.024	-0.093 -0.006	-0.11 -0.022	-0.090 0.001	-0.108 -0.015	-0.071 0.038

Notes: as above

Table A4.2i: Notifications by Age Group, Gender and Maltreatment Type (percentages)

Age_Group	Sex	Neglect	Emotional	Physical	Sexual	Unc	TOTAL
0-1	F	51.28	35.04	9.40	1.71	2.56	100%
	M	49.62	34.62	11.54	1.54	2.69	100%
0-1 Total		50.40	34.82	10.53	1.62	2.63	100%
1-2	F	44.57	39.67	11.41	1.63	2.72	100%
	M	46.00	41.50	8.50	2.50	1.50	100%
1-2 Total		45.31	40.63	9.90	2.08	2.08	100%
2-3	F	43.07	32.67	11.88	9.90	2.48	100%
	M	38.92	40.54	14.05	2.70	3.78	100%
2-3 Total		41.09	36.43	12.92	6.46	3.10	100%
3 +	F	39.13	35.27	12.56	10.63	2.42	100%
	M	37.34	42.49	13.30	6.01	0.86	100%
3 + Total		38.18	39.09	12.95	8.18	1.59	100%
TOTAL		43.99	37.60	11.55	4.52	2.35	100%

Table A 4.3c. Number of notifications, notification rates and SEIFA indexes of relative socio-economic disadvantage (IRSD) and their rankings per POA in rural and urban regions

Rural Ns	Urban Ns	Notfns Total	SIs Ntfd.	Pop. (<4 yrs)	Notifcation Rate	IRSD	Tas. Rank
25	283	308	146	1023	0.301	861	8
0	201	201	94	696	0.289	900	17
0	126	126	70	401	0.314	799	1
0	109	109	51	721	0.151	918	25
0	106	106	54	820	0.129	991	73
92	0	92	58	534	0.172	904	19
0	86	86	45	598	0.144	932	40
61	0	61	35	303	0.201	956	53
0	56	56	25	153	0.366	828	3
0	52	52	25	495	0.105	1003	78
0	51	51	35	575	0.089	1013	82
0	42	42	22	572	0.073	1038	90
40	0	40	25	397	0.101	964	59
1	38	39	19	289	0.135	1060	99
30	0	30	14	92	0.326	902	18
0	22	22	14	283	0.078	1042	92
0	21	21	11	367	0.057	1041	91
19	0	19	9	95	0.200	912	24
15	0	15	8	49	0.306	957	54
13	0	13	7	73	0.178	1046	93
0	12	12	5	339	0.035	1069	103
12	0	12	4	149	0.081	957	55
11	0	11	7	130	0.085	909	22
9	0	9	7	31	0.290	935	42
0	8	8	7	128	0.063	1054	94
8	0	8	6	129	0.062	988	72
0	6	6	2	39	0.154	1024	85
6	0	6	4	114	0.053	1006	79
6	0	6	3	17	0.353	960	56
0	6	6	3	186	0.032	1100	107
6	0	6	1	10	0.600	928	35
5	0	5	3	49	0.102	1027	88
5	0	5	3	129	0.039	938	44
0	4	4	4	253	0.016	1055	96
4	0	4	4	27	0.148	980	69
4	0	4	3	407	0.010	1061	100
0	3	3	2	109	0.028	1068	102
3	0	3	3	27	0.111	863	9
2	0	2	2	44	0.045	1022	84
0	2	2	2	157	0.013	1087	105
2	0	2	1	40	0.050	1054	95
1	0	1	1	128	0.008	1088	106

Table A4.4b: Calculated confidence intervals (95%) for the differences between pairs of maltreatment types of their proportions of allocated response classifications

		Differenced maltreatment pairs											
Classification	Interval Points	NEG – EMO		NEG – PHY		NEG – SEX		EMO – PHY		EMO – SEX		PHY – SEX	
17a	Estimate	0.089		0.025		-0.021		-0.064		-0.110		-0.046	
	Bounds	0.045	0.133	-0.052	0.102	-0.154	0.112	-0.135	0.007	-0.24	0.019	-0.191	0.098
17b	Estimate	-0.108		0.089		0.132		0.197		0.239		0.043	
	Bounds	-0.192	-0.023	-0.029	0.207	-0.035	0.298	0.076	0.318	0.07	0.408	-0.145	0.231
18/0	Estimate	-0.073		-0.006		0.047		0.067		0.119		0.052	
	Bounds	-0.146	0.001	-0.109	0.098	-0.094	0.187	-0.041	0.175	-0.025	0.263	-0.109	0.214
18/1	Estimate	0.044		-0.165		0.006		-0.209		-0.038		0.171	
	Bounds	0.013	0.075	-0.264	-0.066	-0.079	0.092	-0.305	-0.113	-0.12	0.044	0.047	0.296
18/2	Estimate	0.051		0.033		-0.127		-0.018		-0.178		-0.160	
	Bounds	-0.015	0.117	-0.066	0.132	-0.306	0.051	-0.117	0.08	-0.357	0	-0.353	0.033
18/3	Estimate	-0.004		0.024		-0.036		0.028		-0.032		-0.060	
	Bounds	-0.034	0.026	-0.001	0.049	-0.128	0.056	0	0.055	-0.125	0.06	-0.151	0.031

Notes:
1. The Estimate is our best estimate of the difference and should be approximately half-way between the and upper bounds of the confidence interval.
2. The shaded calls are intervals which exclude zero – and hence we claim the corresponding difference is truly a difference at the 5% significance level.

Box A4.1: Codes for mandated sources of notifications in descending order of frequency

Individuals and organisations mandated to notify:

DPPS: Department of Police and Public Safety

NGO: Non-Government Organisation (e.g. Centacare; Anglicare; Salvation Army, Tasmanian Aboriginal Centre; shelters and refuges)

DO: Departmental Officer employed in the Children and Family Services sector (Child Protection Services)

DEd: Department of Education (includes: School Principal, Teacher, School Social Worker/Guidance Officer

HOP: Hospital Other Professional (includes: Nurses, Social Workers, and hospital-based allied health professional)

CHN: Child Health Nurse (Community Child Health)

GP: General Medical Practitioner or other Medical Practitioner (not hospital based)

CSW: Community Health Social Worker/support worker

COURT: A representative of the Family Court or Magistrate's Court who is involved with matters relating to children

DO-H: Departmental Officer employed in Housing Services

HMO: Hospital Medical Officer: any medical doctor who works in a hospital (includes: Resident Medical Officers, Registrars and Medical Specialists)

CCSP: Child Care Service Provider (includes: any principal or employee providing service)

DO-IS: Child Protection Departmental Officer from an Interstate Department

AHP: Allied Health Professionals (not hospital based) (e.g. Dentist/Dental Therapist/Nurse; Psychologist; Speech Pathologist/Therapist)

CL: Centrelink

SASS: Sexual Assault Support Services

DO-FV: Departmental Officer (Family Violence Support Services)

DC: Departmental carer

DO-PC: Departmental Officer – Parenting Centre

DO-DS: Departmental Officer – Drug Service

Non-mandated notifiers:

PARENT: Mother/father/step-mother/step-father of Subject Infant/Child.

GRANDP: Grandparent (including step-grandparent and foster-grandparent)

CM: Community member (named – e.g. friend, neighbour, community business person; other non-mandated member of the community)

REL: Relative of Subject Infant/Child

ANON: Anonymous notifier (un-named and not belonging to an identifiable group)

Table A4.6c: Notifications for the SG according to maltreatment type, region, and CP Response classification (numbers)

Classn	*Region*	*Neglect*	*Emotional*	*Physical*	*Sexual*	*Unc*	*TOTAL*
17a	R	22	10	1	5	5	43
	U	69	11	16	6	13	115
	ns	1		2		2	5
17a Total		92	21	19	11	20	163
17b	R	65	65	15	9		154
	U	215	245	40	10	4	514
	ns	6	1	2			9
17b Total		286	311	57	19	4	677
18/0	R	28	32	10	1		71
	U	125	141	30	11	8	315
	ns		3	1			4
18/0 Total		153	176	41	12	8	390
18/1	R	9	2	11	1	3	26
	U	34	6	33	2	3	78
	ns	1	1		1		3
18/1 Total		44	9	44	4	6	107
18/2	R	35	26	8	5		74
	U	120	76	27	21		244
	ns	4					4
18/2 Total		159	102	35	26		322
18/3	R	7	4				11
	U	15	17	1	5		38
18/3 Total		22	21	1	5		49
Unc	R					1	1
	U	2	2			1	5
Unc Total		2	2			2	6
TOTAL		758	642	197	77	40	1714

Note: 'ns' is 'not specified'

Table A4.6d: Notifications for the SG according to maltreatment type, region, classification (percentage of row totals)

Classn	*Region*	*Neglect*	*Emotional*	*Physical*	*Sexual*	*Unc*	*TOTAL*
17a	R	51.16	23.26	2.33	11.63	11.63	100.00
	U	60.00	9.57	13.91	5.22	11.30	100.00
	ns	20.00	0.00	40.00	0.00	40.00	100.00
17a Total		56.44	12.88	11.66	6.75	12.27	100.00
17b	R	42.21	42.21	9.74	5.84	0.00	100.00
	U	41.83	47.67	7.78	1.95	0.78	100.00
	ns	66.67	11.11	22.22	0.00	0.00	100.00
17b Total		42.25	45.94	8.42	2.81	0.59	100.00
18/0	R	39.44	45.07	14.08	1.41	0.00	100.00
	U	39.68	44.76	9.52	3.49	2.54	100.00
	ns	0.00	75.00	25.00	0.00	0.00	100.00
18/0 Total		39.23	45.13	10.51	3.08	2.05	100.00
18/1	R	34.62	7.69	42.31	3.85	11.54	100.00
	U	43.59	7.69	42.31	2.56	3.85	100.00
	ns	33.33	33.33	0.00	33.33	0.00	100.00
18/1 Total		41.12	8.41	41.12	3.74	5.61	100.00
18/2	R	47.30	35.14	10.81	6.76	0.00	100.00
	U	49.18	31.15	11.07	8.61	0.00	100.00
	ns	100.00	0.00	0.00	0.00	0.00	100.00
18/2 Total		49.38	31.68	10.87	8.07	0.00	100.00
18/3	R	63.64	36.36	0.00	0.00	0.00	100.00
	U	39.47	44.74	2.63	13.16	0.00	100.00
18/3 Total		44.90	42.86	2.04	10.20	0.00	100.00
Unc	R	0.00	0.00	0.00	0.00	100.00	100.00
	U	40.00	40.00	0.00	0.00	20.00	100.00
Unc Total		33.33	33.33	0.00	0.00	33.33	100.00
TOTAL		44.22	37.46	11.49	4.49	2.33	100.00

Note: 'ns' is 'not specified'

APPENDIX D

Table A5.4. Basic care and protection needs in infancy, early childhood and prenatally, essential to normal development, health and wellbeing

Developmental Sphere(s)	Domains of Developmental and Care Needs (Neglect Sub-Types)	Need constructs/Measures
Physical and psychological development and wellbeing	100. Provision: basic physical needs	101. Food / nutrition 102. Medical care needs 103. Appropriate / adequate clothing 104.1 Personal hygiene 104.2 Environmental hygiene 105. Adequate basic shelter/ housing conditions
Physical and psychological development and wellbeing (including inter-subjective development)	200. Provision of physical and psychological developmental needs: Love and nurture [sensory and emotional experience; security, stability and attachment]	200. Provision of physical and psychological care and nurture: 201. Emotional care and nurture / Love: affectionate, affective, sensitive, responsive, interactive care; emotional experience (requires maternal emotional availability, empathy and attunement; infants' needs prioritised) 202. Physical care and nurture: sensitivity and responsiveness to infant's physical needs, signals, cues; physical affection, sensory experience (maternal empathy and attunement) 203. Caregiver stability and security 204.1 Family stability and security 204.2 Residential stability and security

Developmental Sphere(s)	Domains of Developmental and Care Needs (Neglect Sub-Types)	Need constructs/Measures
Physical and Psychological development, health and wellbeing	300. Protection from physical and psychological harm: physical and psychological safety and security [302.1-2. Safety needs specific to newborn infants; 302.3-4. Safety needs for all < 4 yrs]	301 Protection from Harm (PFH): 301.1. PF: Physical abuse/harm (by other caregiver/family member in home) 301.2. PF: Exposure to emotional abuse / emotional/ psychological harm 301.3. PFH: Exposure to sexual abuse /harmful experience 302. Protection from harm: 302.1. Physical safety (newborns) 302.2. PFH: Health and wellbeing (Newborns) 302.3. Physical safety and security: home environment 302.4. PFH: Health and wellbeing 302.5. PFH: Physical safety outside home: 303. PFH: Inadequate Supervision 1 (caregiver) 304. PFH: Inadequate Supervison 2 (substitute care) 305. PFH: Health, wellbeing and safety in care of alternative primary caregiver.
Global development: Cognitive, language and (fine and gross) motor development	400. Provision: cognitive, language and motor developmental needs: Stimulation and opportunity:	401. Stimulation of intellectual and language development (personal): sensitivity responsiveness; interaction and encouragement 402: Opportunities for language and cognitive development (environmental/ social) 403. Opportunities for fine and gross motor development

Developmental Sphere(s)	Domains of Developmental and Care Needs (Neglect Sub-Types)	Need constructs/Measures
Socio-emotional development (Subjective development: Age-appropriate behaviour, self-esteem, autonomy)	500. Provision: Socio-emotional developmental needs: 501. Behavioural: guidance/boundaries (self-regulation and appropriate behaviours; self-esteem; social inclusion) 502.1. Self-care/hygiene guidance/training (autonomy, self-esteem; social inclusion) 502.2. Self-care skills (autonomy, self esteem, social inclusion) Toilet training	501. Behavioural guidance: Appropriate/adequate role modelling, guidance, discipline, boundaries; opportunities for socialisation 502. Personal hygiene and self-care skill guidance / training/ development 502.2. Toilet training
Socio-moral development (social inclusion)	600. Provision and protection: Moral guidance / social inclusion and protection from conflict with the Law	601. Moral guidance: exposure / witness to criminal activities; asking child to lie (to relatives, medical professionals, teachers) 602. FTPF conflict with the law/ illegal activities (teaching young child to steal; involving child in illegal/criminal acts)

Developmental Sphere(s)	Domains of Developmental and Care Needs (Neglect Sub-Types)	Need constructs/Measures
General physical and psychological development	700. Unspecified or general physical and psychological needs unmet or 'at risk' of not being met – due to maternal drug/alcohol dependence/ mental health problems; intellectual disability	700. Provision of basic care and/or protection from harm: 701. due to drug/alcohol dependence 702. due to intellectual disability 703. [untreated(-able)] mental health problems
Pre-natal development and wellbeing	800. Protection from harm: Prenatal health and development and peri-natal health and wellbeing	Unmet basic needs: Protection from pre- and peri-natal harm due to: 801. Exposure to alcohol or substance abuse (legal or illegal) 802. Ongoing exposure to partner violence 803. Lack of appropriate ante-natal care 804. Unmet nutritional needs of unborn (inadequate nutrition) 805. Unmet special health/care needs of newborn

APPENDIX E

Content Analysis Instrument

CONTENT ANALYSIS	
CASE: ID CODE	
REGION: URBAN/RURAL POSTCODE	
CHILDREN < 4 (End 2008) ID CODE: Sex Month/Yr of birth Age at time of death	
TOTAL No. of CHILDREN .(Dec. 2008) ID CODE	
PRE-2003 HISTORY (Number of notifications	
TOTAL NO. OF NOTIFICATIONS (mid-2003–2009)	
SOURCE OF NOTIFICATION: Notification 1 Notification 2 Notification 3 Notification 4	
CLASSIFICATION (maltreatment type; response classification) Notification 1 Notification 2 Notification 3 Notification 4	

CAREGIVER CHARACTERISTICS CAREGIVER 1 Age at birth of 1st child Domestic violence Alcohol mis-use Drug mis-use Mental health problems Intellectual disability Criminal activity Lifestyle problems CAREGIVER 2 Domestic violence Alcohol mis-use Drug mis-use Mental health problems Intellectual disability Criminal activity Lifestyle problems	
PRE- & NEO-NATAL OUTCOMES: 001. Stillbirth 002. Miscarriage 003. NAS/ drug-affected 004. Low birth weight 005. Prematurity 006. Congenital disorder 007. Med./health probs. 008. FASD CHILD OUTCOMES: 01. Death 02. Failure to Thrive 03. Malnutrition 04. Non-specific Dev. delay (infants) 05. Psycho-emotional dev. 06. Cognitive development 07. Language development 08. Socio-emotional. (Behavioural) 09. Socio-emotional dev. (hygiene/ self-care) 10. Socio-emotional dev. (>3 toileting probs) 11. Physical: gross motor 12. Physical: fine motor 13. Med./ health probs	

14. Dental health 15. Injuries (accidental) 16. Injuries (n/accidental)		
Type of neglect reported 100. Provision of basic care needs: health and wellbeing 101. Food/nutrition 102. Medical/health care needs (professional) 103 Clothing 104. Hygiene: 104.1 Personal 104.2.Environmental 105. Shelter/Housing		No. of times notified
200. Provision: physical and psychological developmental needs: 201. Emotional care and nurture / Love: affectionate, affective, sensitive, responsive, interactive care; (including sensory/ physical affection) 202. Physical care and nurture: sensitivity and responsiveness to infant's physical needs, signals, cues; (maternal empathy and attunement) 203. Caregiver stability and security (Transitions Index: Number of changes) 204.1 Family stability and security 204.2 Residential stability and security (Transitions Index: Number of changes) 205. Older siblings: relationship with parent		No. of times notified No. of Changes No. of changes

(s)/ primary caregiver(s)		
300. Protection from harm (PFH): Protection from physical or psychological/ emotional harm or danger (inc. risk) – in circumstances where such exposure or harm is preventable. 301 Protection from Harm (PFH) 301.1. Physical abuse/harm (by other caregiver/family member in home) 301.2. Exposure to emotional abuse / emotional/ psychological harm 301.3. Exposure to sexual abuse /harmful experience 302. Protection from harm: 302.1. Physical safety (newborns) 302.2. Health and wellbeing (Newborns) 302.3. Physical safety and security: home environment (All<4) 302.4. Health and wellbeing (all< 4) 302.5. PFH: Physical safety outside home: 303. PFH: Inadequate Supervision 1 (caregiver) 304. PFH: Inadequate Supervison 2 (substitute care) 305. PFH: Health, wellbeing and safety in care of alternative primary caregiver. 306.Unmet emotional / psychological needs (phys/psych. harm/ probs older sibs) (PFH)		No. of times Notified

400. Provision: cognitive, language and motor developmental needs 401. Stimulation of intellectual and language development (personal): sensitivity responsiveness; attention; verbal interaction; experiential; encouragement 402. Opportunities for language and cognitive development: toys, books, social / educational opportunities / interaction with others 403. Opportunities for fine and gross motor development Opportunities/ stimulation of motor development (grasping, sitting, crawling, walking, self-feeding etc.) (e.g. left in cot / pram / car seat for extended periods; sedation; no room / opportunities to move etc		No. of times notified
500. Provision: Psycho-social developmental needs: Socio-emotional and subjective/personal developmental needs 501. Behavioural guidance: Appropriate role modelling, guidance, discipline, boundaries; opportunities for socialisation. E.g.: anti-social behaviour / acting out psycho-emotional problems 502. Personal hygiene and self-care skill guidance / training/ development		No. of times notified

503. Toilet training 504. Unmet socio-emotional dev. needs (behavioural probs/issues for older sibs)		
600. Socio-Moral development: Provision of social and moral guidance and protection from moral and socio-emotional harm 601. Moral guidance: exposure / witness to criminal activities; asking child to lie (to relatives, medical professionals, teachers) 602. Protection from conflict with the law/ illegal activities (young child taught to steal; child engaged in illegal/criminal acts) (Older siblings)		No. of times notified
700. Unspecified physical and psychological needs unmet or 'at risk' of not being met 701.1. due to drug abuse/ dependence 701.2 due to alcohol abuse/ dependence 702. intellectual disability 703. Mental health problems / psychological disorders. 704. Parent/guardian unwilling or unable to maintain subject child (abandonment; imprisonment) 705. Parent/guardian unwilling/unable to care for or protect other child		No. of times notified
800. Protection from harm: Prenatal health and development and peri-natal		No. of times

health and wellbeing 801. Exposure to alcohol or substance abuse (legal or illegal) 802. Ongoing exposure to partner violence 803. Lack of appropriate ante-natal care 804. Unmet nutritional needs of unborn (inadequate nutrition) 805. Unmet special health/care needs of newborn		notified
900. Other abuse/neglect by Primary Caregiver(s) 901. Physical Abuse 902. Emotional abuse 903. Sexual abuse		No. of times notified
Researcher's comments		

Figure A6.2. Notification history for each family during the study period

● Denotes a notification relating to one or more Subject Infants
◘ Denotes a report about an unborn child (classified as an 'enquiry')
◙ Denotes information received regarding the death of a Subject Infant
○ Denotes a notification made in relation to older siblings or step-sibling(s) temporarily residing in the home (which may contain information relevant to subject infants)

Family 1: Notification and intervention history (2006–2009)

Classification.	EA	EA +N	N+ EA	N+ EA	N+ EA	N+ EA	N+ EA	N+ EA	N	N	N
18.1											
18.2			●					●		●	
18.3											
18.0		●					●				
17b	●			●	●	●					●
17a									◙d.		
Notification	1	2	3	4	5	6	7	8	9	10	11
	|_____1yr_____||					_____1yr_____||			_____0.5 yr_____|		

← 2.5 years →

Family 2 (2006–09)

Class.	N+ PA	N	N	N+ EA	N+ EA	N	N+ EA	N	EA	EA
18.1				●	◙d.	●	●			
18.2		●								
18.3										
18.0										●
17b	●		●					●	●	
17a										
Notification	N1	N2	N3	N4	N5	N6	N7	N8	N9	N10
	|_____1 yr_____||___1.5yr___|									

Family 3 (2004 – 07)

Class.	N.	N	N	PA	N	N	N	N	N	N	N	N	–
18.1											●		
18.2	●			○		●							
18.3													
18.0		●			●								
17b			●				◙d.					●	
17a													
Enquiry								Θ	Θ	Θ			●
	N1	N2	N3	N4	N5	N6	N7	N8	N9	N10	N11	N12	N13
	|_____1yr_____||_____1yr_____||_____1yr_____|												

Family 4 (2004 – 2009)

Class.	EA	EA	Unc.	EA	N	EA	N	N	N	EA	N	P	EA	N	P+ EA	N	N	EA	N	N	N	N	EA +N	N	EA	EA	EA	EA
18.1			●				○		○			○																	○
18.2						●											●								●				
18.3																													
18.0				○	○													●											
17b	●	●						○		●	○		◙d.						●	○	●	○	●	●		●	●		
17a														○	○	●													●
Enquiry																													
Notifications	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	

|_____1yr_____||_____1yr_____||_____1yr_____||_____1yr ____|

Family 5 (2004 – 2007)

Class.	PA EA	PA	PA	EA	N	PA +N
18.1			●			
18.2						
18.3						
18.0	●					◙d.
17b		●		●	●	
17a						
	1st	2nd	3rd	4th	5th	6th

|_____1yr_____||_____1yr_____|

Family 6 (2004 – 2009)

Class.	N	N	EA	EA	N	E+P +N	EA +N	N+ EA	EA	N+ EA	N	N	N	N	N+ EA	EA +N	N	N	N	N	EA	N
18.1																			●			●
18.2				●	●	●						●		○	○		●	●		◙d.		
18.3	●																					
18.0		●					●	●	●	●	●											
17b			●										●			○					●	
17a																						
Notification	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

|_____1yr_____||_1yr_||_____1yr_____||_____1yr_____||_____3 mos____|

Family 7 (2003 – 2009)

Class.	None	N	PA	PA	N
18.1			●	◙d.	
18.2					
18.3					
18.0					
17b					●
17a	●	●			
	1	2	3rd	4th	5th

|_____0.5 yr_____||_____1.5yr_____||_____3 yrs_____|

Family 8 (2005 – 2008)

Class.	N	P+ N	N+ EA	PA	N	N
18.1			●			
18.2						●
18.3						
18.0		●				
17b	●					
17a				●	●	
	1st	2nd	3rd	4th	5th	6th

|_____1yr _____||_____1yr_____||_____9 mos_____|

Family 9 (2003–2009)

Class.	Unc N/A	Unc	N	N	N	N	N	N	EA +N	N+ EA	N	N	N	N	N+ EA	N	UNC	N	EA	N
18.1								●												
18.2				●						●		●			●	●		●		●
18.3											●									
18.0						●														
17b		●	●		●		●		●				●	●					●	
17a																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

|_.5yr_||_____2 yr_____||_____1yr____||_____1yr_____||_____1.25yr_____|

Family 10 (2005 – 2009)

Class.	P+ N	PA	SA	N	N	PA	SA	N+ EA	N	PA	PA	N	N	N	N	N	PA	N	N
18.1	●										○								
18.2			○				●	●				○			●		○		●
18.3																			
18.0		●								○				●		●			
17b					●				●				●					●	
17a				●		●													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
	|_____1yr_____||_____1yr_____||_____1yr_____|																		

Family 11 (2005 – 2009)

Class.	EA	EA	EA	N+ EA	EA	N	N	N	N	SA	EA	N	N	N	N+ EA	N	PA	SA
18.1												●		●			●	
18.2		●	●	●			●								●			
18.3																		
18.0										●	●							
17b	●				●	●		●	●				●			●		●
17a																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
	|_____1yr_____||_____1yr_____||_1.2yr_|																		

Family 12 (2004 – 2009)

Class.	N	SA	PA EA	EA	N	N	N	N	N	N	N+ EA	N	N	N	EA +N	PA	EA	EA	N
18.1										●									
18.2						●					●	●	●	●	●				
18.3									●										
18.0			●					●								●	●	●	●
17b					●		●												
17a	●	●		●															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
	|_____1.3yr_____||_2yr_||_____1yr_____|__0.5yr_|																		

Family 13: 2 SIs (2004 – 2009)

Class.	N	N	N	N	N	N+ EA	EA PA	N	N	EA	N	N	N	N	Unc..	N	N	N	EA PA	PA +N	EA +N	EA
18.1																				●		
18.2											●								●			
18.3																						
18.0		●														●	●	●				
17b	●					●		●	●	●		●	●	●	●							●
17a			●	●	●																●	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
	|_____1yr_____||_____1yr_____||_____2.25_____|																					

Family 14: 2 SIs (2005 – 2008)

Class.	N	N	N+ EA	SA +N	N	N+ EA	PA	EA	N/A
18.1						●	●		
18.2			●	●					
18.3									
18.0					●				
17b	●	●						●	
17a									●
	1	2	3	4	5	6	7	8	9
	|_____1.5 yr_____||				_____0.5yr_____||			_____0.75_____|	