



# Preventing child neglect in New Zealand

A public health assessment of the evidence, current approach, and best practice guidance

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## **References**

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Every effort has been made to ensure the information in this report is accurate to the best knowledge of the author and the Office of the Children's Commissioner. The opinions expressed during the course of interviews undertaken to complete this report reflect the views of the interviewees and do not necessarily reflect the views, opinions or policies of the Children's Commissioner.

## Foreword

As Children's Commissioner, I am required to monitor services delivered under the Children, Young Persons and Their Families Act 1989 and to advocate for the best interests of children and young people.

Each year, I identify a number of issues that have a substantial impact on children and young people. My Office then looks into those areas in some depth, reports on gaps in policies, services and practice and makes recommendations for improvements. This report is the result of one of those focused pieces of work. It examines current responses across government services to neglect of children's needs, as defined in the Children, Young Persons and Their Families Act 1989. Dr Janine Mardani was attached to my Office for some months in 2010, as a requirement of her final year of study toward qualifying as a Public Health specialist. I commissioned this work because of the damaging nature of child neglect in New Zealand. Neglect is the most common form of child maltreatment. Child, Youth and Family report they identify four New Zealand children in every 1000 as experiencing neglect. It has not, however, always received the same attention as the physical and sexual abuse of children.

The report summarises current evidence-based literature on child neglect and the effectiveness of interventions to prevent occurrence, recurrence and impairment from neglect. It then provides information on child neglect in New Zealand and current government responses, specifically the policy and practice of health, education, Police and social services agencies. The current approach to preventing child neglect is then assessed against best-practice guidelines developed by the World Health Organization and the International Society for Prevention of Child Abuse and Neglect (2006). Drawing on the report findings, recommendations are made for actions that will strengthen responses to child neglect by health, education, Police and social service agencies.

In the course of her enquiries, Dr Mardani consulted with Child, Youth and Family, Police, health, education and Plunket staff. Clearly, considerable work is already underway to respond to neglect. I acknowledge the initiatives already underway at a generic level that will improve responses to neglect. Child, Youth and Family told us their social workers are guided by an Engagement and Safety Policy and a suite of key information practice guidelines. They have an assessment framework to help staff

assess strengths and risks in families and a Child and Family Consult process that has significantly strengthened decision-making.

As well as specific responses to neglect through the Children, Young Persons and Their Families Act and willful neglect as defined in the Crimes Act, Police are involved in a number of ways to better understand, detect and respond to child neglect. Police officers respond to children in a number of circumstances where their needs have been neglected; truanting, caught up in family violence situations, found abandoned in cars, present when search warrants are executed, in drug dealing houses and in clandestine drug laboratories. Police officers are required to be mindful of the presence of children and their safety in every situation in which they are found. This requirement is now a part of the core training of all new recruits. Police are also engaged in preventive activities like Keeping Ourselves Safe, campaigns to reduce the number of unrestrained children in vehicles and many others.

I commend the agencies we spoke with for the concern they showed and their positive desire to work together to improve responses to neglect. I applaud Dr Mardani for the passion she brought to her work and for the well-researched, informative report she has produced. It is my hope that this report will be used to further raise awareness of child neglect in key departments and to encourage further development of policies and practices that will improve responses to it.

Dr John Angus  
Children's Commissioner

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*“We believe that child abuse and neglect is an inexcusable problem that needs to be dealt with now. Children and young people feel isolated and powerless because of abuse and this issue impacts on people across society. It is something we should all be concerned about.*

*The first years of life are crucial in forming one’s identity. If these years are spent in an abusive environment the consequences are far-reaching and severe, for example, positive relationships, trust, educational aspirations and achievements. Abuse is not always severe, but has significant affects on its victims. Public awareness around this is a key part of a solution-focused approach. Child abuse exists in many different forms and not all of these are acknowledged and they need to be.*

*Please start implementing programmes and introducing campaigns that address this reality. The responsibility to correct high levels of violence in children’s lives falls on each of us to work collectively as a community. This means improving communication between professionals that interact with children and their families, as well as improving connectedness in neighborhoods, schools monitoring students and generally people not tolerating violent behaviour.”*

An excerpt from the Young People’s Reference Group  
Statement on child abuse and neglect 2009

## EXECUTIVE SUMMARY

Neglect is a serious form of child maltreatment that is at least as damaging as physical or sexual abuse in the long-term (Gilbert, Spatz Widom, et al., 2009). As an act/acts of omission, neglect is however less tangible and harder to define. Failing to meet children's needs can set in motion a cascade of negative impacts which result in reduced quality of life, severe mental and physical illness and in some cases premature death. Despite the seriousness of neglect, it has received less attention and there is "an observable societal phenomenon of neglect of neglect" (McSherry, 2007).

This report has been commissioned to document the nature and consequences of child neglect; describe the prevalence of neglect in New Zealand; summarise government agencies' responses to neglect; compare current responses to a best-practice response; and formulate recommendations for strengthening the prevention of recurrent neglect in New Zealand.

The report focuses on interventions to prevent the recurrence of neglect. It makes brief reference only to interventions to prevent the occurrence of neglect or interventions to prevent long-term impairment from neglect. The report also focuses on responses made by key government agencies and does not consider interventions by other organisations, family and whānau, friends or the public.

A total of 70 published reviews of child neglect informed chapter two. This chapter summarises the nature, causes and consequences of child neglect, and preventive interventions. Child, Youth and Family provided data to inform the description of child neglect in chapter three as epidemiological information is not available in New Zealand. The summary of current responses to neglect is informed by relevant legislation, analysis of Child, Youth and Family, Police, health and education policies, and stakeholder interviews with professionals from each of these sectors.

## **A literature-based understanding of child neglect**

Child neglect is a failure to provide for a child's basic needs or to protect a child from harm or potential harm. It is a form of child maltreatment and family violence, which is categorised by four core components:

- The child's unmet needs
- The responsible parties' capability and culpability
- The harm or risk of harm to the child
- Established standards of care (Davies, Rowe & Hassall, 2009).

Neglect may be physical, emotional, medical, educational, or supervisory. It includes exposure to violent environments, community and societal neglect. The harm neglect causes depends on the child's age (neglect in the early years is more detrimental), the length of time their needs were unmet and whether action to prevent long-term impairment was undertaken (Davies et al., 2009). Harm ranges from impaired development through to risk-taking behaviours and delinquency, psychopathology, teenage pregnancy, maltreatment of children as an adult, substance abuse, crime and premature death.

Neglect arises from "a complex interplay of risk and protective factors" that increase children's vulnerability (Dubowitz & Bennett, 2007). The ability to effectively prevent neglect from occurring is hindered by difficulty identifying vulnerable children and high-risk families. Efforts are further hindered by a lack of evidence on effective universal and targeted interventions (Mikton & Butchart, 2009). Universal preventive methods likely to be effective include beneficial social and economic policies, non-violent cultural and social norms, and provision of quality childcare and health services.

Targeted preventive methods that have shown some benefit include home-visiting, parent education and multi-component programmes. Statutory interventions to prevent the recurrence of neglect must be preceded by identification of neglect, referral to child protection services, investigation and statutory identification of neglect. In professional settings, there is no evidence to suggest that screening tools improve the identification of neglect (Davies et al., 2009; Gilbert, Kemp, Thoburn, Sidebotham, Radford & Glaser, 2009). There is

limited evidence on the effectiveness of professional training and support (Angeles Cerezo & Pons-Salvador, 2004).

Identification of neglect by child protection services is hindered by the need for a comprehensive assessment and the inherent complexity of neglect (Dubowitz, 2007). A database of neglect case studies is suggested as one useful technique to help social workers (McSherry, 2007).

There is no evidence of the effectiveness of interventions in preventing recurrence of child neglect (MacMillan, Wathen, Barlow, Fergusson, Leventhal & Taussig, 2009). Similarly there is some evidence on the effectiveness of resilient peer treatment, imaginative play training and multi-systemic therapy but “rigorous studies of treatments for neglect children and their families are lacking” (Allin, Wathen & MacMillan, 2005). Evidence suggests that prevention of child neglect and abuse is more effective and less costly than responding to neglect to prevent recurrence and impairment (Mikton & Butchart, 2009).

### **Child neglect monitoring information from Child, Youth and Family**

Population-based surveys of exposure to child neglect are not conducted in New Zealand. Statistical descriptions of neglect are therefore limited to formal findings of neglect by Child, Youth and Family. This information reflects not only levels of neglect in New Zealand, but also levels of reporting to Child, Youth and Family and child protection practice in New Zealand. Long-term outcomes for New Zealand children following identified neglect are not routinely described.

Child, Youth and Family information indicates that:

- Neglect is the second most frequent Child, Youth and Family child maltreatment investigation finding. (This excludes emotional neglect, which is defined as emotional abuse by Child, Youth and Family).
- Four in every thousand New Zealand children (0.393 percent) were identified by Child, Youth and Family as experiencing neglect in 2009.
- Neglect is the sole maltreatment investigation finding for two in three (63.1 percent) children with identified neglect.
- Four in ten (41.7 percent) children with identified neglect were aged 0-4 years in the year to June 2009.

- Maori children are 4.5 times more likely and Pacific children 1.6 times more likely to have a finding of neglect, compared to European/Other children.
- Almost half of all children with identified neglect (45 percent) live in New Zealand's most deprived neighbourhoods (NZDep2006 quintile 5).
- The rate of children with Child, Youth and Family findings of neglect ranges by site area throughout New Zealand from 112 – 1321 children per 100,000 population aged 0-17 years.

Child, Youth and Family information on notifications to them and child protection practice, indicates that:

- The rate of notifications to Child, Youth and Family doubled in the five years to June 2009, with increased notifications from all sources. No change occurred in the rate of notifications identified as requiring further action by Child, Youth and Family over this period.
- Notifications with a finding of neglect are most likely to come from Police (39.3 percent), Health (12.0 percent), Family, Whānau, Self or Friend (10.7 percent) and Education services (9.0 percent). Most Police referrals result from family violence.
- Most findings of neglect (60 percent) are made following one or two referrals to Child, Youth and Family.
- The rate of identified child neglect increases in Child, Youth and Family sites with increasing local neighbourhood deprivation. Sites with lower levels of local neighbourhood deprivation have less variation in their rate of child neglect, compared to sites with higher levels of local neighbourhood variation.
- The most common Child, Youth and Family responses to neglect are: Family Group Conference (38.1 percent), No Further Action (24.3 percent), or a Family/Whānau Agreement (19.6 percent). Family Group Conferences are slightly more common in the 15-17 year old age group and Family/Whānau Agreements are slightly more common in the 0-4 year old age group.
- Family Court Orders are sought for one in thirteen (7.9 percent) children with findings of neglect.

- Nearly 300 neglect-related offences are recorded by Police annually. Leaving a child, aged under 14, without reasonable supervision is the most common form of neglect-related offence recorded.

Child, Youth and Family information suggests that current professional assessment tools do not significantly raise the proportion of referrals upheld by their investigation, beyond general public knowledge.

### **Current New Zealand approaches to the definition of neglect and prevention of recurrence**

The Crimes Act 1961 includes an offence of willful neglect of children although there is no exact definition of neglect.

The *Interagency Guide to Breaking the Cycle* (Child, Youth and Family, 1997) defines neglect as:

any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It may include, but is not restricted to physical neglect ... neglectful supervision ... medical neglect ... abandonment ... [and] refusal to assume parental responsibility.

While this definition is used in some policies and interagency protocols (Ministry of Health, 2002b; 2002c), many do not define neglect (Ministry of Health, The Royal New Zealand College of General Practitioners, New Zealand Medical Association, & Child Youth and Family, 2000; Ministry of Social Development, Child Youth and Family, & Work and Income, 2007; Housing New Zealand Corporation & Child Youth and Family, 2007; Ministry of Education, 2010; Te Kohanga Reo National Trust Board & Child Youth and Family, 2009).

Defining child neglect was a challenge for the professionals interviewed. Neglect was seen as harder to define and harder to prove than physical child abuse. One health professional commented: "it's always been a major difficulty describing neglect."

Analysis of the *Interagency Guide to Breaking the Cycle* (Child, Youth and Family, 2001) found that risk factors or red flags for child neglect are not

described, some common risk factors of neglect are omitted and interviewing is not recommended despite the frequent need for professionals to ask questions as part of their assessment. There is inconsistent use of risk factors, signs and symptoms of neglect in the health and education sector policies and New Zealand Police do not have a specific policy on the detection of child neglect (Appendix 2).

Many stakeholders commented on the lack of clarity about established standards of care and the threshold for neglect:

*That comes through strongly in the survey that I have done, that training is not there as much as it is needed. That training to identify what is a concern. Not so much the referral process, but what are the actual things that they need to be looking at, the threshold, people are still wanting more clarity on that.*

(Education professional)

Education professionals also reported that flagging of child protection concerns on the education ENROL computer system was not common practice.

## **Notifying a child with suspected or actual neglect to Child, Youth and Family**

Professionals are not able to freely access a Child, Youth and Family notification form prior to contacting the Child, Youth and Family National Contact Centre. The notification form is largely free text and does not explicitly seek information on key risk-factors, red flags and signs of abuse and neglect. Most agency policies and protocols do not cover the issue of re-notification, which is a central component of Child, Youth and Family assessment.

However, the quality of the notification to Child, Youth and Family is an important step in the identification process. One Child, Youth and Family professional commented “the quality of their referral, for us, is also a good indication of the seriousness of it”.

Stakeholders external to Child, Youth and Family perceived a large discrepancy between their thresholds for neglect and the threshold held by Child, Youth and Family professionals.

Child, Youth and Family professionals reported an absence of guidelines specifically related to child neglect and an absence of “practice forum sessions” on neglect:

*In terms of having everybody on the same page about neglect, I think that's probably one of the things that we need to do in training. I am just thinking we haven't had any training in neglect for a quite a while, but we are quite clear around safety plans around abuse. Safety plans should be used for neglect as well.*

(Child, Youth and Family professional)

In practice, harm or risk of harm to physical safety is the clear threshold for Child, Youth and Family intervention for neglect.

### **Guidance for responding to neglect from best practice guidelines**

The five key components of the best practice, systematic approach to addressing child neglect and abuse developed by the World Health Organization (WHO) and International Society for Prevention of Child Abuse and Neglect (ISPCAN) (2006) are:

1. **DEFINITION:** Common conceptual and operational definitions of child neglect and abuse to enable case identification and recording.
2. **PREVENTION:** Policy and programme measures to address risk and protective factors.
3. **SERVICES:** Measures and mechanisms to detect and intervene in cases of neglect, and to provide services to victims and families.
4. **INFORMATION FOR EFFECTIVE ACTION:** Mechanisms to gather information through epidemiological surveys, facility-based surveillance, monitoring and evaluation.
5. **ADVOCACY:** to raise awareness of the need for investment in evidence-based prevention programmes.

The challenges faced by New Zealand include firstly a lack of a shared common understanding of what neglect is. Secondly, information on the prevalence of neglect is limited, and collection of this information is hindered by the lack of a shared understanding. Available information tells us that professional referrers are not able to accurately identify child neglect and abuse, and this again is

related in part to the lack of a shared understanding, including the threshold for established standards of care. There is an absence of information on interventions to prevent the recurrence of neglect, interventions to prevent impairment and information on the prevalence of long-term impairment from neglect to understand how this problem may be impacting on other social problems including violence, crime, and early death. Without this information it is difficult to meaningfully manage child neglect prevention interventions or make recommendations on the best pathway forward.

Respecting the best-practice advice given by the World Health Organization and the International Society for Prevention of Child Abuse and Neglect (2006), this report recommends that two key steps must be taken initially to strengthen the response to child neglect:

1. development of a greater shared understanding and stronger policy guidance for child neglect identification and interventions, and
2. collation and sharing of information to inform action.

## **Recommendations**

### **Development of a shared understanding and policy guidance for child neglect identification and interventions**

A shared understanding of child neglect and the intervention pathway is central to collaborative efforts to prevent neglect from occurring and recurring. The shared understanding arises from shared policy, which leads to a consistent basis for training and action. A common understanding also arises from sharing child neglect information with the public.

**1. It is recommended that the Ministry of Social Development work with Child, Youth and Family, the Ministry of Health, Ministry of Education and Police to develop a shared understanding of child neglect and ensure that all child neglect and abuse policies contain the shared understanding which should include the four common core elements of neglect and the category of emotional neglect. Policy definitions of family violence should also be reviewed to ensure inclusion of child neglect.**

**2. It is recommended that Child, Youth and Family, in consultation with the Ministry of Health, Ministry of Education and Police, produce a revised *Interagency Guide to Breaking the Cycle* that includes the shared understanding of child neglect.**

In revising the *Interagency Guide to Breaking the Cycle*, Child, Youth and Family could consider providing information on:

- the use of guideline indicators of neglect, risk factors, red flags, and sample interview questions. Child, Youth and Family assessment tools could be included to assist professional referrers in their referral decision making;
- indications for identified interventions to prevent the recurrence of child neglect;
- indications for identified interventions to prevent long-term impairment from child neglect with identification of the service responsible for providing the named interventions;
- the roles and responsibilities of core agencies and services;
- the legislative responsibility of Child, Youth and Family to inform referrers of the referral outcome;
- intra- and inter-sectoral training;
- inclusion of the written Child, Youth and Family referral form for professionals; and
- case scenarios that describe common neglect situations and suitable responses. This descriptive case series will support a shared understanding of child neglect.

**3. It is recommended that Child, Youth and Family develop practice material around the management of child neglect, as a source of reference for Child, Youth and Family social workers.**

Consideration could be given to locating this practice material on the Child, Youth and Family Practice Centre website and to including indicators of neglect, risk and protective factors, red flags, legislative responsibilities, case scenarios, the roles and responsibilities of core agencies and services, identified interventions to prevent the recurrence of child neglect or to prevent long-term impairment from child neglect.

This practice advice could be strengthened by including information on the key risk and protective factors that should be recorded (as present or not present) in all children's records, a discussion around the role of the statutory agency and examples of known child neglect interventions, to assist decision-making.

**4. It is recommended that Child, Youth and Family consider, with the Police, whether existing guidelines are sufficient to assist with the detection of neglect and serious willful neglect.**

Child, Youth and Family and Police have worked together to produce an updated Child Protection Protocol, which sets out each agency's responsibilities in cases of abuse and neglect. This recommendation is asking that that Protocol be checked to ensure it covers sufficiently the areas of neglect and serious willful neglect.

**5. It is recommended that the Ministry of Social Development consider providing information to parents through *Strategies with Kids – Information for Parents* and other strategies managed by the Ministry, explaining neglect, the impact of neglect and how to prevent it.**

**6. It is recommended that the Ministry of Social Development consider reviewing all other child maltreatment information which the Ministry provides to the public, to ensure that information on child neglect is included, and that information is consistent with the shared understanding of child neglect and guidelines for referral.**

### **Collation and sharing of information to inform effective action**

Routine collection and reporting of population-based survey information and Child, Youth and Family data are both needed to establish the true nature of child neglect in New Zealand, identify emerging trends, problem areas, and priorities for prevention as well as monitor for the impact of interventions. Where child neglect has occurred it is important that referring agencies retain this knowledge, to help identify very vulnerable children who are at risk of recurrent neglect.

**7. It is recommended that the Ministry of Social Development note that surveys designed to monitor child maltreatment are being used in the USA and the Ministry could examine options for collecting population-based measures.**

As part of this work, the Ministry of Social Development could work, with Child, Youth and Family, the Ministries of Health and Education and Police to identify a common, agreed 'dashboard of indicators' to monitor child neglect.

**8. It is recommended that the Ministry of Social Development explore a child neglect research agenda, using the data available to it from Child, Youth and Family.**

An agenda could consider issues around strengthening the prevention of the occurrence, recurrence and impairment from child neglect. Areas for research could include an examination of the strength of association between known risk factors and identified child neglect outcomes and/or an evaluation of the effectiveness of a revised *Interagency Guide to Breaking the Cycle*.

**9. It is recommended that Child, Youth and Family consider auditing those 18 cases of child neglect with 15+ notifications identified in this report, identify barriers to earlier prevention and identification of neglect and use this information to advance practice advice and guidelines.**

**10. It is recommended that Child, Youth and Family consider communicating annually with the Ministry of Health, Ministry of Education and Police, providing information to those agencies on numbers of referrals received from them, referral substantiation rates and referral outcomes.**

**11. It is recommended that the Ministry of Health consider providing ongoing support for District Health Board development of the child protection alert system.**

**12. It is recommended the Ministry of Education consider reviewing the use of ENROL for child protection purposes and implement a plan of action for strengthening child protection alerts within the school system.**

**13. It is recommended that the Ministry of Social Development note that some overseas jurisdictions are sharing information more freely amongst those engaged in child protection work and the Ministry could progress the development of a New Zealand model for information sharing.**

# 1.0 METHODOLOGY

This report examines the prevalence and prevention of child neglect and related long-term outcomes in the literature, New Zealand data, legislation, policy and government practice.

A mixed methods approach was used for the report. The inquiry included:

1. A literature review
2. Analysis of Child, Youth and Family data
3. Examination of relevant legislation
4. Policy analysis
5. Stakeholder interviews
6. Analysis and integration of data collected to identify elements of best practice for further development.

Additional description of the methodology is provided in Appendix 1.

## **Limitations to the report**

The Commissioner sought a report that broadly covered an understanding of child neglect and interventions to prevent child neglect, with a focus on areas relevant to moving towards a best practice approach. Some focus has been given to the definition of child neglect in New Zealand policy and practice, as this is central to identification and preventive interventions, but resource availability limited the overall depth of inquiry.

The report focuses on government prevention of child neglect, and does not consider non-governmental organisations, community, family and whānau, parental and child measures to prevent child neglect.

## **Use of the term 'children'**

For reasons of brevity the term children has been used throughout the report for children and young people aged 0-17 years.

## Definitions

<i>Notifications</i>	the number of notifications made to Child, Youth and Family
<i>Children</i>	New Zealand children aged 0-17 years referred to Child, Youth and Family
<i>Investigation Finding</i>	the number of children who have been notified to Child, Youth and Family, identified as requiring further Child, Youth and Family investigation and then found to have been neglected or abused. Findings are made only for the most serious cases of child neglect and abuse. Findings are based on the forensic evidence obtained and social work analysis, which includes a subjective component. The threshold for findings of neglect or abuse may therefore vary between social workers, Child, Youth and Family sites and may be influenced by demand for Child, Youth and Family services.
<i>Child neglect</i>	includes failing to provide for a child's basic needs and includes physical neglect, neglectful supervision, medical neglect, abandonment and refusal to assume parental responsibility. Child neglect <b>excludes</b> emotional neglect, which is defined as emotional abuse by Child, Youth and Family.
<i>Emotional abuse</i>	includes treatment that has damaged the child's mental health, social and/or emotional functioning and development. Emotionally abusive behaviour may include: constant criticism, shaming and humiliation; or emotional neglect through ignoring or rejecting a child or limiting physical contact; or the negative impact of mental illness or substance abuse of family members.
<i>Physical abuse</i>	includes situations where the child has sustained a physical injury or was at serious risk of sustaining an injury.
<i>Sexual abuse</i>	can include non-contact abuse (eg: exhibitionism, voyeurism and suggestive behaviours), contact abuse or involvement of the child in activities for the purposes of pornography or prostitution.

**Data source**

Numerator: Child, Youth and Family's electronic database, CYRAS  
Denominator: Census 2006

**Indicator quality**

Proxy indicator only, further work required to improve data quality (Craig, Jackson, Han and NZCYES Steering Committee, 2007).

**Notes on interpretation**

Data was provided by Child, Youth and Family from their CYRAS database, which records information on all children notified, or for whom investigation findings were made, for the five-year period July 2004 – June 2009. Notification information, which is not provided as a rate, includes instances of multiple notifications for the same child from one or more sources.

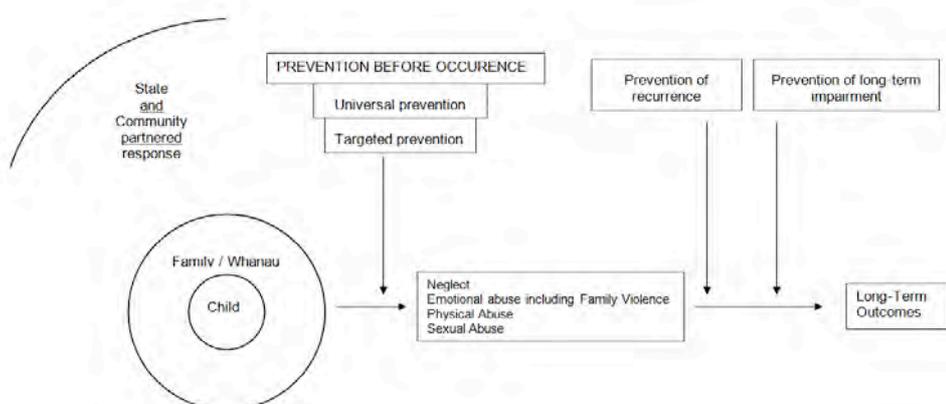
The total response ethnicity method was used for ethnicity statistics whereby a child may be represented in all ethnic groups with which they are affiliated.

## 2.0 LITERATURE REVIEW FINDINGS

This review has focused on literature reviews related to child neglect and associated preventative interventions. In some instances the literature review covers the broader area of child maltreatment, which includes both child neglect and child abuse. Inclusion of child maltreatment literature reviews was necessary as it is common practice to research child neglect and child abuse together. The logic model depicted in Figure 1 is used as a framework to present the findings:

- Section 2.1 reports findings on the nature of child neglect. It considers the definition, causes and consequences of child neglect. This is the pathway indicated along the bottom of Figure 1.
- Section 2.2 reports findings on interventions to prevent child neglect and related adverse long-term outcomes. The interventions are described in three subsections, and are represented by the three points of intervention in the framework below. Firstly, section 2.2.1 reviews interventions to prevent child neglect before it occurs. Secondly, section 2.2.2 reviews interventions to prevent recurrence of child neglect. And finally, section 2.2.3 reviews interventions to prevent long-term impairment in children who have experienced neglect.

**Figure 1: Framework for prevention of child maltreatment and adverse long term outcomes**



Based on the framework for prevention of child maltreatment and associated impairment in MacMillan, H., Wathen, C., Barlow, J., Fergusson, D., Leventhal, J., & Taussig, H. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet*, 373(9659), 250-266.

## 2.1 The nature of child neglect

This chapter provides a brief summary of the definition of child neglect, its determinants and consequences. At the outset, the complexity of child neglect must be acknowledged. Defining neglect “has been the subject of heated debate for the past two decades” (Dunn, Tarter, Mezzich, Vanyukov, Kirisci & Kirillova, 2002). Furthermore, oversimplification of the problem has been a common mistake which has hindered child maltreatment prevention throughout the last 30 years (Daro & Donnelly, 2002).

The World Health Organization suggests that it is useful to view child neglect within the wider categorisations of child maltreatment<sup>1</sup> and violence<sup>2</sup> (WHO & ISPCAN, 2006). This is because child neglect, child maltreatment and violence are all “different expressions of a common underlying problem” (Davies, Rowe, & Hassall, 2009, p. 74). Children who experience neglect are also commonly exposed to other forms of maltreatment (Gilbert, Spatz Widom, Browne, Fergusson, Web and Janson, 2009). While this is true, a focus on the more tangible aspects of child maltreatment and violence has led to the observable phenomenon of “neglect of neglect” (McSherry, 2007).

Neglect is at least as damaging as physical or sexual abuse in the long term, but has received the least scientific and public attention.  
(Gilbert, Spatz Widom, et al., 2009, p. 68)

This chapter, and indeed this report, focuses on neglect while acknowledging the interconnected nature of neglect, maltreatment and violence at the multiple levels of individual, family, community and society.

Finding	Comment
Child neglect is a form of maltreatment and a component of family violence.	It is important to understand the nature and long-term consequences of neglect so that it can be responded to as an integral component of family violence.

<sup>1</sup> Child maltreatment includes child neglect, emotional abuse, physical abuse and sexual abuse.

<sup>2</sup> Violence includes: self directed violence (self-abuse and suicide), interpersonal violence (family, intimate partner and community), and collective violence (social, political and economic).

### 2.1.1 What is child neglect?

Child neglect can be simply defined as “failure to provide for a child’s basic physical, emotional, or educational needs or to protect a child from harm or potential harm” (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). Neglect can occur as an isolated incident, a series of incidents or it can be a continuous state (WHO & ISPCAN, 2006). In most instances it is unintentional (Dubowitz & Bennett, 2007), but degrees of intent to harm may be observed, particularly in fatal cases of neglect (Gilbert, Kemp, et al., 2009).

There are many other definitions of child neglect, each of which examines parts of the same phenomenon from varying perspectives. Operational definitions of neglect differ between professions, communities and cultural groups (McSherry, 2007).

In their review of the many approaches to defining child neglect, Davies et al., (2009) identified four core elements that are common in the various definitions of child neglect:

1. the child’s unmet needs
2. the responsible parties’ capability and culpability
3. the harm or risk of harm to the child and
4. established standards of care.

The same review observed that the definition of child neglect varies between government agencies depending on the focus of their work, that is, what they are responsible or *culpable* for:

- health and welfare agencies tend to use ‘child-focused’ definitions of neglect which focus on the child’s unmet needs and adult capability in meeting the needs
- child protection agencies tend to use ‘parent-focused’ and ‘risk-focused’ definitions
- the criminal justice sector emphasises parental culpability and
- community standards are often prominent in political and media discourse on child neglect (Davies et al., 2009).

Dubowitz, Newton, Litrownik, Lewis, Briggs and Thompson (2005) note that while most legislative definitions of child neglect include the risk of harm to the child, most states in practice require actual harm to have occurred to the child. The exception to this observation is extreme circumstances of neglect like abandonment.

Reading, Bissell, Goldhagen, Harwin, Masson and Moynihan (2009) point out that the definition is critically important because it defines how neglect is recognised, managed and prevented. For example, limiting consideration of responsible parties to primary caregivers will not lead to recognition of collective harm caused by institutions, harmful laws or policies, failure of governance etc.

### **Types of child neglect: the unmet need and responsible parties**

Child neglect is commonly described in the medical literature according to the type of need that has not been met and the party responsible for the wellbeing of a child. Parents and caregivers are the responsible party most frequently considered. However, there is growing recognition of the role of neighbourhoods and wider society in ensuring that children are safe, secure and well nurtured (WHO & ISPCAN, 2006).

Table 1 summarises the various types of child neglect, which are defined according to the child's unmet need and the ecological level of responsibility. Some of the complexity in describing children's needs more fully arises from the changing 'unmet needs' of children throughout the stages of their progressive development (Dunn et al., 2002).

**Table 1: Types of child neglect**

Type of omission	Omission subtype	The child's unmet needs
Parent/ caregiver failure to provide	Physical Neglect	Failure to provide for the child's most basic physical needs, including adequate shelter, clothing, nutrition or hygiene. The child may be consistently hungry, malnourished, dressed inappropriately, or have poor hygiene.
	Psychological/ Emotional Neglect	Inattentiveness to the child's emotional needs and well-being. Inadequate provision of opportunities for cognitive development. The child may be developmentally delayed, lack parental attachment, have a habit disorder (sucking, rocking, biting), show extremes of passive/aggressive behaviour or destructive antisocial behaviour.
	Medical/ Dental Neglect	Refusal or delay in providing access to healthcare for injuries, health, vision or dental problems.
	Educational Neglect	Allowing chronic truancy, failure to enrol child in school, inattention to special education needs.
Parent/ caregiver failure to supervise	Supervisory Neglect	Abandonment. Failure to protect from harm or danger, for example through inadequate supervision, exposure to household hazards, and failure to protect a child from maltreatment perpetrated by another caregiver.
	Exposure to violent environments	Exposure to family conflict and/or violence, use of drugs.
Community Neglect		Neighbourhood failure to supervise and help children and their parents, for example: availability of child care services; low cost housing; and schools that fail to have stable and involved staff for the children.
Societal or "Collective" Neglect		"A culture that fails to provide adequate food, shelter, housing, child care and education to all children and fails to protect them from danger" (Polonko, 2006)

Sources: (Donohue, 2004; Dubowitz et al., 2005; Leeb et al., 2008; Polonko, 2006)

Finding	Comment
The definition of child neglect contains common core elements upon which varying operational definitions are built.	Collaborative responses will benefit from a shared understanding of child neglect from which neglect can be recognised, managed and prevented.

## **2.1.2 What causes child neglect?**

There is no single causative agent for child neglect (WHO & ISPCAN, 2006). Child neglect arises from “a complex interplay between risk and protective factors” (Dubowitz & Bennett, 2007, p. 1891). These factors, which raise a child’s susceptibility to neglect, have been collectively described as “vulnerability” (Tuohy, 2007). The literature identifies a range of factors that increase a child’s vulnerability to neglect through a range of ecological levels (Table 2, p. 11).

Daniel, Taylor and Scott (2010, p. 3) found that:

mothers who neglect their children often have mental-health problems, low self-esteem, lesser problem-solving skills, lesser parenting skills, poorer knowledge of parenting and child development, poorer connection and less empathy with their children, a history of abuse in childhood, a history of substance abuse and are parenting alone.

Evidence strongly suggests that the presence of an increasing number of risk factors increases the risk of child neglect (Daniel et al., 2010). Within the myriad of co-existing risk factors, substance misuse, mental health problems, family violence, poverty and children with conduct disorders appear to be factors that particularly heighten the risk of neglect (Barth, 2009; Daniel et al., 2010).

The presence of multiple factors increases the likelihood, but does not assure, an outcome of child neglect.

### **Protective factors for child neglect**

Protective factors are aspects of a child’s life that may reduce the likelihood of neglect. Examination of these factors has been limited to date. There is scientific evidence that a supportive family environment and social networks are protective factors for child neglect (Centers for Disease Control and Prevention & National Center for Injury Prevention and Control, 2009; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Research is underway to determine whether the following factors are protective for child neglect:

- nurturing parenting skills
- stable family relationships
- household rules and child monitoring
- parental employment
- adequate housing

- access to health care and social services
- caring adults outside the family who can serve as role models or mentors and
- communities that support parents and take responsibility for preventing abuse.

(Centers for Disease Control and Prevention & National Center for Injury Prevention and Control, 2009).

Finding	Comment
Child neglect is caused by a complex interplay of risk and protective factors.	It is essential that professional screening and assessment of child neglect incorporates an examination of child, caregiver, family, community and societal factors to provide an optimal assessment of risk.

**Table 2: Factors that increase vulnerability to child neglect**

Ecological level	Factors
Child	<p>High needs (e.g. born prematurely, one child from a multiple birth, has a disability or chronic illness)</p> <p>Personality or temperament traits that are perceived by the parent as problematic</p>
Parent / caregiver	<p>Difficulty bonding and less empathy with the child</p> <p>Maltreatment as a child</p> <p>Lack of understanding of child development</p> <p>Poor parenting skills (can be a result of young age or lack of education)</p> <p>Parental psychopathology or cognitive impairment</p> <p>Parental stress and social isolation, low self-esteem and lesser problem-solving skills</p> <p>Substance abuse (estimated to be a factor in 80 percent of child maltreatment in USA)</p>
Family life	<p>Other siblings who are demanding of parental attention, family size</p> <p>A family member with physical, mental or developmental health problems</p> <p>Financial difficulties, chronic poverty</p> <p>Family breakup</p> <p>Family violence</p> <p>Frequent changes in household members</p> <p>Homelessness</p> <p>Involvement with criminal activity</p>
Community Factors	<p>Isolated in the community, lack of a support network</p> <p>Poor prenatal and postnatal care</p> <p>Discrimination against the family because of ethnicity, religion, sexual orientation, lifestyle etc.</p> <p>Lack of or inadequate housing</p> <p>Transient neighbourhoods</p> <p>The easy availability of alcohol</p> <p>A local drug trade</p> <p>Inadequate policies and programmes within institutions</p>
Societal Factors	<p>Socioeconomic inequalities</p> <p>Poor living standards, poverty</p> <p>Gender and social inequality</p> <p>Lack of services and institutions to support families</p> <p>High levels of unemployment</p> <p>Poor social, economic, health and education policies</p> <p>Social and cultural norms that diminish the status of the child or demand rigid gender roles</p>

Sources: (Daniel et al., 2010; Donohue, 2004; Heller, Larrieu, D'Imperio, & Boris, 1999; Hildyard & Wolfe, 2002; Krug et al., 2002; Reading et al., 2009; WHO & ISPCAN, 2006)

### **2.1.3 How can children be harmed by neglect?**

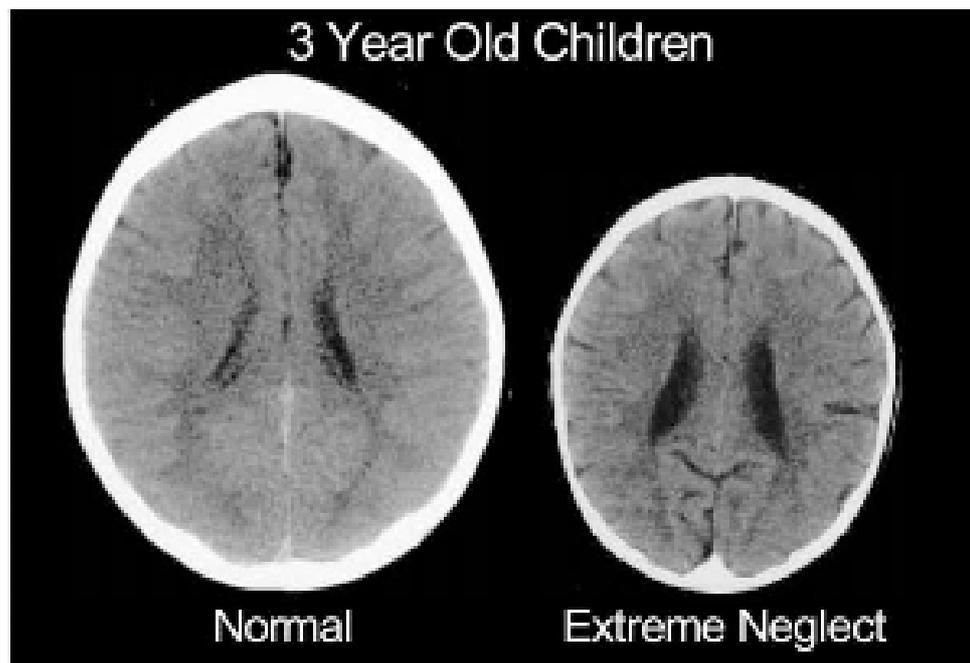
When children are not safe, secure and well nurtured their physical, mental, emotional, and social health and development may be harmed. Some assert that harm from child maltreatment is almost guaranteed (Polonko, 2006). Child maltreatment can not only cause serious injury and death, but it can also harm the child's adult life, their family, and society in general (Gilbert, Spatz Widom, et al., 2009).

Despite the clear evidence of harm from neglect, current knowledge is unable to establish an unequivocal cause and effect relationship between neglect and its multiple adverse outcomes, while controlling for the multiple other risk factors that a child has been exposed to (Truman, 2004).

A growing body of evidence does, however, describe a cascade of negative impacts from early exposure to the toxic stresses of recurrent child abuse or neglect, severe depression, substance abuse or violence within a family (Center on the Developing Child at Harvard University, 2007). Such exposures can result in persistently elevated stress hormones that disrupt brain development (see Figure 2), immune responses and metabolic regulatory functions. This in turn may result in increased susceptibility to multiple physical and mental health illnesses.

Two studies have reported ongoing stress hormone elevation even after a child has been moved to a safe and loving home (National Scientific Council on the Developing Child, 2005).

**Figure 2: Abnormal brain development following sensory neglect in early childhood**



Source: Perry, B. (2002) Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, 79-100.

These images illustrate the negative impact of neglect on the developing brain. The CT scan on the left is an image from a healthy three year old with an average head size (50<sup>th</sup> percentile). The image on the right is from a three-year-old child suffering from severe sensory-deprivation neglect. This child's brain is significantly smaller than average (3<sup>rd</sup> percentile) and has enlarged ventricles and cortical atrophy.

The impact of neglect depends on when it occurs in a child's life, (early neglect has greater consequences); how long the neglect lasts; and the action taken to repair the damage ... Without intervention, the sequelae of neglect appear across the mental health spectrum. (Davies et al., 2009, p. 26)

The appearance of negative consequences from early neglect is evident during the preschool years. Studies found increased internalising and externalising behaviour at three years of age among psychologically neglected children (Daniel et al., 2010). Increased language and communication delays and socio-adjustment and behavioural problems were observed at four years of age in children who were physically neglected and emotionally abused/neglected.

While the harms of child neglect are not limited to mental development and mental health, the majority of adverse outcomes are related to this health domain (Table 3).

**Table 3: Adverse outcomes related to child neglect**

Area of Harm	Outcome	Comment
Mental Development and Mental Health	Lower IQ, poorer cognitive development and academic achievement. Serious and diverse problems in school functioning	Physical neglect has a significant and pervasive impact in this area of development (Polonko, 2006)
	Lower self-esteem, negative self representation, insecure attachment to perpetrating mother	
	Psychopathology and character disorders	Emotional neglect in particular is associated with higher levels of psychopathology (Polonko, 2006)
	Substance abuse	Related both to the use of drugs as a teenager and drug addiction (Dunn et al., 2002; Polonko, 2006)
	Risk taking behaviours (eg; sexual behaviour, school truancy, drug trafficking)	
Physical Health	Poor physical health	
	Diminished birth weight	
	Failure to thrive, obesity	
	Accidental Injuries	
	Teen pregnancy	
	Death	40 percent of maltreatment related deaths are due to neglect. Neglect often plays a role in other causes of death, for example in suicide, fatal accidents with inadequate supervision etc. (Gilbert, Kemp, et al., 2009)
Social Health	Aggression, delinquency and arrests for violent crime	The significantly increased aggression and later arrests for violent crime are less than those observed with people who have experienced physical abuse as a child (Polonko, 2006)
	Maltreatment of children, primarily in the form of neglect	

Sources: (Dubowitz et al., 2005; Dunn et al., 2002; Gilbert, Kemp, et al., 2009; Polonko, 2006; Tyler, Allison, & Winsler, 2006)

Further to this long list of adverse outcomes, the World Health Organization has reported growing evidence that childhood abuse and neglect is related to major forms of adult illness, including ischaemic heart disease, cancer, chronic lung disease and irritable bowel syndrome (Krug et al., 2002; WHO & ISPCAN, 2006). It is thought that this relationship is mediated by the adoption of health risk taking behaviours like smoking, drug abuse, poor diet and insufficient exercise. Further research is needed to understand how children can be harmed by neglect in the long-term (Hildyard & Wolfe, 2002).

<b>Finding</b>	<b>Comment</b>
Early exposure to neglect has a cascade of negative impacts, particularly in the domain of mental health and mental development.	Prevention of neglect is particularly vital in the early years.

## **2.2 Intervention to prevent child neglect and adverse long-term outcomes**

There are three key intervention points in the prevention of child neglect and adverse long-term outcomes. The first intervention point is prevention before neglect occurs. This is commonly called primary prevention and can include both universal interventions and interventions targeted towards high risk families. The second intervention point is after neglect has occurred. This secondary prevention of neglect includes identifying that neglect is occurring and actions to prevent its recurrence. Finally, the third intervention relates to the prevention of long term impairment following child neglect. The following subsections review current evidence at each of the three intervention points.

### **2.2.1 What do we know about preventing child neglect before it occurs?**

Interventions to prevent neglect can be either universal or targeted to family/whānau and individuals. The similarity in risk factors and epidemiology for each type of child maltreatment (neglect, emotional abuse, physical abuse, and sexual abuse) suggest that a common approach to prevention may be undertaken (WHO & ISPCAN, 2006). However, overall there is insufficient evidence of the effectiveness of prevention programmes in improving physical neglect and abuse outcomes (Mikton & Butchart, 2009).

Evidence is lacking that national poverty, education and employment policies significantly reduce the rates of child neglect and abuse in any population (WHO, 2002). Such policies do, however, have a direct impact on risk factors for child maltreatment, suggesting that they should also improve maltreatment outcomes. Similarly legal frameworks, which prohibit maltreatment of children and recognise children's rights, should impact positively on risk factors for child maltreatment. They also send a clear message to society that children are to be valued, not maltreated. Guidelines to preventing child maltreatment suggest these messages can benefit from public awareness and media campaigns to change cultural and social norms (WHO & IS PCAN, 2006).

**Table 4: Strategies for preventing child neglect and abuse by level of influence**

Level of intervention	Prevention strategy
Societal and Community	Implementing legal reform and human rights Introducing beneficial social and economic policies including universal education, unemployment minimisation and mitigation, and investment in good social protection systems Changing cultural and social norms that support violence including media-based interventions Reducing economic inequalities by tackling poverty and reducing income and gender inequalities Environmental risk factor reduction (eg: reducing alcohol and drug availability)
Family / Whānau	Home visitation programmes <sup>3</sup> Training in parenting <sup>4</sup> Support and mutual aid groups Provision of quality child-care Multi-component interventions <sup>5</sup>
Individual	Reducing unintended pregnancies Access to maternity and post-natal/child health services Access to individual risk factor interventions (substance abuse, mental health, violence) Training children to recognize and avoid potentially abusive situations

Sources: WHO, & ISPCAN (2006). and Mikton & Butchart (2009).

Evidence in relation to mass media campaigns and social support and mutual aid groups is either mixed or insufficient (Mikton & Butchart, 2009). Mass media campaigns to increase awareness and understanding of child neglect and abuse may in theory reduce child neglect through changes in perpetrator behaviour and increased public reporting of suspected maltreatment to child protection services. While mass media campaigns have been shown to increase child protection

<sup>3</sup> Homevisiting involves trained personnel visiting parents and children in their homes to support, education and information to improve child health and parental caregiving abilities and prevent child neglect and abuse.

<sup>4</sup> Parent education is usually a group-based programme in a centre which focuses on parents' child-rearing skills, parental knowledge of child development and positive child management strategies.

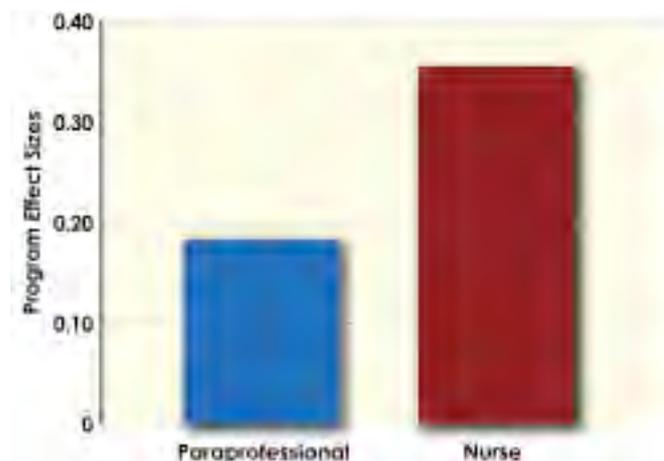
<sup>5</sup> Multi-component interventions often include a combination of family support, preschool education, parenting skills and child care.

referrals there remains insufficient evidence about the impact on substantiated child neglect and outcomes for children (Mikton & Butchart, 2009; WHO, 2002).

Home visiting, parent education and multi-component programmes have been identified as “promising” for preventing actual child neglect and abuse (Mikton & Butchart, 2009). This is because some benefit has been demonstrated internationally from Nurse-Family Partnerships and the Early Start programme<sup>6</sup>, although the weight of evidence has still found most interventions of this type to be ineffective (Howard & Brooks-Gunn, 2009; MacMillan et al., 2009; Mikton & Butchart, 2009).

The home visitors with Nurse-Family Partnerships are public health nurses, and the Early Start programme employed nurses or social workers with five weeks additional training. Of note, the Nurse-Family Partnership also measured the effect of nurse visiting, compared to paraprofessional visiting (Olds, Robinson, Pettit, Luckley, Holmberg, & Ng, 2004). Child development effects were roughly twice as large for nurse-delivered intervention, compared to paraprofessional-delivered intervention (Figure 3).

**Figure 3: Average effects of paraprofessional and nurse home visits on child development outcomes at ages two and four**



Source: Olds, et al., 2004 quoted in Center on the Developing Child at Harvard University (2007). A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children. Available from <http://developingchild.harvard.edu/>

<sup>6</sup> In New Zealand the Early Start programme is available in Christchurch only.

Maternity and post-natal/child health services provide an opportunity for needs assessment and recruitment of families and whānau to home visiting and parent education programmes. They also aim to reduce premature births and babies born with low birth weight, illness or disability – all of which are associated with poor attachment and child maltreatment risk (WHO, 2002).

In addition to further research to pinpoint what makes parenting programmes effective, research should also compare the effectiveness of parenting programmes with programmes that aim to reduce related risk factors like substance abuse, mental illness and family violence (Barth, 2009).

In theory, efforts to reduce unintended pregnancies could reduce child maltreatment because unintended pregnancies are associated with low birth weight, increased risk of infant mortality, developmental delay and child maltreatment (WHO, 2002).

### **Identification of high risk families for targeted intervention**

Additional targeted interventions require the identification of high-risk families. However, the use of risk assessment tools to identify children at high risk of neglect is fraught with difficulty.

Numerous screening methods have been developed for use during antenatal and postnatal periods to identify parents at high risk of maltreating their children ... Their poor specificity and low positive predictive value, combined with the possible stigmatising effect of a false-positive result, restrict their application to clinical practice.  
(Gilbert, Kemp, et al., 2009, p. 170)

Despite these difficulties, Daniel et al., (2010) found policy optimism for the use of neglect prediction tools. Such tools may provide helpful assistance with the analysis of assessment information, but Daniel et al concluded:

Health visitors should continue to draw upon their clinical and assessment skills when working with parents and young children rather than rely on the false reassurance of predictive checklists.  
(Daniel et al., 2010, p. 8)

### Reasons for a lack of evidence

Nearly all studies (99 percent) on child maltreatment prevention research are conducted in high income countries (Mikton & Butchart, 2009). Furthermore, most of this research (approximately 80 percent) is from the United States of America and the research focuses on risk factors as outcomes (64 percent) rather than measures of actual neglect or abuse. Mikton and Butchart (2009) note that evidence strongly suggests prevention of child neglect and abuse is more effective and less costly than responding to neglect to prevent recurrence and impairment.

Findings	Comments
There is insufficient evidence of the effectiveness of universal and targeted interventions to prevent child neglect. Nurse-Family Partnerships and the Early Start programme have shown some promise.	Where possible the impact of interventions could be measured to contribute to the evidence base.
Ability to provide effective targeted preventive services is hindered by difficulty identifying high-risk families. Current screening tools for the identification of high risk families and vulnerable children are weak (poor specificity and predictive strength).	Further research could be considered to support the identification of high risk families for targeted intervention and to inform policies and programmes.

### 2.2.2 What do we know about preventing the recurrence of child neglect?

Preventing the recurrence of child neglect involves professional or public identification and referral of child neglect, followed by child protection service assessment and confirmation, and either statutory or community-based intervention.

Gilbert, Kemp et al. (2009) recently conducted a review of the evidence about recognising and responding to child maltreatment. They found that only a small proportion of children who are maltreated access interventions, suggesting a failure by professionals to identify and report maltreatment and failure by child protection agencies to investigate or substantiate maltreatment. However, Gilbert,

Kemp et al. (2009, p. 168) also point out that “we do not know whether the process from recognition to reporting and subsequent interventions by child-protection agencies improves lives overall”. In summary they conclude, “serious shortfalls exist at every step of the process in all sectors” (Gilbert, Kemp, et al., 2009, p. 176).

### **Inter-agency identification and notification of child neglect**

Numerous screening tools have been developed for the identification of child maltreatment (including neglect). Systematic reviews have found, however, that experienced professional assessment is likely to be more accurate than current screening tests (Daniel et al., 2010; Gilbert, Kemp, et al., 2009).

Because neglect is an act of omission rather than an act of commission it is more challenging to substantiate. Establishing neglect often requires systematic collection of information over a period of time (McSherry, 2007). This may be a further barrier to referring child neglect. Daniel et al. (2010) report that neglect notifications are often triggered by other events or concerns about vulnerable children. Such events reduce this information barrier.

There is also significant variation in thresholds for neglect by agency and between professionals depending on their area of work and resources (Dubowitz, 2007). Professional training and support may help to reduce inter-agency variation in thresholds. Angeles Cerezo and Pons-Salvador (2004) reported an increase in the proportion of confirmed cases of maltreatment referred by schools from less than 5 percent to 24.5 percent with professional training and support in a large Spanish study.

Professionals have been found to have higher thresholds for neglect, compared to the general public (Daniel et al., 2010). Gilbert, Kemp et al. (2009) report growing evidence of under-reporting by health and education professionals and suggest that although the education sector are key notifiers, they are also responsible for failing to report most cases. Reasons for not reporting suspected neglect or abuse include:

- current parental behaviour;
- concerns about betrayal of relationship with family;
- level of training about neglect;
- uncertainty about what constitutes reasonable grounds for suspicion;

- a fear of “being found out”;
- difficulties in communication with social services;
- turnover of social service staff;
- inadequate feedback; and
- negative perceptions about the effectiveness of social services (Gilbert, Kemp, et al., 2009).

Most child maltreatment referrals (57.9 percent) in the United States came from professional sources (US Department of Health and Human Services. Administration for Children and Families. Administration on Children Youth and Families. Children's Bureau, 2010). The education sector is seen as particularly important because of its near daily contact with children. This facilitates opportunities for recognition and responses to child neglect (Angeles Cerezo & Pons-Salvador, 2004; Gilbert, Kemp, et al., 2009). (See Table 7 on p. 34 for a comparison of the relative contributions of professionals to child maltreatment referrals in New Zealand and United States).

Some studies have suggested that the general public is as skilled as professionals in recognising aspects of child neglect, if not more so (Daniel et al., 2010).

Findings	Comments
There is no evidence to suggest that current screening tools improve identification of child neglect.	Further development of tools to assist with the identification of child neglect could be considered.
There is limited evidence to suggest that professional training and support may reduce inter-agency threshold variation, improving the proportion of confirmed referrals.	Inter-agency professional training may result in more efficient use of limited child protection resources. Consideration could be given to increased alignment between the education and child protection sectors in particular.

### Identification of child neglect by child protection services

Many studies have shown that failure to substantiate maltreatment does not indicate lack of welfare need or diminished risk of future maltreatment compared with substantiated cases. (Gilbert, Kemp, et al., 2009, p. 173)

Daniel et al., (2010) found that children have often experienced periods of neglect for some time before contact with social services, but a focus on whether it is a ‘care and protection issue’ and consideration of parental culpability can affect the substantiation threshold.

Full assessments of child neglect are complex and time consuming. “This need for comprehensive assessment raises perhaps the biggest barrier to addressing neglect: its inherent complexity and the paucity of quick fixes” (Dubowitz, 2007, p. 605).

One useful technique or guide to help social workers (and others) gain a better understanding of child neglect might be to develop a database of neglect case studies, in either single case or composite form, that typify good practice. These would allow for better informed decision-making processes and would facilitate a deeper understanding of the complexity of neglect. (McSherry, 2007, p. 612)

The tendency to prioritise physical abuse above neglect in a resource restricted environment (despite the damaging and pervasive effects of neglect) may also lead to a delay in identification of neglect until an act of abuse also occurs (McSherry, 2007). McSherry also asserts that intensive child neglect training for child protection staff would reduce the allocation of neglect cases “to the bottom of the (intervention) list” in a resource restricted environment.

Finding	Comment
Child protection services are charged with the prioritisation and substantiation of child maltreatment referrals. The complexity of neglect and prioritisation of abuse adversely affect the substantiation of neglect.	Child neglect training and a suite of neglect case studies may assist with the appropriate prioritisation of child neglect within child protection services.

### **Interventions to prevent recurrence of neglect**

There is no evidence of the effectiveness of interventions in preventing recurrence of neglect (MacMillan et al., 2009). The World Health Organization report on Violence and Health (2002) found there has been little investigation of the effectiveness of child protection services in reducing rates of abuse and neglect.

Measuring the effectiveness of responding to neglect may be compounded by the fact that “neglect is a disparate problem that needs varied responses to address each case” (Dubowitz & Bennett, 2007, p. 1895).

If, as the research suggests, child abuse and child neglect are generated out of complex interplays between different factors that may act at the level of the individual, the family, the community, and the cultural system, then the response must also be multi-dimensional. (Saville-Smith, 2000, p. 32)

Common secondary prevention interventions for child neglect include case management and supervision, individual and family counselling, respite care, parenting education, housing assistance, substance abuse treatment, child care and home visits (Waldfoegel, 2009).

A literature review of individual and group-based parenting programmes for the treatment of physical child abuse and neglect found insufficient evidence to support the use of parenting programmes to treat physical abuse or neglect (MacMillan et al., 2009).

A 2009 review of family preservation programmes<sup>7</sup> found that despite widespread adoption, most studies did not show a reduction in placements for children in the intervention group (MacMillan et al., 2009). McSherry (2007) suggests that in the best interests of the child, a critical time scale should be developed for rehabilitation in cases of child neglect. Parents and practitioners would then be clear about the time parents have to address neglect before a child is placed in care.

Although assessing the effectiveness of out-of-home placements for maltreated children is restricted by the lack of randomised studies (MacMillan et al., 2009), some studies have reported improvements in school attendance and academic achievement, anti-social behaviour, sexual activity, and quality of life (MacMillan et al., 2009).

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<sup>7</sup> Family preservation programmes are intensive short-term services designed to stabilise families and keep maltreated children at home, thus avoiding out-of-home placements for children.

Finding	Comment
There is no evidence demonstrating the effectiveness of child protection service interventions in reducing recurrent child neglect.	Child neglect outcomes following child protection service intervention require monitoring to provide evidence of service effectiveness.

### 2.2.3 How can impairment following child neglect be prevented?

After comprehensively reviewing the treatment of child neglect, Allin et al. (2005, p. 497) concluded that “rigorous studies of treatments for neglected children and their families are lacking”. Some evidence exists of improvement after resilient peer treatment, imaginative play training, and multi-systemic therapy (Allin et al., 2005). The same study also identified some evidence of an improvement in neglected children’s self-concept following a specific therapeutic day treatment programme.

Given the insufficiency of current evidence, MacMillan et al. (2009, p. 250) concluded that “future research should ensure that interventions are assessed in controlled trials, using actual outcomes of maltreatment and associated health measures”.

Finding	Comment
There is no evidence of the effectiveness of services to prevent impairment from child neglect.	Prioritisation of investment in controlled trials to assess interventions for the prevention of impairment may be beneficial.

## 2.3 Summary of literature review findings and implications

Neglect is a form of child maltreatment that has significant adverse long-term outcomes. Collaborative responses to child neglect will require a shared definition of child neglect and a shared understanding of its complex risk and protective factors. Many questions remain about the effectiveness of interventions to prevent child neglect, prevent recurrence after identification and to prevent long-term impairment following exposure to neglect.

### **3.0 THE PREVALENCE OF CHILD NEGLECT**

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 difficult to develop a proper awareness of child abuse and neglect and expertise in addressing the problem within the health care, legal and social service professions. (World Health Organization, 2002, p. 78)

#### **Background**

Most child neglect is not reported. This makes the prevalence of child neglect difficult to measure (Dubowitz & Bennett, 2007; Gilbert, Spatz Widom, et al., 2009). Scant attention to neglect in self-report and parent-report maltreatment studies has further hindered an understanding of the prevalence of child neglect (Gilbert, Spatz Widom, et al., 2009).

Child neglect is most commonly measured through child protection agency information. Monitoring the prevalence of the occurrence and recurrence of neglect allows a country to assess the size of the problem and the effectiveness of preventive interventions over time. In the United States, monitoring of child neglect and abuse informs the annual report to Congress on Child Welfare Outcomes, the activities of the Federal Government, child welfare professionals, researchers and others (US Department of Health and Human Services, 2010).

However, there are significant limitations to the understanding of child neglect based on child protection agency information. Child neglect measured by self-reporting tools typically has a ten-fold higher prevalence than child protection agency reports both in New Zealand and overseas (Davies et al., 2009; Gilbert, Spatz Widom, et al., 2009). Part of the reason for this is the systematic error or bias in child protection agency information. It is reliant upon notifications made to the agency, the current policy of the child protection agency and the standard of policy implementation.

Given this limitation, it can be difficult to ascertain whether any change or lack of change in the prevalence of child neglect as measured by a child protection agency is accurate. Where serial population-based surveys of childhood exposure to neglect have been undertaken, like in the United States, evidence is provided to assist the

interpretation of child protection agency information (Finkelhor, Turner, Ormond & Hambly, 2009).

Other common sources of child neglect information include hospital and Police data. Hospital admission data in New Zealand is of limited value because only a small number of children are admitted annually for neglect or abandonment (nine children in 2005 and 13 children in 2006) (Davies et al., 2009). Similarly, recorded offences for neglect provide information about only the most severe forms of neglect (Refer Figure 15, p. 48).

The annual prevalence of all forms of substantiated maltreatment ranges between 0.3 percent and 1.25 percent in the United Kingdom, Australia, Canada, USA and New Zealand (Davies et al., 2009). This report finds that for the 2009 financial year the annual prevalence of substantiated child maltreatment in New Zealand was 1.46 percent.

Davies et al. (2009) highlight the challenges of inter-country comparison of child neglect prevalence statistics. It is difficult to determine the contribution of measurement error and variability to the differences seen between New Zealand and other developed countries like the United Kingdom, United States, Canada and Australia. Certainly Police reporting of child emotional/psychological abuse through witnessing partner violence has made this form of maltreatment the most common form in New Zealand and complicated inter-country comparisons.

The information provided in the following section uses data from investigation findings of child neglect made by Child, Youth and Family. It examines:

- Notifications to Child, Youth and Family
- Child, Youth and Family investigation findings of neglect; and
- Child, Youth and Family responses to neglect

Finding	Comment
Monitoring of the prevalence of child neglect and abuse is currently limited to Child, Youth and Family data.	Without regular estimation of the prevalence of neglect and abuse in the community (by self-report or parent-report methods) it is unknown whether maltreatment is increasing or detection of maltreatment is improving.

## **A brief summary of the child protection process**

The information in this chapter relates to the process of preventing recurrence of child neglect through child protection services in New Zealand (Figure 4, p. 30).

The prevention of recurrence is one of three key intervention points in the framework for the prevention of child maltreatment (Figure 1, p. 4). It begins with a referrer's identification of a child protection concern and action to refer this concern to Child, Youth and Family or the Police.

Notifications made to Child, Youth and Family are triaged and allocated as either "further action required" or "no further action" required. Before the introduction of Differential Response in July 2009 the process of further action always involved an investigation from which a finding would be made. From this date, during the 2008/09 fiscal year for 17 pilot sites, Further Action would always involve a Safety Assessment, and then, if necessary, an Investigation or Child and Family Assessment would be carried out. Differential Response also introduced a third option where a non-statutory intervention coordinated by Child, Youth & Family is provided by the NGO Sector.

Seven key investigation/assessment findings can be made, four of which relate to child maltreatment (neglect and emotional abuse, physical abuse and sexual abuse), two relate to behavioural concerns (behaviour/relationship difficulties and self-harm/suicide concerns) and the remainder have a "not found" finding. Findings of behavioural concerns are not considered in this report.

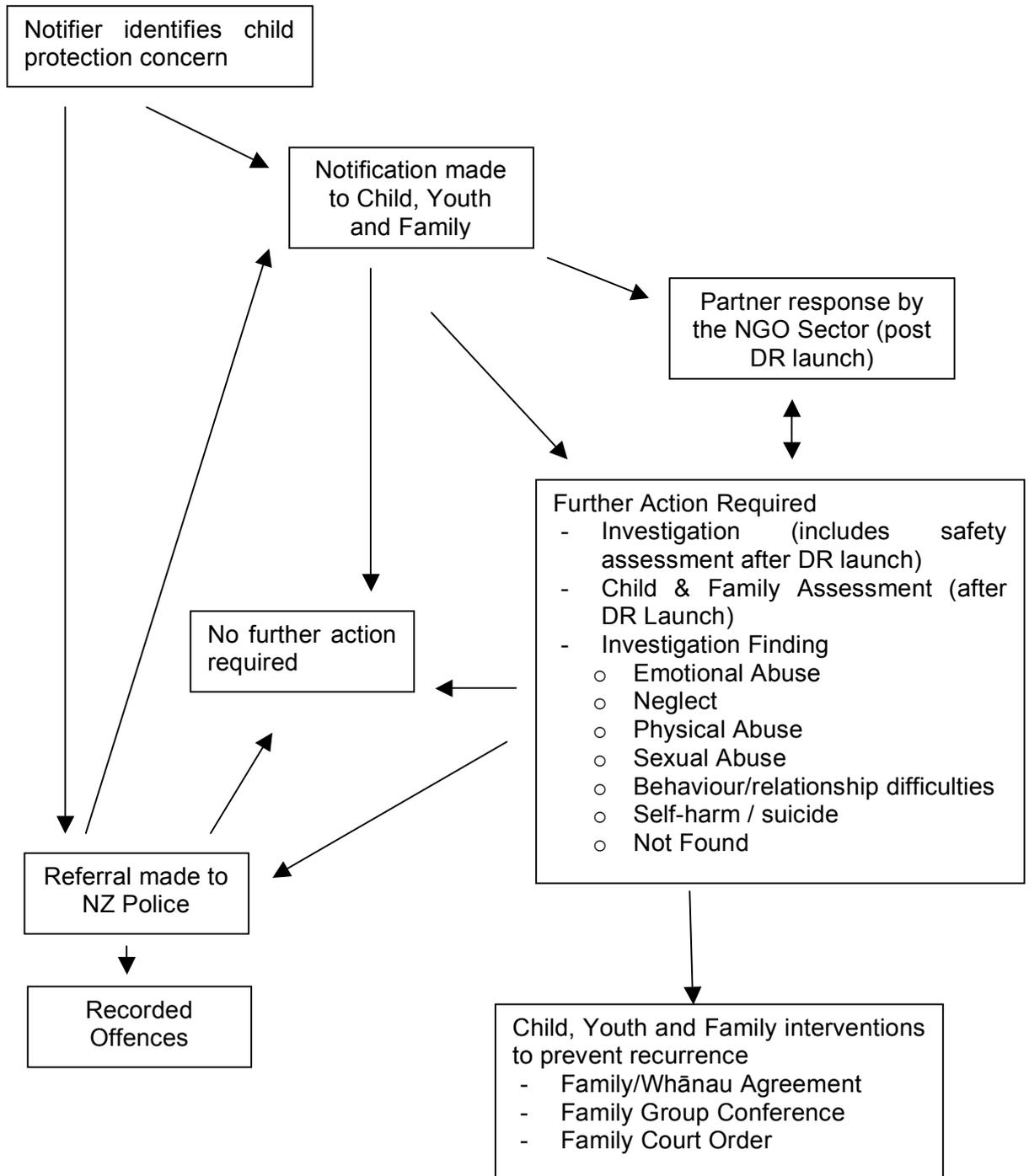
This chapter focuses on Child, Youth and Family findings of child neglect. One limitation of the Child, Youth and Family definition of neglect is the exclusion of emotional neglect, which is recorded as emotional abuse.

The four key child protection responses in order of seriousness of intervention are Differential Response, family/whānau agreement, family group conference and family court order. Each of these responses results in an action plan with further interventions that are not described in this report.

Notifications to Police include serious cases of child maltreatment and family violence. Police investigation of notifications can lead to the recording of offences and charges against the perpetrators.

Findings	Comments
<p>Emotional neglect is excluded from the Child, Youth and Family definition of neglect, and included in the definition of emotional abuse.</p> <p>Responses to child neglect beyond the initial service response are not cohesively described.</p>	<p>Use of Child, Youth and Family findings of neglect as a proxy indicator for neglect in New Zealand is limited by the absence of children with emotional neglect within the existing Child, Youth and Family definition.</p> <p>Consideration could be given to recategorising emotional neglect as a component of neglect.</p> <p>The description of responses to prevent the recurrence and impairment from child neglect could be considered.</p>

**Figure 4: The process of preventing recurrence through child protection services in New Zealand**



### 3.1 Clients notified to Child, Youth and Family

In the 2009 financial year, 74,340 children and young people were notified to Child, Youth and Family (Table 5). One in two children (fifty two percent) were identified as requiring further investigation.

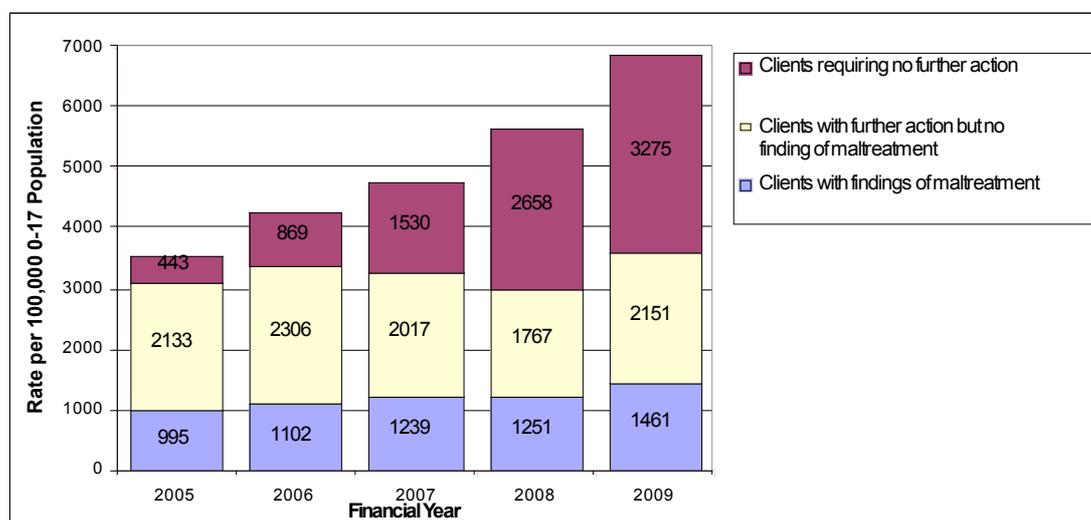
**Table 5: Clients notified, requiring further action and identified with maltreatment by Child, Youth and Family, July 2004 - June 2009**

Financial Year	Clients Notified to Child, Youth and Family	Clients requiring further action	Clients with findings of maltreatment
2005	38431	33665	10706
2006	46045	36690	11862
2007	51343	34927	13288
2008	61403	32646	13528
2009	74340	38990	15771

Source: Child, Youth and Family, 2010

Notifications increased annually in the five years to June 2009, doubling the number of clients and client notification rate<sup>8</sup> (Table 5, Figure 5).

**Figure 5: Rate of clients notified and initial outcome, July 2004 - June 2009**



Source: Child, Youth and Family, 2010

<sup>8</sup> Rate is the number of clients notified to Child, Youth and Family per 100,000 of the 0-17 year New Zealand population.

Although there was a large increase in the clients notified, the rate of clients requiring further action but without any maltreatment finding<sup>9</sup> remained stable at approximately 2,000 per 100,000 population aged 0-17 years. The increased rate of clients notified in the five years to June 2009 largely resulted in an increase in the rate of clients with no further action.

### **3.1.1 Variation by Child, Youth and Family site**

Notifications were made to Child, Youth and Family for 6,888 children per 100,000 population aged 0-17 years in the year to June 2009. There was a 22-fold variation in this notification rate among Child, Youth and Family sites throughout New Zealand (Figure 6), ranging from 885 – 19,092 children per 100,000 population aged 0-17 years.

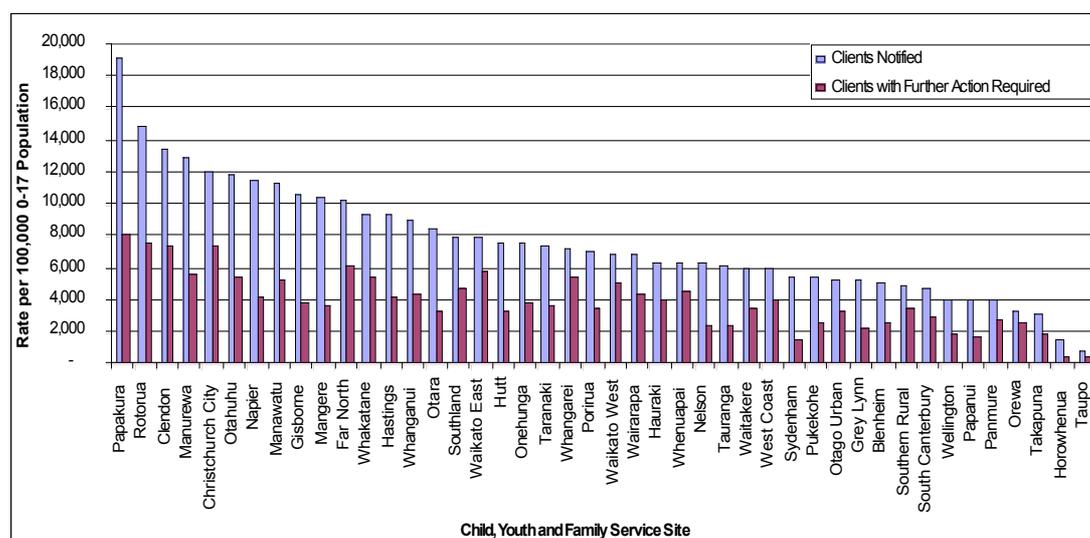
Further child protection investigation was required for 3,612 children per 100,000 population aged 0-17 years in the year to June 2009. This investigation rate had an 18-fold variation by Child, Youth and Family site, ranging from 440 - 8123 children per 100,000 population aged 0-17 years for the same period (Figure 6).

The proportion of notified clients requiring further investigation varies by Child, Youth and Family site. Between three in ten (28.9 percent) and eight in ten (79.3 percent) notified clients are identified as requiring further investigation by a Child, Youth and Family site.

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<sup>9</sup> This is derived as the difference between the number of clients requiring further action and the number of clients having a maltreatment finding.

**Figure 6: Rate of clients notified and requiring further investigation, by Child, Youth and Family Site, July 2008 - June 2009**



Source: Child, Youth and Family, 2010

### 3.1.2 Source of client notifications

The key sources of Child, Youth and Family notifications are shown in Table 6 below. Most notifications are made by professional agencies, with a significantly smaller proportion sourced from the New Zealand public. On average, Police, health and education services were the professional agencies most likely to notify children to Child, Youth and Family services.

**Table 6: Source of Child, Youth and Family notifications, July 2004 - June 2009**

Source of notification	Percentage of notified clients (by financial year)					
	2005	2006	2007	2008	2009	5-year total
PFV	20.9	34.7	41.5	49.8	52.6	37.0
Police	17.4	15.6	15.6	19.3	17.3	17.1
Education	13.1	11.4	10.3	10.4	9.0	10.5
Health	12.6	11.5	11.6	11.2	10.0	11.3
Justice	6.2	5.4	5.8	5.7	5.1	5.7
Child, Youth and Family	5.3	5.4	5.2	4.6	4.1	5.1
Other Social Services	1.8	1.3	1.6	1.7	1.5	1.7
Other Agencies	7.1	6.6	5.7	5.3	4.6	5.9
Family, Whānau, Self or Friend	20.1	16.6	14.8	14.0	12.0	14.4
Neighbour or Other Individual	7.1	5.7	5.4	4.9	4.6	5.6
Anonymous	6.8	6.7	5.9	6.2	5.2	6.2

Source: Child, Youth and Family, 2010. Note: A child may be referred by more than one source. PFV = Police Family Violence.

Of the clients notified by the education sector in the year to June 2009, primary schools notified most clients (53.5 percent), followed by secondary schools (24.7 percent), and Early Childhood Education (18.1 percent). Two notifications were recorded from Te Kohanga Reo in the five years to June 2009 (it is unknown if some notifications are miscoded as general education). The pattern of highest notifications from the 5-13 year old age group differs from the age distribution of identified neglect, which is most common in the preschool age (Figure 10, p. 41).

Table 7 below compares the source of child protection notifications in New Zealand and United States after the removal of Police family violence notifications from New Zealand data. Overall, professional sources contribute similar proportions of notifications in both countries. In New Zealand, Police contribute a greater proportion of notifications and education and social services contribute a smaller proportion of notifications, compared to the United States.

**Table 7: Comparison of source of notifications: New Zealand and USA**

Source of notification	New Zealand 2008-2009	USA 2008
Police	17.3 %	16.3 %
Health	10.0 %	12.6 %
Education	9.0 %	16.9 %
Social Services	10.2 %	10.6 %
Total from these sources	46.5 %	56.4 %

Note: Police Family Violence related referrals have been excluded to improve inter-country comparison.

Sources: Child, Youth and Family 2010 and the US Department of Health and Human Services.

All notification sources increased the number of clients they notified to Child, Youth and Family in the five-year period from July 2004 – June 2009 (Table 8). Professional notifiers had larger proportional increases in the number of clients notified, compared to non-professional referrers (family, friends, neighbours etc.). The largest increase of 387 percent occurred with Police Family Violence.

**Table 8: Clients notified - by source, July 2004 – June 2009**

Source of notification	2005	2006	2007	2008	2009	percent increase over 5-year period
PFV	8029	15991	21322	30607	39137	387 %
Police	6688	7203	8006	11841	12874	92 %
Education	5026	5259	5293	6376	6667	33 %
Health	4830	5305	5951	6906	7444	54 %
Justice	2378	2502	3003	3486	3804	60 %
Child, Youth and Family	2020	2465	2688	2805	3024	50 %
Other Social Services	690	580	833	1031	1081	57 %
Other Agencies	2722	3043	2927	3251	3393	25 %
Family/Whanau, Self or Friend	7730	7633	7621	8566	8950	16 %
Neighbour or Other Individual	2736	2630	2791	3001	3424	25 %
Anonymous	2608	3066	3034	3796	3852	48 %

Source: Child, Youth and Family 2010. Note: A child may be notified by more than one source.

### 3.1.3 Clients with a finding of maltreatment

Overall, there has been a falling proportion of clients notified to Child, Youth and Family who have a finding of maltreatment (neglect or abuse), from 27.9 percent in 2005 to 21.2 percent in 2009.

There was a decrease in the proportion of clients with confirmed maltreatment from all sources in the five-year period to June 2009 (Table 9).

**Table 9: Proportion of clients with findings of maltreatment, by source, July 2004 - June 2009**

Source of notification	2005	2006	2007	2008	2009	5-year total
PFV	33.6%	26.4%	25.9%	18.5%	17.3%	24.2%
Police	36.7%	35.9%	35.5%	25.7%	25.3%	32.1%
Education	30.9%	33.6%	32.4%	29.5%	27.7%	32.4%
Health	36.5%	35.1%	34.5%	31.0%	30.9%	34.9%
Justice	26.9%	29.3%	32.4%	28.5%	24.1%	29.8%
Child, Youth and Family	46.5%	39.6%	41.5%	35.9%	38.4%	40.7%
Other Social Services	38.3%	45.2%	36.0%	36.6%	32.4%	37.5%
Other Agencies	39.9%	36.9%	36.2%	33.3%	30.9%	36.2%
Family, Whanau, Self or Friend	25.7%	25.1%	25.7%	22.8%	22.4%	26.5%
Neighbour or Other Individual	29.3%	29.0%	28.2%	26.2%	24.3%	28.0%
Anonymous	28.4%	26.1%	26.1%	24.9%	23.2%	26.5%

Source: Child, Youth and Family 2010. Note: A child may be referred by more than one source.

### 3.1.4 Clients with a finding of neglect

In the year ended June 2009, clients with a finding of neglect were most likely to be notified by Police Family Violence, Police, Health and Family/Whānau, Self or Friend (Table 10). There appears to be a trend towards decreasing clients from public sources (family or neighbour) that have an investigation finding of neglect.

**Table 10: Clients with a finding of neglect, by source, July 2004 - June 2009**

Source of notification	2005	2006	2007	2008	2009	5-year total
PFV	799	1058	1287	1247	1261	5502
Police	917	1002	1035	1111	1088	5020
Education	644	745	690	729	623	3339
Health	891	857	886	1002	989	4520
Justice	247	277	372	376	319	1572
Child, Youth and Family	550	481	560	502	463	2530
Other Social Services	129	143	170	173	170	784
Other Agencies	481	540	481	466	418	2347
Family, Whanau, Self or Friend	937	825	826	788	756	4038
Neighbour or Other Individual	467	414	418	437	355	2068
Anonymous	467	495	422	503	445	2300

Source: Child, Youth and Family. Note: A child may be referred by more than one source.

### 3.1.5 Number of notifications prior to finding of neglect

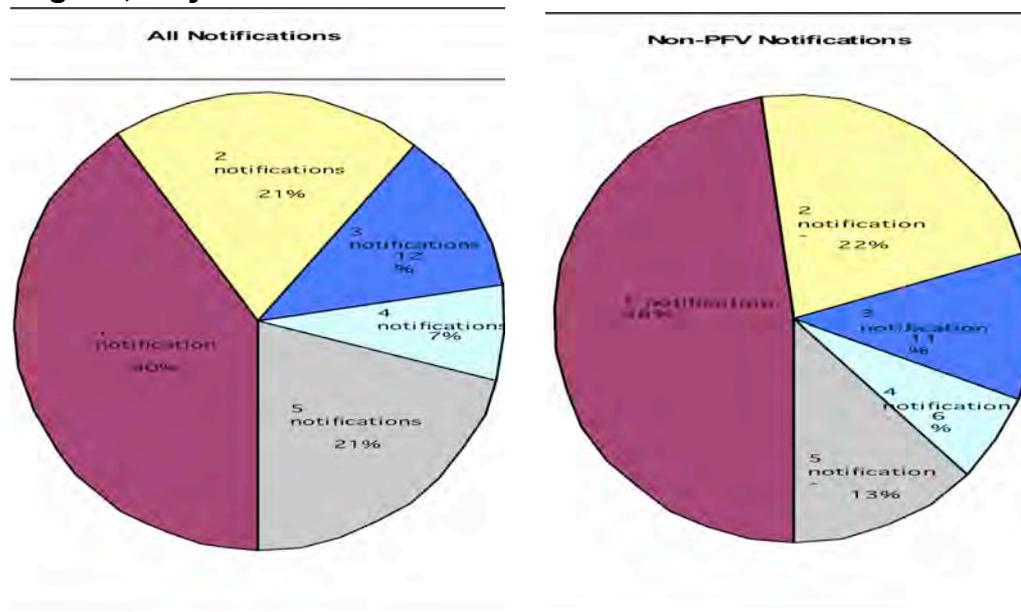
Most findings of neglect (61 percent) are made following one or two notifications to Child, Youth and Family<sup>10</sup> (Figure 7). On average, 3.1 notifications were made prior to an investigation finding of neglect in 2009. This average drops to 2.4 when the Police Family Violence notifications are excluded.

<sup>10</sup> Note that this is a count of the number of notifications within the same engagement of the first abuse finding in any particular year. Please note also that an engagement could span several years and some notifications may follow the neglect finding.

The highest number of notifications prior to a finding of neglect was 29 notifications in the year to June 2009. However, the highest number of notifications was 20 when only the non-PFV notifications are considered.

The category of 5 plus notifications included 211 children with between 10-19 notifications prior to the investigation finding of neglect and 18 children with between 20-29 notifications prior to the investigation finding of neglect. There were 76 clients who had more than 10 non-PFV notifications.

**Figure 7: Number of notifications prior to investigation finding of neglect, July 2008 – June 2009**



Source: Child, Youth and Family.

Findings	Comments
Notifications have increased from all sources over the past 5 years.	There is increasing child protection concerns in the community as well as increased family violence notifications.
There has been a significant increase in the rate of clients being notified and clients that require no further action. Most notifications are made by professional sources. Professional referrers are just as likely or slightly more likely to have their child maltreatment concerns upheld by Child, Youth and Family investigation, compared to the public.	Current professional assessment tools do not significantly raise the proportion of notifications upheld by Child, Youth and Family investigation, beyond general public knowledge.  Improving the quality of professional notifications could significantly decrease the burden of notifications that require no further action on child protection services. <b>Cont...</b>

Findings	Comments
<p>Over half of all notifications from child protection professionals (Child, Youth and Family staff) are not upheld by Child, Youth and Family investigation.</p> <p>The proportion of professional notifications upheld by any Child, Youth and Family Site vary widely.</p>	<p>Even with extensive knowledge of the New Zealand child protection system it is difficult for Child, Youth and Family professionals to accurately identify notifications that will be upheld following investigation.</p> <p>This may be because of difficulty making an assessment with incomplete information. Equally it may be because of variability in Child, Youth and Family decision-making following investigation.</p>
<p>No further action is taken on most notifications.</p>	<p>Letters to confirm receipt of notification could inform referrers that no further action will be taken if an assessment is not to be undertaken.</p>
<p>Most professional agencies with which Child, Youth and Family have a memorandum of understanding have a code on the child protection database.</p>	<p>Child, Youth and Family could consider providing professional agencies with area-based and national summaries of child protection notifications and notification outcomes for audit and monitoring purposes.</p>
<p>More than 20 notifications were made for 18 children prior<sup>11</sup> to an investigation finding of neglect in the 2009 financial year.</p>	<p>An audit of these cases with an extreme number of notifications could be considered to understand why so many notifications were made prior to a child protection service response.</p>
<p>Police are the largest source of notifications that result in an investigation finding of neglect.</p>	<p>Child, Youth and Family investigation findings of neglect are likely to be associated with family violence. This could be described with the current Child, Youth and Family dataset.</p> <p>Police as a professional group are regularly exposed to children experiencing neglect. It is therefore important that Police as a profession are well trained in the assessment and reporting of child neglect.</p>
<p>The education sector has a low notification rate in comparison to USA data, considering the almost daily contact with children.</p>	<p>Further training in the education sector has the potential to significantly raise notifications.</p>

<sup>11</sup> Note that this is a count of the number of notifications within the same engagement of the first abuse finding in any particular year. Please note also that an engagement could span several years and some notifications may follow the neglect finding.

### 3.2 Child, Youth and Family investigation findings

Neglect is the second most frequent Child, Youth and Family child maltreatment investigation finding (Table 11, Figure 8). In the financial year 2009, it was identified 1.6 times as often as physical abuse, four times more often than sexual abuse and less than half as often as emotional abuse.

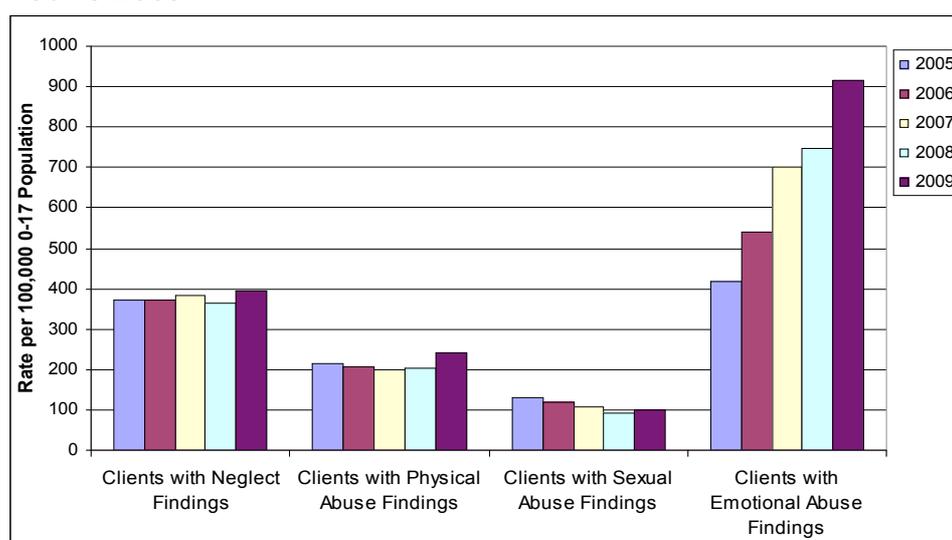
**Table 11: Clients with Child, Youth and Family findings, by maltreatment subtype, July 2004 - June 2009**

Financial year	Clients with Child, Youth and Family finding of neglect	Clients with Child, Youth and Family finding of emotional abuse	Clients with Child, Youth and Family finding of physical abuse	Clients with Child, Youth and Family finding of sexual abuse	Clients with Child, Youth and Family finding of maltreatment (neglect and/or abuse)
2005	4008	4502	2314	1409	10706
2006	3983	5806	2240	1286	11862
2007	4093	7503	2148	1152	13288
2008	3946	8087	2186	978	13528
2009	4240	9886	2625	1060	15771

Source: Child, Youth and Family, 2010

Four in every thousand New Zealand children (0.39 percent) were identified by Child, Youth and Family as experiencing neglect in 2009 (Figure 8). The rate of neglect remained stable during the five-year period to June 2009.

**Figure 8: Trends in identified child maltreatment, by subtype, July 2004 - June 2009**



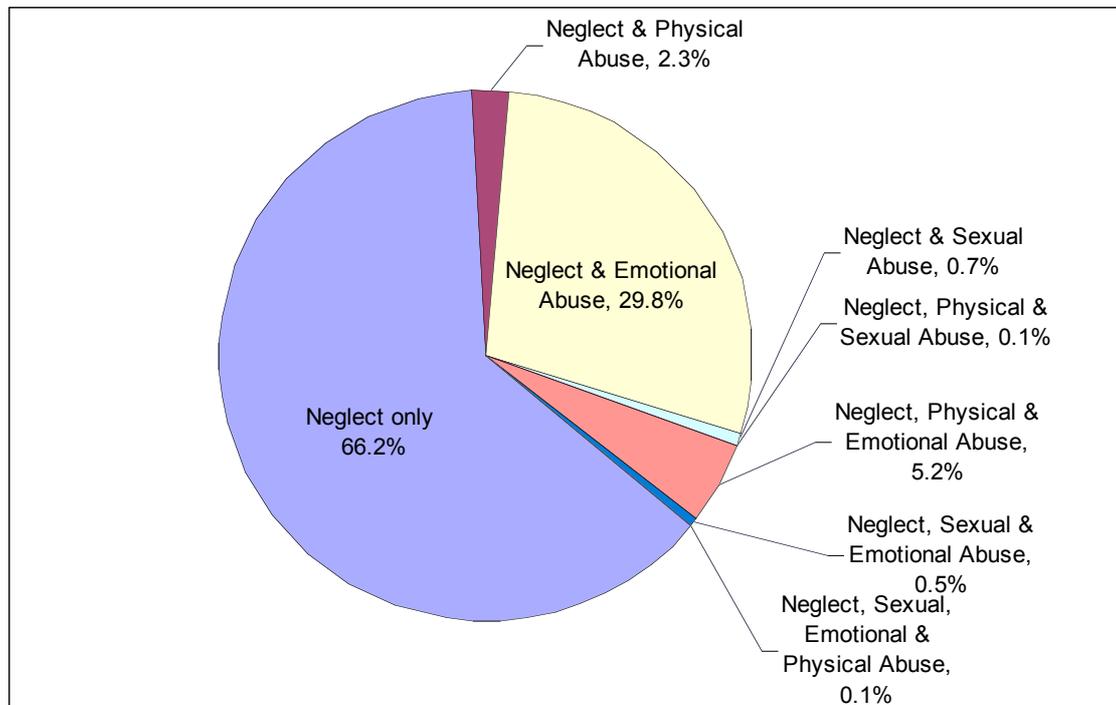
Source: Child, Youth and Family, 2010

### 3.2.1 Neglect and other maltreatment co-findings

Neglect was the sole investigation finding for two in three (66.2 percent) clients with identified neglect in the year ended June 2009 (Figure 9). Emotional abuse is the most frequent investigation co-finding for children with identified neglect (29.8 percent).

A 50 percent increase in clients with findings of neglect and emotional abuse together (from 845 to 1264) was observed in the five-year period to June 2009. This corresponded with a slight decrease in the proportion (3.4 percent) of clients with findings of neglect only.

**Figure 9: Co-findings for clients with identified neglect, July 2008 - June 2009**



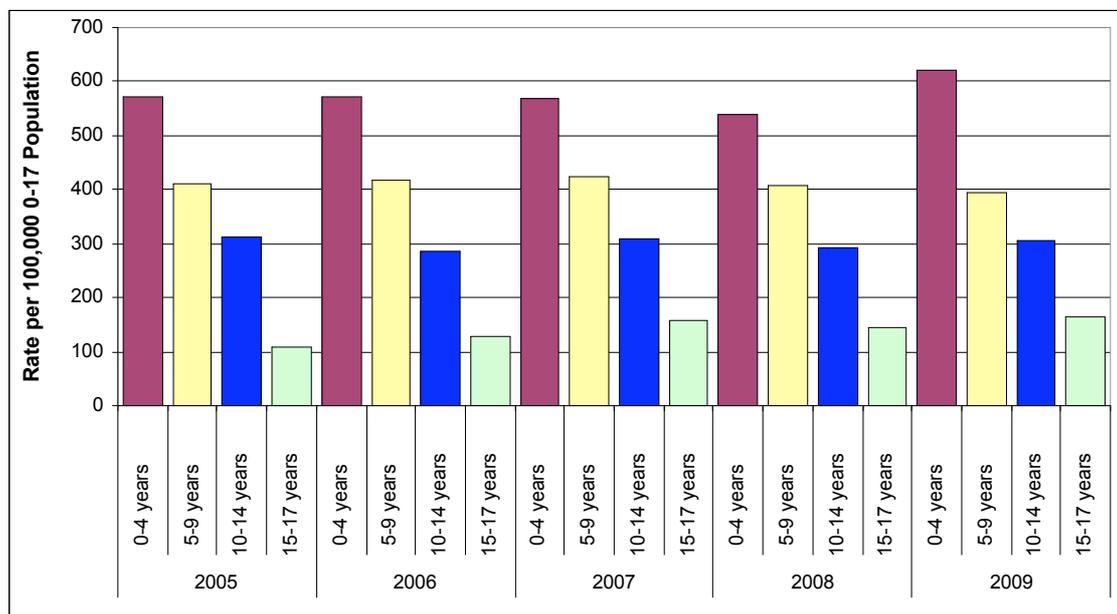
Source: Child, Youth and Family, 2010.

### 3.2.2 Findings of neglect by age and gender

Neglect is more commonly identified in younger children. Four in ten (43.7 percent) children with identified neglect were aged 0-4 years in 2009 (Figure 10).

There was a 52.1 percent increase in the rate of identified neglect in the 15-17 year old age group between July 2004 and June 2009. All other age groups had a relatively stable rate of identified neglect through this period.

**Figure 10: Trends in clients with neglect findings, by age group, July 2004 – June 2009**



Source: Child, Youth and Family, 2010.

There is no difference by gender among children with identified neglect. In the 2009 financial year the rate of identified neglect was 384 for girls and 389 for boys per 100,000 population aged 0-17 years.

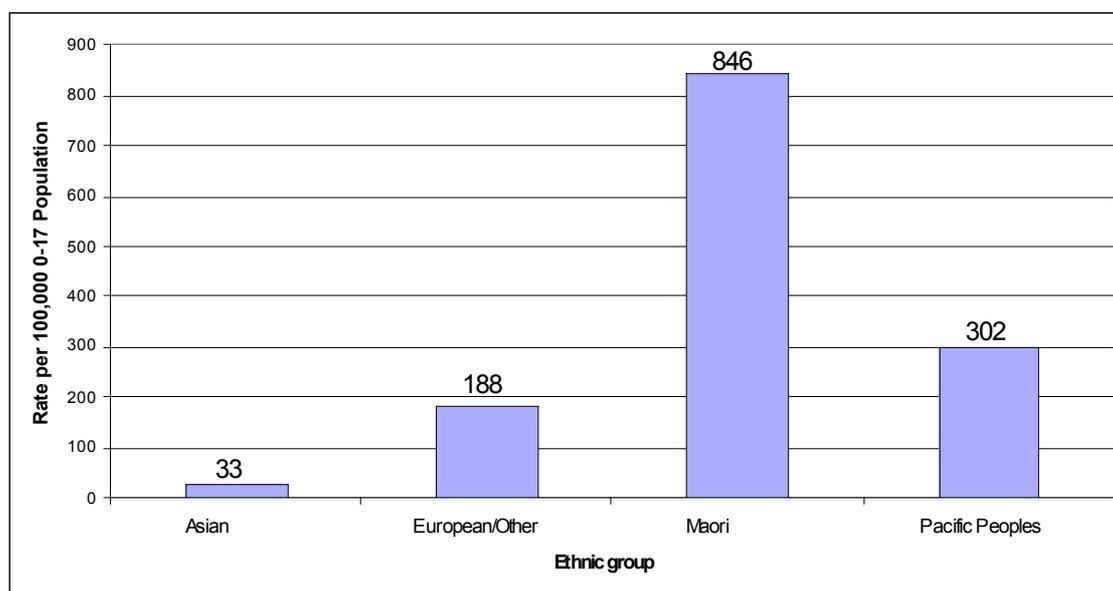
### 3.2.3 Clients with findings of neglect by ethnicity<sup>12</sup>

The rates of Asian, European, Māori and Pacific children found to have experienced neglect is shown in Figure 11 for the year ending June 2009. Māori children have the highest rate of identified neglect in New Zealand. Māori children were 4.5 times more likely to have a finding of neglect compared to European/Other children. Māori children were 2.8 times more likely to have a finding of neglect, compared to Pacific children.

Pacific children were 1.6 times more likely than European/Other children to have a finding of child neglect. Asian children were 5.7 times less likely than European/Other children to have a finding of child neglect.

There was no change in the rate of neglect among European/Other, Māori and Pacific children between 2006 and 2009<sup>13</sup>. The rate for Asian children decreased by 60.6 percent, however, this group has small numbers.

**Figure 11: Clients with neglect findings, by ethnicity, July 2008 - June 2009**



Source: Child, Youth and Family, 2010. Note: One child or young person may have more than one ethnicity.

<sup>12</sup> Clients with neglect findings who had unknown ethnicity were ignored from the analysis.

<sup>13</sup> The ethnic population data was not available for 2005, since this data was sourced from the 2006 Census (StatsNZ website, 2010).

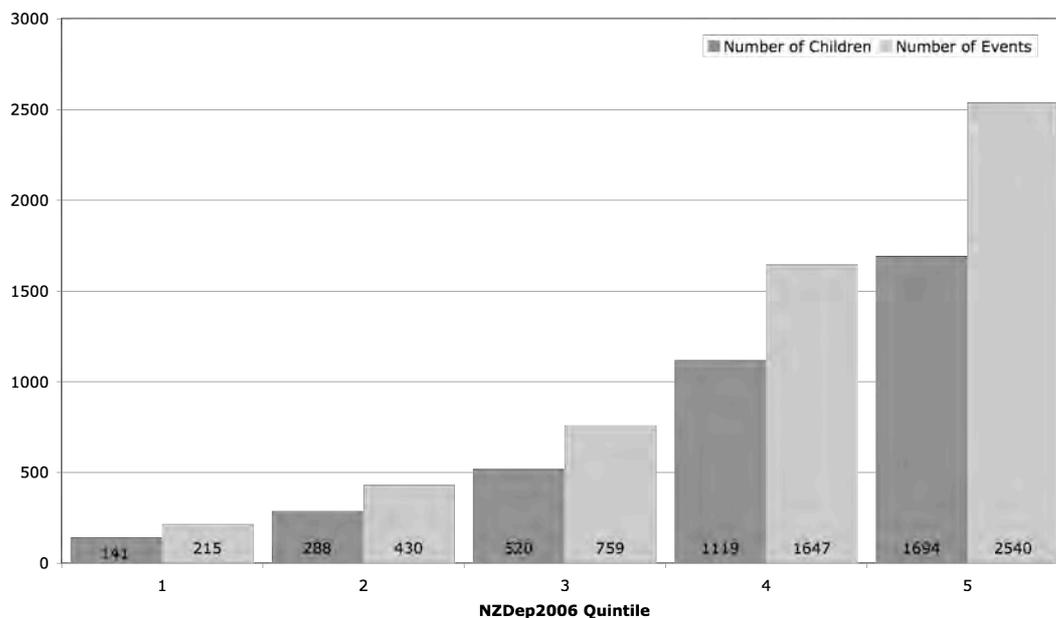
### 3.2.4 Findings of neglect by deprivation

Most clients identified with maltreatment (84 percent match rate) can be linked to a neighbourhood deprivation rating for their usual place of residence. The New Zealand Index of Socioeconomic Deprivation created from Census 2006 data places neighbourhoods in one of five even groups (quintiles) allowing comparison of the population living in areas with the least deprivation (quintile 1) with areas of higher levels of deprivation (quintile 5 containing the most deprived neighbourhoods). (Salmond, Crampton & Atkinson, 2007). More information on the deprivation index can be found in Appendix 1.

Child, Youth and Family have reported both the number of children and the number of neglect findings made for each neighbourhood in the 2009 financial year (Figure 12). Overall there is a trend of increasing findings of child neglect in more deprived neighbourhoods. Four out of ten (45 percent) of all clients identified with neglect live in New Zealand's most deprived neighbourhoods (NZDep2006 quintile 5).

In all neighbourhoods, an average of 1.5 neglect findings were made in the 2009 financial year for each client with identified neglect.

**Figure 12: Number of clients with identified child neglect, by neighbourhood deprivation, age 0-17 years, July 2008 - June 2009**



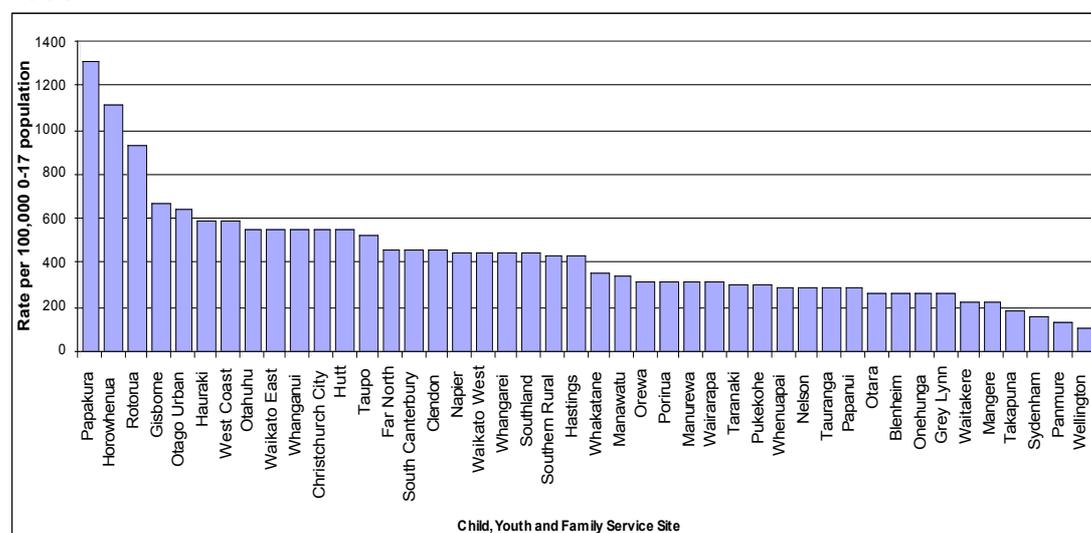
Data Source: Child, Youth and Family 2010 / Ministry of Health 2010.

Note: NZDep2006 quintile was unknown for 16 percent of children with identified maltreatment.

### 3.2.5 Clients with findings of neglect by Child, Youth and Family site

The rate of clients with Child, Youth and Family findings of neglect ranges throughout New Zealand by Child, Youth and Family site from 112 – 1321 children per 100,000 population aged 0-17 years (Figure 13). Half of all Child, Youth and Family sites have a local rate of child with neglect finding which exceeds the national rate of 393 children per 100,000 population aged 0-17 years.

**Figure 13: Rate of children with a Child, Youth and Family finding of neglect, by Child, Youth and Family Site, 0-17 years, July 2008 – June 2009**

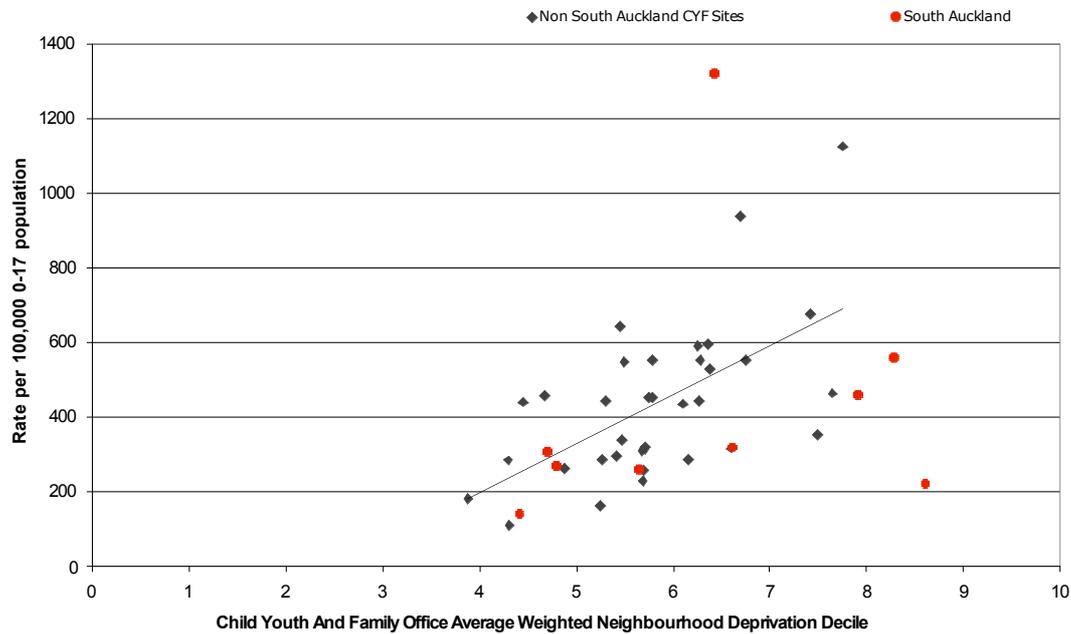


Source: Child, Youth and Family, 2010.

The rate of identified child neglect per 100,000 0-17 population increases in Child, Youth and Family sites with increasing local neighbourhood deprivation (Figure 14). Sites with lower levels of average deprivation have less variation in their rate of child neglect, compared to sites with higher levels of average neighbourhood deprivation.

Of note, the rate of children with findings of neglect among South Auckland Child, Youth and Family sites tends towards the lower end of the observed range for each average weighted neighbourhood deprivation decile (Figure 14).

**Figure 14: Rate of child neglect by Child, Youth and Family site average weighted deprivation decile, by site, July 2008 - June 2009**



Data source: Child, Youth and Family 2010/ Ministry of Health 2010.

Findings	Comments
<p>Children aged 0-4 years have the highest risk of identified neglect, by age group.</p> <p>Maori children have the highest risk of neglect by ethnicity.</p> <p>About 40 percent of the clients with identified child neglect live in the most deprived neighbourhoods.</p>	<p>Maori children aged 0-4 years living in the most deprived neighbourhoods (NZDep2006 quintile5) are likely to have the highest rate of identified child neglect. Further analysis could be undertaken to describe the rate among this and other sub-populations.</p>

### 3.3 Child, Youth and Family responses to neglect

In 2009, after an investigation finding of neglect, the most common Child, Youth and Family response is a Family Group Conference (41.8 percent), a Family/Whānau Agreement (23.9 percent) and No Further Action (21.8 percent).

Some Partnered Response outcomes were recorded in the year to June 2009 (Table 12). This represents the beginning of the Differential Response Pathway, which was rolled out nationwide by Child, Youth and Family in July 2009.

**Table 12: Child, Youth and Family responses to neglect, July 2004 – June 2009**

Investigation Outcomes	2005	2006	2007	2008	2009
Family Court Orders	367	405	383	289	289
Family Group Conference	1640	1603	1591	1746	1772
Family/Whānau Agreement	658	754	950	928	1015
Incorrect Phase - FAR	74	76	121	98	51
No Further Action	1185	1162	1110	944	926
Partnered Response					53
Refer to Service - NFA	338	269	295	303	333
Safety Assessment				9	172
Unknown	2				
Grand Total	4264	4269	4450	4317	4611

Note: One child can have more than one finding of neglect (for different investigations), thus investigation outcome in any given year - 4240 children had a finding of neglect in 2008/2009. Source: Child, Youth and Family 2010.

The use of Family Group Conferences as a response to neglect tends to increase with increasing age (Table 13). Correspondingly, the use of Family/Whānau Agreements reduces with increasing age.

Family Court Orders are sought for one in fifteen (6.8 percent) children with findings of neglect (Table 13). Family Court Orders are more likely to be sought for children aged 0-4 years or 15-17 years, and less likely to be sought for children aged 5-14 years, compared to the national average.

**Table 13: Child, Youth and Family responses to neglect, by age group,  
July 2008 – June 2009**

<b>Investigation Outcomes</b>	<b>0-4 years</b>	<b>5-9 years</b>	<b>10-14 years</b>	<b>15-17 years</b>	<b>Total</b>
Family Court Orders	8.4%	5.1%	4.9%	9.5%	6.8%
Family Group Conference	40.5%	39.9%	43.1%	52.2%	41.8%
Family/ Whanau Agreement	24.3%	27.1%	21.3%	17.7%	23.9%
No Further Action	22.6%	21.8%	22.1%	16.8%	21.8%
Refer to Service - NFA	7.4%	8.8%	8.8%	4.4%	7.9%
Other	6.2%	6.4%	7.6%	5.4%	6.5%

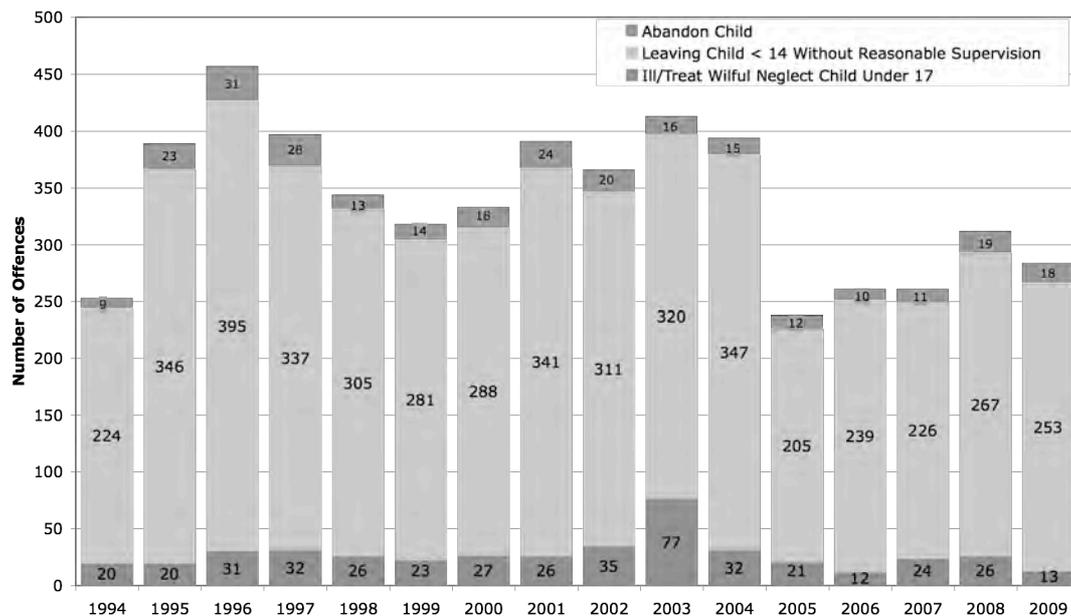
Source: Child, Youth and Family

### 3.4 Police recorded neglect offences

Leaving a child, under 14 years of age, without reasonable supervision is the most common form of recorded child neglect offence (Figure 15). Recorded offences for children without reasonable supervision have fallen in the last five years to levels not seen since 1994.

Comparatively few offences are recorded annually for abandonment and willful neglect of children. With the exception of 77 cases of willful neglect in 2003, offences for abandonment and willful neglect have varied little over the past 16 years (Figure 15).

**Figure 15: National Annual Recorded Child Neglect Offences, 1994 - 2009**



Source: Statistics New Zealand, 2010.

Finding	Comments
<p>Police recorded neglect offences provide an indication of some of the most serious neglect in New Zealand.</p>	<p>A review of recorded willful neglect cases could usefully provide a descriptive snapshot of severe willful neglect in New Zealand.</p> <p>Such a review could provide guidance to child protection Police officers now charged with investigating serious willful neglect. A review could also inform Child, Youth and Family staff who are the primary referrers to child protection Police officers.</p> <p>The sharp fall in recorded offences for children without reasonable supervision suggests a change of practice in 2005.</p>

### 3.5 Summary of identified neglect findings and implications

The epidemiology of child neglect is not routinely described. Population-based surveys of childhood exposure to neglect are not conducted. This report has found that monitoring of child neglect in New Zealand is currently limited to findings of neglect within the formal child protection and prosecution systems. Child, Youth and Family findings are further limited by the exclusion of findings of emotional neglect. Despite these limitations, useful information can be obtained to describe child neglect in New Zealand.

#### Summary of findings which describe identified child neglect

- Neglect is the second most frequent Child, Youth and Family child maltreatment investigation finding.
- Four in every thousand New Zealand children (0.393 percent) are identified by Child, Youth and Family as experiencing neglect in 2009.
- Neglect is the sole maltreatment investigation finding for two in three (63.1 percent) children with identified neglect.
- Four in ten (41.7 percent) children with identified neglect were aged 0-4 years in the year to June 2009.
- Maori children are 4.5 times more likely and Pacific children 1.6 times more likely to have a finding of neglect, compared to European/Other children.
- Almost half of all children with identified neglect (45 percent) live in New Zealand's most deprived neighbourhoods (NZDep2006 quintile5).
- The rate of children with Child, Youth and Family findings of neglect ranges by Child, Youth and Family site area throughout New Zealand from 112 – 1321 children per 100,000 population aged 0-17 years

Child neglect is an indicator that reflects not only levels of neglect in the population but also levels of reporting to Child, Youth and Family and child protection practice in New Zealand. The disaggregated findings in this chapter suggest that both child protection notifications and child protection practice vary significantly throughout New Zealand.

## **4.0 THE CURRENT APPROACH TO ADDRESSING CHILD NEGLECT**

### **Introduction**

This chapter provides information on current approaches to child neglect in New Zealand, with particular focus on approaches to prevent the recurrence of child neglect through detection of child neglect and referral to child protection services (see Figure 1, p. 4). It examines the definition of child neglect in legislation, policy and practice and then describes child neglect prevention in New Zealand.

### **4.1 The definition of child neglect**

#### **4.1.1 Neglect in legislation**

Neglect of a child is identified in national legislation as a serious act. The Children, Young Persons, and Their Families Act 1989 identifies children and young people in need of care or protection in situations where

- (a) the child or young person is being, or is likely to be, harmed (whether physically or emotionally or sexually), ill-treated, abused, or seriously deprived; or
- (b) the child's or young person's development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable.

However, neglect is undefined in the Children, Young Persons, and Their Families Act 1989.

Willful neglect of a child is a crime under the Crimes Act 1961. Again it is a serious offence which carries with it a term of imprisonment not exceeding 5 years. In their recent review of crimes against the person in the Crimes Act, the Law Commission (2009) noted that “the terms ‘ill-treats’ and ‘neglects’ are undefined in the Act, which makes it difficult to articulate the precise bounds of the provision”.

The Law Commission (2009) has therefore proposed that the term neglect is replaced by a gross negligence test, in effect providing a definition of neglect. The gross negligence test includes:

1. failure to perform the parental statutory duty of providing the ‘necessaries’ and taking all reasonable steps to protect the child from injury

2. which is a major departure from the standard of care to be expected of a reasonable person
3. and finally is likely to cause unnecessary suffering, injury, adverse effects to health, or any mental disorder or disability.

This amendment is included within the drafted Crimes (Offences Against the Person) Amendment Bill.

Finding	Comment
The gross negligence test within the drafted Crimes (Offences Against the Person) Amendment Bill contains the four core elements of child neglect as identified by Davies et al. (2009).	If included in legislation, this new definition of willful neglect will improve legislative understanding of neglect.

#### 4.1.2 Neglect in New Zealand's overarching interagency guide

New Zealand's *Interagency Guide to Breaking the Cycle: Let's stop child abuse together* (Child Youth and Family, 2001, p. 9) defines neglect as:

Neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It may include, but is not restricted to:

- physical neglect - failure to provide the necessities to sustain the life or health of the child or young person
- neglectful supervision – failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm
- medical neglect – failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development
- abandonment – leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning
- refusal to assume parental responsibility – unwillingness or inability to provide appropriate care or control for a child.

Finding	Comments
<p>The Interagency Guide definition of neglect:</p> <p><b>omits</b> the risk of harm to the child and requires a resulting impairment to have occurred. This makes the definition used by government agencies inconsistent with the Children, Young Persons, and Their Families Act 1989 as the Act also includes situations where harm is likely to occur;</p> <p><b>omits</b> psychological or emotional neglect – failure to provide for the child’s emotional needs and well being and failure to provide opportunities for cognitive development;</p> <p><b>omits</b> educational neglect – failure to enrol child in school, allowing chronic truancy and inattention to special education needs; and</p> <p><b>omits</b> reference to established standards of care or recognition that caregiver action should be a major departure from the standard of care to be expected of a reasonable person.</p>	<p>Consideration be given to updating the <i>Interagency Guide to Breaking the Cycle</i>. This could include incorporating the proposed common understanding of neglect.</p>

Emotional neglect, including isolation, deprivation of affection or cognitive stimulation is included within the interagency definition of emotional/psychological abuse (Child Youth and Family, 2001).

Finding	Comment
<p>In monitoring child neglect it must be understood that neglect which results in psychological, social, intellectual and/or emotional functioning and development are included in the investigation finding of emotional abuse rather than neglect.</p>	<p>Further investigation to describe the prevalence of emotional neglect in New Zealand could be undertaken.</p>

Neglect is also included within the definition of child abuse and the definition of family violence:

Child abuse means the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect or deprivation of any child or young person (Section 2, Children and Young Persons Amendment Act, 1994). (Child Youth and Family, 2001, p. 7)

Family violence represents a serious abuse of power within family, trust or dependency relationships ... It can involve killing or physical and sexual assault. It also involves other forms of abusive behaviour, such as emotional abuse, financial deprivation and exploitation, and neglect. (Child Youth and Family, 2001, p. 7)

Finding	Comment
Inclusion of neglect within the interagency definition of child abuse and family violence is consistent with the World Health Organization and International Society for Prevention of Child Abuse and Neglect perspective that it should be considered within these broader categorisations (see chapter 2).	Responses to child neglect form part of all responses to child abuse and all responses to family violence.

#### 4.1.3 The definition of neglect in sector protocols or policies

The *Interagency Guide to Breaking the Cycle* definition of neglect (Child Youth and Family, 2001) is used within agency child protection policies including the Ministry of Health's *Family Violence Intervention Guidelines: Child and Partner Abuse* (2002c), and the draft DHB Management of Child Abuse and Neglect Policy (Ministry of Health, 2002b). All components noted as omitted from the definition of child neglect in the Interagency Guideline (Section 4.1.2) are also omitted from these documents.

The *Family Violence Prevention Policy and Protocols* defines neglect briefly as "e.g. medical neglect, abandonment, neglectful supervision" (Ministry of Education, New Zealand School Trustees Association, & Child Youth and Family, 2009, p. 2).

Neglect is undefined in:

- ❖ the *Recommended referral process for General Practitioners: Suspected child abuse and neglect* (Ministry of Health, The Royal New Zealand College of General Practitioners, New Zealand Medical Association, & Child Youth and Family, 2000)
- ❖ The *Procedures for Notification of Suspected or Actual Child Abuse and Neglect: Between Work and Income, Integrity Services (Benefit Control) and Child, Youth and Family* (2007)
- ❖ *Interagency protocol: Notification of Suspected or Actual Child Abuse and Neglect between Housing New Zealand Corporation, and Child, Youth and Family* (Housing New Zealand Corporation & Child Youth and Family, 2007)
- ❖ The *ECE Child Protection Policy* template (Ministry of Education, 2010)
- ❖ The *Kohanga Reo and Child, Youth and Family Protocol for Protection of Mokopuna* (Te Kohanga Reo National Trust Board & Child Youth and Family, 2009)

In some of these documents, the undefined term neglect is included within the definition of abuse or family violence.

The *Interagency Guide to Breaking the Cycle* includes neglect within the definition of family violence (Child Youth and Family, 2001). Neglect is not however included in the Police definition of Family Violence: “violence that is physical, emotional, psychological and sexual, and includes intimidation and threats of violence” (New Zealand Police, Year unknown).

### **Policy definition of serious willful neglect**

Without a clear legislative definition of willful neglect, Child, Youth and Family and New Zealand Police have defined serious willful neglect as:

When a person willfully ill-treats or neglects a child or willfully causes or permits the child to be ill-treated in a manner likely to cause the child actual bodily harm, injury to health or any mental disorder or disability. This includes failure to provide the necessities of life.  
(Child Youth and Family & Police, 2010)

Findings	Comments
<p>Neglect is either not defined or partially defined in policy. Key omissions include the risk of harm as an outcome, psychological and emotional neglect, educational neglect, omission of reference to neglect as a major departure below community standards of care.</p>	<p>The common understanding of child neglect in sector policies and protocols could be reviewed. Child, Youth and Family play a key role in assisting other agencies with the development of child protection policies and protocols, particularly through the <i>Interagency Guide to Breaking the Cycle</i>. It is therefore well-positioned as the lead advisor in child protection matters to ensure the common understanding of neglect is reflected in policies and protocols.</p>
<p>The meaning of family violence varies between government agencies. Neglect is included within the interagency definition of family violence, but not the Police definition.</p>	<p>A clear shared understanding of family violence is required for collaborative interagency responses.</p>

#### 4.1.4 Stakeholder comments on the definition of child neglect

*It's always been a major difficulty describing neglect.*  
(Health Professional)

*I think we have got a long way to go in terms of the neglect stuff, and the emotional abuse, in terms of our understanding and our working with it. It's harder to define and much, much harder to work with.*  
(Health Professional)

*Having things clearly defined, it's like it's impossible. I don't know if you have seen the new child protection policy and the really clear guidelines about what is serious physical abuse? You get a whole room full of senior Child, Youth and Family workers and senior Police workers and watch the debate begin. And generally there is agreement, but there is debate.*  
(Child, Youth and Family professional)

*I come back to the definition issue, I think we all flounder with that. And in the health system the social worker's assessment is a very variable feast. I think we have got a long way to go on that.*  
(Health Professional)

Defining child neglect was a challenge for the professionals interviewed. Neglect was seen as harder to define and harder to prove than physical forms of child abuse. Some professionals made reference to their policy, which they assumed contained a definition of neglect.

Of the four components of the definition of neglect<sup>14</sup> outlined by Davies et al. (2009) the unmet need of the child was the component most frequently described. In addition to consideration of the remaining components, the fifth component identified by professionals was time, and how the components changed over time:

*Embedded in the detection of child neglect is a perspective around how serious, is it a one off or again and again and again, and a kind of change. Is it getting better, is there insight? Is the parent turning their behaviour around and is the child's situation getting better?*  
(Health Professional)

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<sup>14</sup> the child's unmet need, the responsible parties' capability and culpability, the harm or risk of harm to the child and established standards of care.

Many professionals commented on the difficulty of working with parents who did not understand the concept of neglect. Without this understanding, professionals found it difficult to help parents develop insight or obtain buy-in to interventions.

### **Serious willful neglect**

Police and Child, Youth and Family staff expressed a need for greater clarity about the definition of willful neglect, particularly as it is now within the scope of work of police child protection teams. Attendees from both organisations in different parts of New Zealand noted an absence of discussion about the definition of willful neglect or associated case scenarios during recent training on the Child Protection Protocol. Professionals from both organisations were therefore unclear about how to define serious willful neglect or when referrals should be made. Lawyers for children also commented *“a definition of serious neglect would be good”*.

*Certainly I think between Child, Youth and Family and Police in terms of the Child Protection Protocol I think there needs to be some thought around what cases we would actually be referring to Police and some clearer guidelines.*

(Child, Youth and Family professional)

<b>Findings</b>	<b>Comments</b>
Professionals find neglect difficult to define but comfortably describe key features of neglect. Consideration of changes over time was also a key component of neglect.	In practice, the definition of neglect includes an assessment of neglect over time.
Limited understanding of neglect hinders professional efforts to intervene.	Increasing families understanding of concerns and educating on parenting practice may improve the effectiveness of interventions.
Professionals are unclear about the definition of serious willful neglect	Further training related to willful neglect could be considered for inclusion in the next round of joint Child, Youth and Family and NZ Police training. Interim guidance on cases suitable for referral to police would be appropriate.

## 4.2 Detection of child neglect

Initial detection of child neglect includes screening and a risk assessment examining the history, signs and symptoms associated with child neglect.

Screening is the systematic application of enquiry, either written or verbal, to clients about their personal history ... to identify at risk individuals in order to determine if they should be offered the opportunity of intervention.

Risk assessment is a process allowing for a full examination of circumstances and interactions to begin to form an opinion about a person's risk of harm either to themselves or to others. Risk assessment is a dynamic process, as situations of domestic violence, child abuse and neglect may change rapidly. (Standards New Zealand, 2006, p. 14)

A summary of policy findings related to the detection of child neglect is provided in Appendix 2.

### 4.2.1 Interagency guidelines for the detection of child neglect

The *Interagency Guide to Breaking the Cycle (Child Youth and Family, 2001)* provides a basis for service policies or protocols. The quality of this document is therefore central to the quality of intra-agency policy.

The Guide does not provide screening risk factors. Rather it focuses on considering the possibility of child neglect or abuse when clear behavioural or physical symptoms are observed. The Guide advises that a high risk of suspicion should be held when a child experiences injury, distress, depression without obvious reason, persistent or new behavioural problems or unusual or fearful responses to caregivers (Child, Youth and Family, 2001).

Notable risk factors omitted from the Guidelines include: history of previous abuse or neglect or suspected abuse or neglect, severe social stress, parental mental illness including postnatal depression, alcohol and drug use, teenage parent and parents abused as children (Ministry of Health, 2002c; Royal New Zealand Plunket Society, 2008). Red flags are also not provided (Table 14).

**Table 14: Red flags for child neglect and/or abuse**

1. Uncorroborated history, eg: discrepancy between: history/injury, history/developmental age
2. Inappropriate parent response
3. History of Child, Youth and Family engagement
4. Delay in seeking medical advice
5. History of repeated trauma
6. Varying/changing history

Source: Ministry Of Health. (2002a). Child Abuse & Neglect: Brief Intervention HP 4558

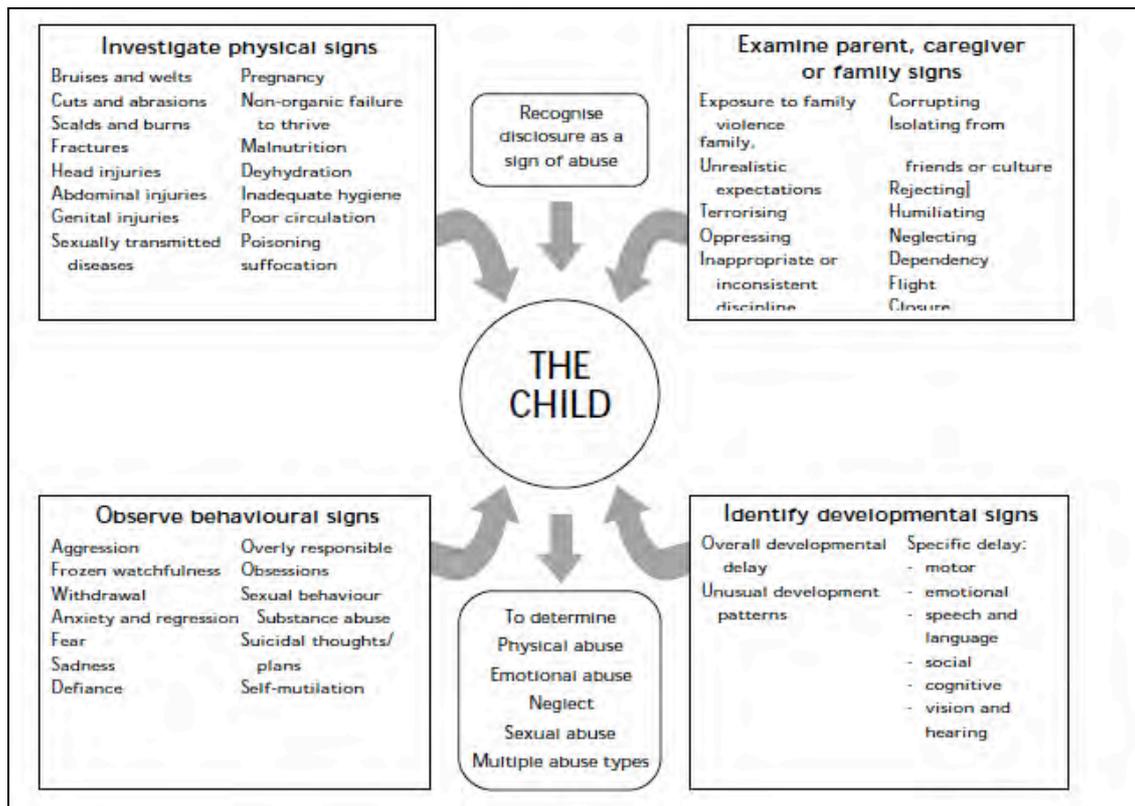
To assist risk assessment, the Guide provides a description of signs associated with abuse and neglect (Figure 16). Common signs including dental neglect,<sup>15</sup> poor parent child bonding, and ‘child known to social services’ are omitted from the guide (BMJ Evidence Centre, 2010). Behavioural signs do not provide an indication of the age at which these signs may be observed.

Interviewing children or caregivers to support the identification of child neglect or abuse is not recommended in the Guidelines. Sample questions like those provided in the *Ministry of Health Family Violence Intervention Guidelines* (2002c) are therefore not provided.

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<sup>15</sup> Failure to take a child to a dentist for previous dental injuries, rampant untreated caries and gum disease should also arouse suspicion of abuse as they indicate dental neglect. Parents may underestimate the extent of dental neglect, but these problems can cause considerable pain to the child and may result in a reduction in their dietary intake. Dental neglect may also be a reflection of inappropriate dietary intake. Source: bestpractice.bmj.com

**Figure 16: The signs of child neglect and abuse**



Source: Child, Youth and Family. (2001). *An Interagency Guide to Breaking the Cycle: Let's stop child abuse together*. (2nd ed.). Wellington: Child, Youth and Family.

Finding	Comment
<p>The <i>Interagency Guide to Breaking the Cycle</i> does not describe risk factors or red flags for child neglect. Some common risk factors of neglect are omitted. Interviewing is not recommended yet professional agencies must interview to assess neglect.</p>	<p>The <i>Interagency Guide to Breaking the Cycle</i> could be updated to include risk factors, red flags and sample interview questions for child neglect.</p>

#### **4.2.2 The detection of child neglect in sector protocols or policies**

Examination of health and education sector policies found that:

1. risk factors, signs and symptoms for the identification of child neglect are inconsistent through the policies examined; and
2. policy position on questioning/interviewing children varies.

This section will briefly elaborate on these findings. A summary of the findings for each policy is also provided in Appendix 2.

##### **Inconsistent use of risk factors, red flags, signs and symptoms**

Analysis of guidelines (Appendix 2) found an inconsistent use of risk factors, red flags, signs and symptoms for child neglect and abuse.

Risk factors associated with child neglect and abuse are not provided in the policies examined from the education sector (Appendix 2). The Interagency Guide to which they refer also does not provide risk factors or red flags for child neglect and abuse (Child, Youth and Family, 2001). Plunket and General Practitioner guidelines recommend observations for child neglect and abuse and use of either the Manitoba Risk Assessment Model (Royal New Zealand Plunket Society, 2008) or similar (Ministry of Health et al., 2000).

Within the health sector, the presence of multiple risk factors is a reason for referral for children where current concerns exist (Ministry of Health, 2002b, 2002c; Royal New Zealand Plunket Society, 2008).

Red flags for child neglect and abuse identification and risk assessment are only used in the Ministry of Health and District Health Board policies (Ministry of Health, 2002b, 2002c).

Signs and symptoms of child neglect and abuse are not included in policies within the education sector. They are included in Ministry of Health, District Health Board and general practitioner guidelines (Ministry of Health, 2002b, 2002c; Ministry of Health et al., 2000). Plunket guidelines do not provide physical and behavioural/developmental signs of child neglect and abuse (Royal New Zealand Plunket Society, 2008).

### **Policy position on questioning/interviewing children varies**

The *Family Violence Intervention Guidelines: Child and Partner Abuse* (Ministry of Health, 2002c) recommend that “a thorough history for child abuse and neglect be taken in high-risk groups and/or if there are signs or symptoms suggestive of abuse”. This contrasts with the interagency guide and education sector policies all of which do not recommend questioning children or caregivers (Child, Youth and Family, 2001; Ministry of Education, 2010; Ministry of Education, et al., 2009; Te Kohanga Reo National Trust Board & Child, Youth and Family, 2009).

The *Family Violence Intervention Guidelines* provide sample questions to assist with the identification of possible abuse and/or neglect (Table 15). These questions are not included in the Draft DHB Management of Child Abuse and Neglect Policy (Ministry of Health, 2002b), the Plunket Family Violence Prevention Policy and Protocols (Royal New Zealand Plunket Society, 2008) or the Recommended Referral Process for General Practitioners (Ministry of Health et al., 2000).

The sample questions provided are directed at family violence and abuse rather than neglect (Table 15).

**Table 15: Questions to assist with the identification of possible abuse and/or neglect**

Questions for older children

- ❖ How are things at home?
- ❖ What happens when people disagree with each other in the house?
- ❖ What happens when things go wrong at your house?
- ❖ What happens when your parents/caregivers are angry with you?
- ❖ Who makes the rules? What happens if you break the rules?

Questions for the caregiver

- ❖ Do you ever fear for your children's safety?
- ❖ Have you ever been worried that someone was going to hurt your children?
- ❖ Who looks after your children when you are not home?

If you suspect the caregiver may be the abuser

- ❖ Do you ever worry about your children's safety when they are with you?
- ❖ What methods of discipline do you use with your children?
- ❖ What do you do when your child misbehaves?
- ❖ Are you ever afraid that you might hurt your child?
- ❖ Have you ever hurt your child?
- ❖ Do you know what practical help is available to assist you?

When asking young people about possible neglect or abuse a thorough psychosocial assessment for adolescents such as the HEADSS assessment, which outlines a review of home environment, education and employment, peer activities, drugs, sexuality and suicide or depression may be useful.

Note: Key assessment questions recommended for use during brief interventions (Ministry Of Health, 2002a) are underlined. The HEADSS assessment questions are provided in Appendix C of the source document. Source: Ministry of Health. (2002b). *Family Violence Intervention Guidelines - Child and Partner Abuse*. Wellington: Ministry of Health.

Findings	Comments
<p>Examination of health and education sector policies found that:</p> <ol style="list-style-type: none"> <li>1. risk factors, signs and symptoms for the identification of child neglect are inconsistent through the policies examined; and</li> <li>2. policy position on questioning/interviewing children varies.</li> </ol>	<p>Consideration could be given to strengthening of the <i>Interagency Guide to Breaking the Cycle</i> to facilitate consistent policy guidelines.</p>
<p>Ministry of Health sample questions to assist with the identification of possible abuse and/or neglect currently focus on abuse.</p>	<p>Where interview tools exist, sample questions could be strengthened by including questions appropriate for neglect scenarios.</p>

#### 4.2.3 Detection of child neglect in the justice sector

New Zealand Police do not have policy that relates specifically to the detection of child neglect. However, Police are required to identify children who have suffered serious neglect during frontline work including family violence investigations and remove/detain these children in addition to notifying Child, Youth and Family (New Zealand Police, Year unknown).

Staff use the Crimes Act to gather evidence and prove culpability for instances of child neglect. The Child Protection Protocol defines serious willful neglect (see section on definitions of neglect). The same protocol gives further guidance on the test for seriousness of physical abuse (Child, Youth and Family & Police, 2010).

Policy excerpts provided by NZ Police suggest that Police intervention is only required when the physical safety of children is threatened. *Police instructions, Specialist Group, Children and Young Persons* advise frontline staff:

The care and protection provisions limit the power of intervention to emergencies only. Families are encouraged to solve their own problems, and children are removed only if no other course of action is available. The role of professional agencies is to help families protect their children, not to intervene and make decisions for families.

However, the most important criterion is the safety of the child. If the child's safety cannot be guaranteed while he or she remains with the family, formal intervention is required. (New Zealand Police, 2010)

Finding	Comments
<p>Information received from Police found that:</p> <ol style="list-style-type: none"> <li>1. Police do not have policy that relates specifically to the detection of child neglect;</li> <li>2. Police are required to identify children who have suffered serious neglect both during frontline work including family violence investigations and for child protection team investigations.</li> </ol>	<p>New Zealand Police may consider the development of guidelines to assist with the detection of neglect.</p> <p>These guidelines could include clarification of the role of Police in detecting and referring non-critical child neglect.</p>

#### 4.2.4 Stakeholder comments on the detection of child neglect

Policy did not feature strongly in the practice of detecting child neglect. Many interviewees perceived neglect as different for every child, the differences between neglected children more prominent than the commonalities. A group of education professionals suggested that policy is probably not helpful for defining or detecting neglect because each case is different and response is adjusted according to individual family need. Other professionals liked the use of policy tools like the Manitoba Risk Assessment tool and the HEADSS assessment tool for the identification and substantiation of neglect. Some Child, Youth and Family professionals also liked referrers' use of tools

*Plunket here do quite a good referral here when they do a referral. They are really clear about the information, they use the RES (Risk Estimation Screen) type stuff*  
(Child, Youth and Family professional)

#### The unmet needs of the child

The unmet need of the child was the element of child neglect most commonly identified by the professionals interviewed (see Table 16, p. 68). Some variation

exists in the commonly identified 'unmet needs of the child' by profession. Within the health sector, professionals acknowledged that the commonly observed signs of neglect varied depending on whether the child was seen in the health care setting or in the home.

### **The responsible party's capability and culpability**

Professionals reported talking to parents to consider the reasons for neglect, which included an assessment of capability and culpability. Some definitions of types of neglect included an assessment of parental culpability: "*poor nutrition when food money is used for other things*". Similarly professionals altered their views about children initially perceived as neglected when parents provided further information about their circumstances. Examples included a parent who missed a child's medical appointment because of work commitments and parents who did not seek medical services because of the cost. Implicit in some assessments is a judgment about the role and responsibility of the society in supporting the provision of children's needs.

Parental risk factors for neglect are also included in the assessment of parental capability and culpability:

*One of our biggest neglect areas is children with parents who have a very major mental health illness, who have drug and alcohol problems, who have severe personality disorder. That's routinely identified...The thing that you really have to be careful about is that those are risk factors for an infant or a child, but not everyone who has those conditions, its not predictive that way... If you look at the group who have their infants removed, they are the group with drug and alcohol problems in New Zealand.*

(Health professional)

**Table 16: Commonly cited examples of neglect, by sector**

	<b>Health</b>	<b>Education</b>	<b>Police</b>
<b>Outcome</b>	Global or specific developmental delay Failure to thrive		Child offenders with neglect issues. Malnourished children
<b>Unmet Physical Need</b>	Lack of lunches, poor nutrition, unkempt, no clean clothes, school sores, head lice, skin infections.	No coats, no lunch, unkempt, untreated school sores and head lice.	
<b>Unmet Psychological / Emotional Need</b>	Transient living, parents with mental health problems, parents with alcohol and other drug problems, children parenting parents, family violence.	Time starved families. "Parents wound up and children cowering"	
<b>Unmet Medical / Dental Need</b>	Not giving children medications or attending medical appointments, not accessing dental care, parents who can't be contacted to give consent for care, children ending up in hospital and we know it is because parents don't take their children to the doctor	Unable to contact parents for medical treatment	

<b>Unmet Educational Need</b>	Not turning up to school on time, lots of absences	Children not coming to school. Students looking after children at home while parents work.	Truancy
<b>Unmet Supervisory Need</b>	Babies injured through a lack of supervision, children left to look after babies	Children at school early. Children coming back to school while still sick. Students looking after children at home while parents work.	Young children left at home alone
<b>Unmet Environmental Need</b>	Dirty unclean homes		Witnessing family violence, children in P-labs. Dirty unclean homes

### **Established standards of care**

Interviews that included discussion about established standards of care for children focused on the lack of clarity about a New Zealand standard, and of the variability in standards between professionals, communities and individuals.

*Is there a community standard, an individual standard and a professional standard? If there is a community standard is there one community standard or are there different community standards?*

(Health professional)

*I know too writing affidavits for the court about neglect and the judge would say yes and let's not grant these orders, so what.*

(Health professional)

*That comes through strongly in the survey that I have done, that training is not there as much as it is needed. That training to identify what is a concern. Not so much the referral process, but what are the actual things that they need to be looking at, the threshold, people are still wanting more clarity on that.*

(Education professional)

Some participants felt that the lack of guidelines on what is and isn't acceptable, a laissez-faire approach to children's needs, resulted in a sub-standard individual "good enough" test. Children living in the poorest neighbourhoods and children seen by professionals working in deprived communities were seen as most disadvantaged by the absence of an established standard of care.

### **Use of agency information to confirm and further substantiate concerns**

Professionals talked about parents “capacity to hide from the system” when they knew that concerns existed for their children. This often included children changing schools and health services or moving to other communities. Health and education professionals talked about wanting the ability to check with Child, Youth and Family about the presence of a previous Child, Youth and Family history in assessing the degree of importance about their concerns.

Frontline Police officers reported the usefulness of keeping files for high-risk families active on the Police family violence database for ongoing review. The police family violence database was also useful for detecting ‘repeat presentation families’ for prioritisation. It was hoped that this detection tool would be further supplemented in the future by linkage between the Police family violence database and the Child, Youth and Family database.

In a number of areas, Plunket reported they receive Police Family Violence incident information. It was used for the identification and prioritisation of high-risk children in the service and strengthened referrals to Child, Youth and Family.

Health professionals in secondary care also had the ability to check for an alert on the child’s medical record<sup>16</sup>. While in theory, education professionals can flag child protection concerns on the ENROL computer system, the transfer of child protection information between principals does not seem to be standard practice:

*We do not get a flagged message on ENROL if a child has previously been referred to Child, Youth and Family by a previous school. Sometimes a principal of a school will ring us when they have been alerted to the fact that a child has enrolled in our school. The principal may fill us in on some of the details relating to the child if Child, Youth and Family have been involved.*

*Most of the time we hear through Child, Youth and Family social workers who are following up a case or are checking on children in their care. The caregivers will also give some details on enrolment due to the fact that they are care givers and not the parents. There is no consistency on the information sharing between schools, enrol or other agencies. This does make it difficult.*

(Education Professional)

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<sup>16</sup> Work is currently underway to strengthen the National Medical Warning System.

The Ministry of Education advises that child abuse and neglect concerns should be flagged in the ENROL system (in Teaching and Learning Notes) when children change from one school to another. This alerts the new school to contact the principal of the old school for further information. Alerts can be placed under the categories of Academic, Attendance, Behavioural, Custodial, Health and Personal (Ministry of Education, 2008). The user guide does not suggest or indicate where school referrals to Child, Youth and Family should be recorded.

The User Guide notes that “all Teaching and Learning Notes except Custodial and Health have a life span of 12 months, at which time they will be automatically removed” (Ministry of Education, 2008, p. 6). This implies that alerts of educational neglect (under attendance alerts) and all Child, Youth and Family referrals recorded as personal alerts will be lost after 12 months.

<b>Findings</b>	<b>Comments</b>
<p>Policy is currently of limited usefulness in the practice of detecting child neglect.</p> <p>Interviewing parents and/or children is in practice an essential component of assessing neglect.</p> <p>Established standards of care, a core component of the definition of neglect, are critical in practice but not covered in policy.</p> <p>Assessment of neglect over time is a core component of the practice of detecting neglect. Agency information is essential for this component of the assessment. Current systems are not fully utilised, particularly in education. Lack of access to other agencies information hinders assessment, and where access has occurred, assessment and practice/intervention has been strengthened.</p>	<p>Interviewing is common practice in the assessment of neglect and should be included in policy.</p> <p>Challenges in current practice support the need for consideration of the inclusion of established standards of care in policy.</p> <p>Professionals need access to intra- and inter-agency information to assess child neglect and strengthen professional intervention. Education may wish to consider recording child protection events permanently on the Education ENROL system. Further analysis is required of potential for local and national information sharing opportunities.</p>

### **4.3 Referring a child with suspected or actual neglect to Child, Youth and Family**

The Children, Young Persons, and Their Families Act 1989 states:

Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived may report the matter to a social worker or a constable. (Section 15, CYP & F Act 1989)

The National Contact Centre is the first point of contact for Child, Youth and Family services (Child Youth and Family, 2010a). Referrals can be made by phone, fax, letter or email.

All policies reviewed outlined the referral process to Child, Youth and Family (and police in critical cases). The National Contact Centre number was provided in all policies. A more detailed summary of key child neglect policy and protocols is provided in Appendix 2.

A copy of the current National Contact Centre email/fax referral form can be obtained from the National Contact Centre. It cannot be obtained from the Child, Youth and Family website. This is because Child, Youth and Family would like all public referrals to be made by phone. The referral form essentially is largely free-form and does not explicitly identify risk-factors, red flags, and signs of abuse and neglect.

The current referral form is not within any of the policies reviewed. Health policies require a written referral to be sent for all referrals. The draft DHB policy suggests that the referral form be kept on the DHB intranet. An older referral form is contained within the general practitioners' guidelines. Child, Youth and Family are happy to accept referrals provided on the child protection referral form of any agency.

### Repeat notifications

Of the policies reviewed, only Plunket included consideration of the circumstances where repeat notifications may be indicated. Repeat notifications are indicated where:

1. the children are still at an unacceptable level of risk;
2. there is new information relevant to a previous notification; and
3. another incident or concern has occurred (Royal New Zealand Plunket Society, 2008).

Plunket also note that Child, Youth and Family should be informed in instances where Well Child services are to be discontinued and the child is in Child, Youth and Family care, or a recent notification has been made (Royal New Zealand Plunket Society, 2008). Similarly when a family that is previously lost to Plunket and known to Child, Youth and Family is located, staff are required to inform Child, Youth and Family.

Finding	Comments
<p>Professionals are not all able to easily access a Child, Youth and Family referral form prior to contacting the National Contact Centre, which may hinder the quality of the referral.</p> <p>The Child, Youth and Family referral form is largely free text. Key risk-factors, red flags, and signs of abuse and neglect are not explicitly sought and therefore may not be provided, lowering the quality of the referral.</p>	<p>The quality of referrals could be increased through inclusion of key risk-factors, red flags, and signs of abuse and neglect on the written referral form and by providing open access to the referral form.</p>
<p>Most policies do not cover the issue of renotification, which is a central component of Child, Youth and Family assessment.</p>	<p>Consider updating the <i>Interagency Guide to Breaking the Cycle</i> to include a section on renotification.</p>

### 4.3.1 Stakeholder comments on neglect referrals to Child, Youth and Family

Professionals reported referring only the “very tip of the iceberg” of neglected children to Child, Youth and Family. For many professionals, referrals are made to Child, Youth and Family “when it’s absolutely the last straw”. Examples of “working our bums off, and trying to do everything we can” included talking to parents, feeding children at school, accessing food banks, providing donated clothing and applying to trusts for school uniforms, accessing community or school social services and referring to mental health or special education services.

*When we ask for help [from Child, Youth and Family] it’s because we damn well need it. If other agencies can be used, then they are*  
(Education professional)

Assessments of neglect were often described by professionals as highly detailed and included an assessment of the nature of the neglect, the timeline of interventions by named services, clear use of Child, Youth and Family language (e.g. risk and harm), as well as clear extrapolation to the anticipated outcomes (e.g. “if this child does not have this medicine he will have a seizure and this can damage his brain”).

Professionals reported that they would like increased clarity about the Child, Youth and Family threshold for intervening in cases of child neglect. More specifically, greater definition and clarity around the current policy discourse of need (below the threshold) versus risk (above the threshold) would be helpful.

*The indicators are not clearly defined for when you should refer something*  
(Education professional)

*If we are referring to Child, Youth and Family it is often because we are assessing risk. We have identified that the concerns that we have seen meet a risk threshold. It can be for a lot of reasons but the basic one is that we have looked at the legislation, we have looked at section 14 of the Children, Young Persons and their Families Act and have identified that what we are seeing is likely to or has harmed a child in a particular way. So we believe it has already met the risk criteria otherwise we wouldn’t be referring.*

*But what is happening is that it is going into Child, Youth and Family and Child, Youth and Family are saying it doesn’t meet our criteria for risk and therefore it’s need, therefore we are not going to do anything. So we are in this constant dilemma around what is need and what is risk.*  
(Health professional)

In order to circumnavigate the challenges of the neglect threshold, many professionals sought to link referrals to physical or emotional abuse.

*I have to make notifications all the time and I am always very reluctant to make neglect the top line. I'll try and find anything else to put in the top line. I will include neglect but I will try and find the bruise or the partner violence or something else.*

(Health professional)

If linkage cannot be found, then many professionals reported waiting for circumstances to escalate and of the ironic relief when a child's circumstances worsen.

*Kids do us a favour by committing a crime because Youth Justice gets involved and wrap around services are provided.*

(Education professional)

*You are waiting for something to happen, you are waiting for them to be driven over in the driveway or burn their arm, some days I walk away and I just wish something would happen ... because then I would get some help.*

(Health professional)

Interviews suggested some degree of variability in the degree of neglect referred, ranging from ongoing head lice to situations where children's life span would be shortened by failing to provide medications. Overall, the degree of neglect required severity before children are referred. In situations of physical neglect, "if there is a roof over their head and food on the table or the money to go down the road and buy food" then referrals are not made.

*I will not jump up and down if a child is not having lunch at school, because that's the majority of our children. If I talk to a child and the child says 'oh I haven't had breakfast' and I say 'when did you last eat?' 'Oh two days ago' then I will go and talk to the social workers ...*

(Education professional)

### **Professional respect including dialogue post referral**

Interviewees spoke universally about the absence of Child, Youth and Family initiated feedback to their referrals. This commonly led to problems when assumptions had been made about interventions that had been provided to children

experiencing neglect. The absence of feedback gave the perception that procedural justice<sup>17</sup> was lacking in Child, Youth and Family.

### **Referrals to prevent impairment from neglect rather than recurrence**

Given the difficulties in defining, assessing and referring neglect, professionals sometimes prefer to refer for preventing long-term impairment from neglect rather than preventing its recurrence. Some professionals found it easier to focus on the child's impairment rather than parental neglect of children's needs.

*They go with the band-aid things on the top, the developmental delay, rather than the underlying neglect*  
(Education professional)

In the education sector this commonly included referrals to Special Education Services and in the health sector this commonly included referrals to developmental paediatricians or mental health services.

<b>Findings</b>	<b>Comments</b>
Lack of clarity about the threshold for standards of care increases variation in the professional threshold for referrals.	Policy guidelines could be strengthened to include guidance on the threshold for standards of care.
Feedback is not currently provided to professional referrers or their agency/service at the individual, area and population level.	The safety of high-risk children is routinely compromised by failure to inform key professionals of interventions and outcomes following referral.
Some professionals refer directly to services which intervene to prevent long-term impairment and omit referral to services to prevent recurrence from neglect.	Further investigation could be considered into the risk and rate of maltreatment among children referred to impairment prevention services (e.g. Special Education Services, Mental Health and Child Development services). In these settings regular child protection training is particularly important and routine screening may be indicated.

<sup>17</sup> Procedural justice: fairness and transparency of the processes by which decisions are made.

## 4.4 Detection of neglect by Child, Youth and Family

Child, Youth and Family policy does not currently contain a specific section on child neglect (Child, Youth and Family, 2010). The service is planning to develop overarching summaries of child maltreatment, including a section on neglect.

Following referral to Child, Youth and Family, a decision is made about further action to be undertaken. No Further Action (NFA) is undertaken in situations where the information did not meet a response threshold and/or only immediate advice was required. Where the family/whānau is identified at intake as having “low level issues and needs services rather than a formal Child, Youth and Family response” referrals are made to community services without formal assessment and identification of neglect (Child Youth and Family 2010c). “The investigation pathway is reserved for serious child abuse” (Child Youth and Family, 2010c).

A Child and Family Assessment (CFA) or investigation is required when it is indicated that the care, safety or wellbeing of a child/young person may be at risk or where there is an allegation of harm or abuse. It also includes exposure to serious and/or ongoing family violence. Other considerations that assist with determining this response include:

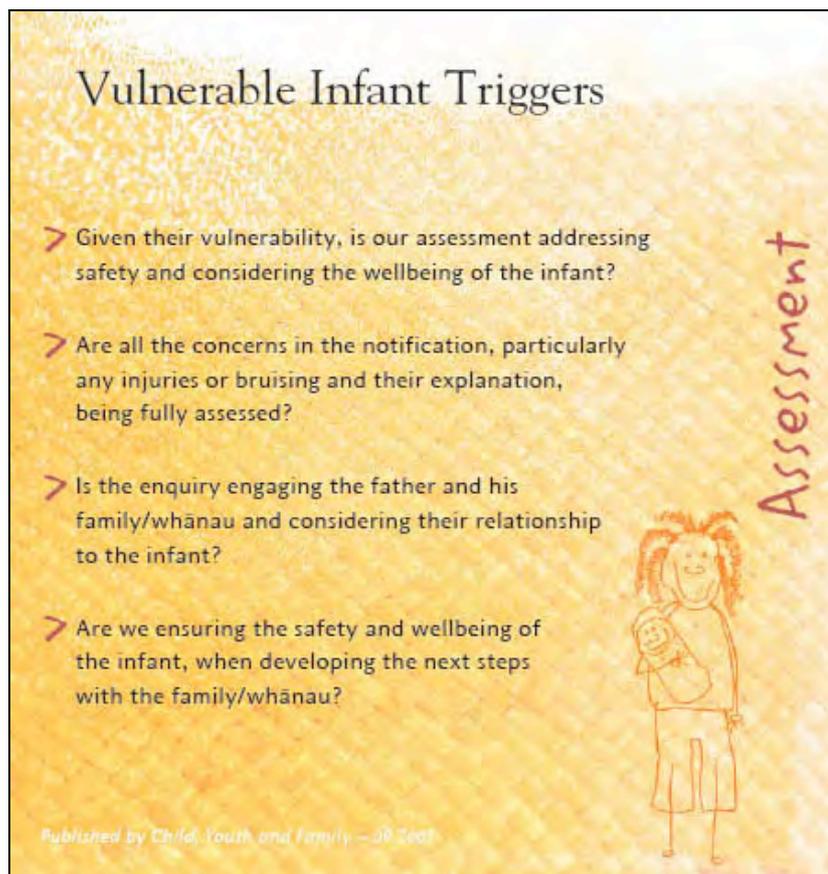
- children aged under 2 years are extremely vulnerable and those aged between 2-5 years are also a vulnerable group
- if Child, Youth and Family is already involved with the family
- if substance abuse, mental health and family violence are recurring themes then consideration needs to be given to a Child, Youth and Family response
- siblings - rationale required as to why they were or were not included in the notification
- the number and pattern of notifications to Child, Youth and Family is also important in determining the appropriate response
- allegation against a Child, Youth and Family caregiver or staff member
- sexualised behaviour between children/young people causing concern.

(Child Youth and Family, 2010c)

### **Assessment of vulnerable infants**

Identified areas of focus for the assessment of children aged under 2 years are physical injuries and their explanation, father and family engagement, and relationship with the child (Figure 17).

**Figure 17: Vulnerable Infant Triggers: Assessment**



Source: Child, Youth and Family (2010) Practice Centre: Assessment.

In comparison, the vulnerability of young children in the Ministry of Health guidelines provide a deeper analysis of high risk indicators (triggers) and signs of infant neglect or abuse (Ministry of Health, 2002c). High-risk indicators include, for example: child with a congenital abnormality, premature infant, colicky or irritable child, and child who is unwanted. Other significant physical signs relevant to infants include, for example, unexplained failure to thrive, recurrent apnoea spells and overall or specific developmental delay<sup>18</sup>.

### **Assessment of Safety, Risk and Protective Factors**

A safety assessment is required for all children who are assigned a Child, Youth and Family response following initial triage. A Family Strengths and Risks Assessment must then follow the safety assessment.

<sup>18</sup> Social workers are expected to have an understanding of developmental stages (Child, Youth and Family, 2010b).

The Family Strengths and Risks Assessment tool requires a scoring between 1-10 for risk and protective factors at the level of the child, parent/caregiver, family/whānau, and community. A comparison between this assessment tool and the risk factors identified at these levels in the literature found that they are virtually all included in the assessment tool<sup>19</sup>.

Findings	Comments
<p>Child, Youth and Family does not currently have policy guidelines on child neglect.</p>	<p>Child, Youth and Family could consider the development of policy on child neglect, including the shared understanding of neglect, the needs of children who may be neglected, short and long-term harms from child neglect, assessment of parent capability and capacity, and current standards of care indicating thresholds for differential response and Child, Youth and Family intervention. The policy could also detail the assessment of neglect, the range of interventions to prevent recurrence of neglect and/or impairment and indications for intervention. Information on the primary prevention of neglect could be included as background information.</p>
<p>The Child, Youth and Family Vulnerable Infant assessment tool omits high-risk features highlighted in the Ministry of Health assessment tool.</p>	<p>A review of the Vulnerable Infant assessment tools with the health sector may strengthen Child, Youth and Family assessment policy.</p>
<p>Child, Youth and Family have stated features for consideration during assessment which are not currently shared/consistent with interagency tools.</p>	<p>Inclusion of Child, Youth and Family assessment tools in the <i>Interagency Guide to Breaking the Cycle</i> would assist professional referrers in their referral decision making.</p>

<sup>19</sup> Omitted risk factors included: maltreatment as a child and family break-up.

#### 4.4.1 Child, Youth and Family comments on detection of neglect by social services

One Child, Youth and Family professional said the detection of neglect focuses primarily on *“is the child safe, is this a care and protection issue?”* However, the Child, Youth and Family Safety Assessment includes needs as well as safety, thus the detection of neglect is not solely focused on safety or care and protection requirements but also considers additional factors.

Failure to meet established standards of care following previous intervention was a key factor in the assessment of child neglect. Child, Youth and Family professionals reported that most children found to have experienced neglect had multiple factors of concern, *“It is rarely an isolated event that everything else is going well and they are just not hygienic or one thing or the other. There are a cluster of problems.”*

**Table 17: Key features of a child neglect assessment reported by Child, Youth and Family professionals**

- Age of the child
- Previous notifications to Child, Youth and Family
- Previous Child, Youth and Family use of Differential Response
- Ongoing or recurrent neglect following intervention: *“We will often have intervened in a supporting education kind of way and that has not resulted in any real change.”*
- Degree of neglect (as in child’s needs not met): *“When the neglect is persistent and grinding”*
- Presence of abuse: *“That’s easier if you have family violence incidents happening between the parents and they are serious and ongoing”*
- Degree of harm or risk of harm to the child: *“Whether it is a life and death issue, in which case we respond immediately”*
- Parental culpability including willfulness, drug and alcohol issues, mental health etc. *“In many of our significant neglect cases there are probably drug and alcohol issues”*
- Parental capacity to change: *“Ability to respond positively to the right kind of supports and education”*

Referrals with clear specific details also made assessment for neglect much easier. *“The quality of their referral, for us, is also a good indication of the seriousness of it.”*

Like professionals in other sectors, Child, Youth and Family professionals viewed each case of neglect as different:

*We look at each situation as a unique situation and evaluating the whole cluster of events that are happening around the children and families.*  
(Child, Youth and Family professional)

### **Training and monitoring the detection of neglect**

Child, Youth and Family professionals reported an absence of guidelines specifically related to child neglect and an absence of “practice forum sessions” on neglect:

*In terms of having everybody on the same page about neglect, I think that’s probably one of the things that we need to do in training. I am just thinking we haven’t had any training in neglect for a quite a while, but we are quite clear around safety plans around abuse. Safety plans should be used for neglect as well.*  
(Child, Youth and Family professional)

Monitoring the detection of child neglect, particularly where detection was delayed was also of concern:

*The frustrating thing for me is actually to have the ability to stop and have enough time to analyse why we might have taken so long.*  
(Child, Youth and Family professional)

<b>Finding</b>	<b>Comment</b>
Child, Youth and Family professionals report an absence of guidelines and training on neglect.	Consideration to enhancing Child, Youth and Family policy and internal neglect training.

## 4.5 Intervention in cases of child neglect

Child, Youth and Family is the lead government agency responsible for the prevention of recurrence of child neglect (Figure 4, p. 30). The key interventions in cases of child neglect are described as:

1. Referral to other government agencies or community services for a Differential Response;
2. Family/Whānau Agreement;
3. Family Group Conference; and
4. Family Court Order.

Child, Youth and Family professionals report that most referrals for neglect are deemed during initial assessment to be “low-level neglect” and are referred for a Differential Response. For referrals that are formally assessed and identified as neglect, Family Group Conference and Differential Response are the most common responses<sup>20</sup>. Each of these interventions are the *initial* interventions which have as their outcome the next tier of *secondary* interventions, identified as appropriate for the safety and well-being of the child (for example, mental health interventions, respite care, educational interventions, etc).

### Differential Response

Differential Response is a new response pathway for Child, Youth and Family, which was rolled out nationwide in 2009. It is an intervention with families that Child, Youth and Family facilitates. Child, Youth and Family does not deliver the services directly but identifies families that are best suited to a response by a community agency. If agencies identify ongoing concerns there is a route back into Child, Youth and Family in this pathway.

Services are provided in the community where the family/whānau has low level issues and needs services rather than a formal Child, Youth and Family response. It recognises that many of the families are already receiving community based services, and it is a way of providing an earlier, more comprehensive and co-ordinated response.  
(Child, Youth and Family, 2010c)

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<sup>20</sup> Child, Youth and Family data in Section 3 identified Family Group Conference as the most common intervention. The current use of Differential Response interventions is not reflected in the data provided due to its recent roll-out.

Policy does not identify the interventions that would be expected to be available in any given community for child neglect or abuse concerns using a Differential Response intervention.

### **Family/Whānau Agreement**

A family/whānau agreement is the lowest level of service intervention provided by Child, Youth and Family. It involves a meeting with family/whānau and the development of a shared written agreement.

The purpose of a family/whānau agreement is to enable a whānau that is experiencing difficulties in caring for their child to:

- receive appropriate services
- help resolve identified issues
- retain care of their child/young person.

(Child Youth and Family, 2010a)

Child, Youth and Family identify appropriate services, the second tier of intervention, as “financial resourcing and/or social work support” (Child, Youth and Family, 2010a). Family/whānau agreements are voluntary (the family can withdraw at any time), and have a maximum length of four months. If the intervention is not effective, referral to a Family Group Conference is indicated.

### **Family Group Conference**

Intervention with a Family Group Conference is indicated when a child/young person is in need of care or protection. It is intended as a diversion from the Court system (Child, Youth and Family, 2010a). This intervention results in a Family Group Conference plan, which states specific relevant tasks and the agreed responsibilities.

The philosophy of the Family Group Conference is that “whānau are supported to develop their own solutions to the issues they face” (Child, Youth and Family, 2010a). Policy available on the Child, Youth and Family practice centre website does not identify the range of secondary interventions which are commonly appropriate for child neglect or abuse.

### **Family Court Order**

An application is made to the Family Court when a child is in need of care or protection. Child, Youth and Family policy specifies the range of orders (secondary interventions) that can be made by the Family Court:

- **Services orders** to provide particular service or assistance to the family (eg: home help, parenting programme, activities for a child/young person after school, or financial support)
- **Restraining orders** to prevent a child from contact with a person
- **Support orders** to support and monitor the child/young person and their caregivers and to provide help when necessary.
- **Custody orders** to assign daily caregiving responsibility

### **Reporting of outcome and interventions undertaken**

The Children, Young Persons and Their Families Act 1989 requires that Child, Youth and Family “inform the person who made the report whether or not the report has been investigated and, if so, whether any further action has been taken with respect to it” (Section 17(3)).

Child, Youth and Family do not have an operational policy related to informing professionals of referral outcomes.

#### **4.5.1 Practice comments on intervention to prevent recurrence**

Child, Youth and Family intervention is “essentially giving them the opportunity to look at whether they are able to parent the child in a way that is safe for the child and that the child will develop emotionally” (Child, Youth and Family professional).

Child, Youth and Family professionals reported that neglect is more likely to receive lower level intervention, compared to abuse:

*Neglect is something that we need to analyse and look at the causes and the solutions that we might apply. We don't take that approach when someone has assaulted a child. It's just unacceptable behaviour and our view is that we intervene strongly and quickly because we have to. And the police of course will be involved and there will be a prosecution.*  
(Child, Youth and Family professional)

In practice, intervention is determined by asking the question “Is the child safe? Is it a care and protection issue?” Physical safety of the child is a clear threshold for Child, Youth and Family intervention. “*With Differential Response the critical concern is need not harm, safety is granted*” (Child, Youth and Family professional).

#### **Differential Response**

Special comment is included here on Differential Response, due to the large proportion of child neglect which receives this intervention and the recent addition of this intervention to Child, Youth and Family services. The threshold for receiving a Differential Response is identified family need without concern for safety or harm.

Differential Response was viewed positively by Child, Youth and Family professionals who saw it as an advancement in practice, compared to no intervention at all. Differential Response Co-ordinators reported that the model had positively contributed to building inter-sectoral relationships with partners, although partner buy-in was restricted by a lack of associated funding. “*The spin off [of Differential Response] is some of the social workers becoming more aware of community organisations that are able to work with the families*”. (Child, Youth and Family professional)

While positive about the Differential Response model, Child, Youth and Family professionals were concerned about early implementation gaps that require further strengthening. Some said Differential Response was implemented quickly with insufficient training, although 'refresher' Differential Response training was planned. Child, Youth and Family have advised Differential Response was piloted in 17 sites for up to 18 months prior to national roll-out.

Some Child, Youth and Family professionals were concerned about the "overuse" of Differential Response as a crutch for propping up a service in heavy demand. Professionals perceived a risk of unsafe practice, particularly as staff were "advised not to be risk adverse". They had observed a reduction in the use of investigations and primary and secondary interventions following the introduction of the Differential Response model. These observations led to a perception of Child, Youth and Family service cutting and cost cutting.

Education professionals interviewed were almost uniformly unaware of Differential Response. Some health professionals reported experiences of neglect referrals to Child, Youth and Family that were then referred back to their service via the Differential Response intervention pathway.

Differential Response Co-ordinators were unclear about monitoring expectations. Cases are referred to partners without a formal feedback system. One professional estimated that 40-50 percent of families in their area were not engaging with Child, Youth and Family Differential Response services and a further 10 percent of families were not engaging with Differential Response partners. Perhaps three in five families in the Differential Response pathway are not engaging with child protection or community services. A Child, Youth and Family professional in another area also estimated 40 percent engagement with Differential Response. This was viewed as a very positive result given the seven percent engagement estimated with the previous system.

Partners to the Differential Response model were clear that, without funding, partners are not and cannot be required to provide feedback to Child, Youth and Family regarding family outcomes. Monitoring engagement with Differential Response was therefore a key area of concern.

Professionals also raised concern that capacity would be an area of growing concern with community organisations as Differential Response continues. Pilot sites reported some community capacity concerns one year post implementation.

### **Secondary interventions**

The common perspective of Child, Youth and Family professionals was that all families are different and secondary intervention responses are unique to each case. Like Child, Youth and Family policy, professionals did not clearly define the secondary interventions that are commonly used for child neglect:

*It used to be family/whānau agreements but we are now discouraged from using family/whānau. So we would go to FGC to identify the issues and make sure we are all on the same page. But we would be looking to put some extra supports in place for the child and ensuring that the family is up to play. They might need to attend parenting courses and a range of other stuff that they need to do.*

(Child, Youth and Family professional)

Funding and access to secondary interventions was a key area of concern for Child, Youth and Family and external professionals. In general, prompt access to intervention was reported for the most critical cases. Police and Child, Youth and Family were observed to access multi-systemic therapy services, in sites where it is available.

However, with serious non-critical cases professionals reported difficulties with funding for intervention services and battles between agencies over funding responsibilities. Services particularly noted as difficult to access included mental health services and emergency care, counseling, self-harm interventions, truancy services, before school care and youth advocacy services.

Despite some external perceptions that Child, Youth and Family is a “cash cow”, there is limited ability to fund secondary interventions:

*I also sit on the panel for Child, Youth and Family ... and I also see at that context of working with the top one to three percent, they don't have the internal resources to work with those cases.*

(Health professional)

## **The quality of child neglect interventions**

Health professionals voiced concern about reliance on the community sector for secondary Child, Youth and Family interventions:

*Child neglect work, if we are looking at interventions, requires a level of expertise that a lot of our NGOs don't have... they are completely underskilled to do it.*  
(Health professional)

Concerns were also raised about the expertise in responding to child neglect among professionals in government services:

*We need to start thinking about the work that we do with our chronically neglected families as specialised work. Just like sexual abuse was, where people threw a lot of resources into learning how to work with sexual abuse, how to train our counselors to work where it was, how to work with families where there is a dynamic of sexual abuse. I think we need to start working with our chronically neglecting families in the same way. I am talking about professionals who have really good skills around how to work with these families. I think we need a lot more residential settings. I think we need to take families into supported living situations where we have workers going into the home on a regular basis modeling.*  
(Health professional)

Intervention outcome studies are one method by which the quality of child neglect interventions can be measured. Professionals raised concerns about the effectiveness of Child, Youth and Family interventions for children who have been harmed:

*On this site we have reduced the number of children in care by a third. That's quite deliberately. The prognosis for children in care is so bloody poor. It damages children very badly to be taken into care...*  
(Child, Youth and Family professional)

## **Case closure**

Professionals in health, education, and Police services all raised concerns about failure to inform whether a referral was investigated or of case closure and any investigation outcomes. Professionals were frequently caught out by thinking that a child of concern was a client of Child, Youth and Family when they weren't, sometimes placing the child at significant risk.

Given the nature of neglect, health and education professionals in particular were concerned with the statutory response of brief intervention only with many high-risk families.

*If we have this view in New Zealand that children should be with their family of origin, then there are some families of origin that are going to need services stand beside them and statutory services stand beside them forever. We don't seem to be well adjusted to that.*

(Health professional)

*The problem with the government funded statutory agencies is the focus seems to be do a piece of work, open a case, do what needs to be done and close a case. So you get this opening and closing, not just in one system but multiple systems.*

(Health professional)

The transient nature of children and families within the Child, Youth and Family system was also echoed within Child, Youth and Family, including refrains like “*We are a train station, not the destination, we have to move them on*”. Such an approach to child neglect intervention differs significantly from the child protection approach of the past:

Preventive cases took a large amount of time owing to their personalized nature. Officers had to make contact and establish relationships before action could be taken, and preventive supervision cases often remained open for several years while child welfare officers worked with families to try to find solutions to their difficulties. ‘It takes much longer to show a person how to help himself’, one child welfare officer noted in commenting on the extra work preventive policies entailed.

(Dalley, 2004, p. 188)

### **Secondary interventions in the health sector**

The *Memorandum of Commitment to Collaborative Practice in Child Protection* (Children, Young Persons & Their Families Service & Ministry of Health, 1997) outlines the key responsibilities of the health sector for intervention with children or young people who have been abused or neglected. Amongst its responsibilities, the health sector is committed to:

- provide medical examinations including developmental assessment for children and young people where there is an allegation of physical or sexual abuse or neglect;
- provide psycho-social/psychiatric assessment of children and young people who have been or are alleged to have been emotionally abused or emotionally neglected; and

- provide services for the medical treatment of children and young people who have been or are alleged to have been abused or neglected. (Children, Young Persons & Their Families Service & Ministry of Health, 1997, p. 3)

Access to medical examinations or psycho-social/psychiatric assessments for children who are found or alleged to have experienced abuse or neglect is not formally monitored.

An area of longstanding challenge has been access to examination and assessments for children in care. Without such assessments, informed efforts cannot be undertaken to prevent longstanding impairment from maltreatment (refer to Figure 1, p. 4). Collaborative work between the Ministry of Health, Ministry of Education and Child, Youth and Family has now resulted in the piloting of a health and education assessment programme for children in care in four district health boards.

An early evaluation has found very high health, social, and education needs among children in care (Jakob-Hoff, Stokes, Postlewaite, Lennan, & Tiatia, 2009). Eight in ten children assessed had previously unidentified health and education needs. The most common referrals for further intervention were to mental health services (40.8 percent), dental services (40.8 percent) and audiology services (36.8 percent).

It is unknown to what extent the health, social, and education needs among children in care differ from children with whom Child, Youth and Family is actively involved, but who remain with their families.

Findings	Comments
Many families are already receiving community-based services prior to Child, Youth and Family use of Differential Response intervention.	Differential Response may be an inappropriate intervention for families who have not responded to community-based services.
Child, Youth and Family policy does not identify the range of secondary interventions that can be used by Child, Youth and Family and the indications for use.	Child, Youth and Family policy could be strengthened to identify secondary child protection interventions and indications for use.
Child, Youth and Family policy makes no reference to the legislative responsibility of staff to inform referrers of the referral outcome including interventions taken. Professionals report that this is not current practice.	Child, Youth and Family training and policy could be strengthened to emphasise the legislative responsibility to inform referrers of the referral outcome.
Harm or risk of harm to physical safety is the clear threshold for Child, Youth and Family intervention for neglect. Differential Response is indicated where there is no concern for safety or harm.	If there is no concern for safety or harm then neglect does not, by definition, exist. Differential Response is however an intervention for neglect, deemed as “low level neglect”. The implication is that the current thresholds for Differential versus Child, Youth and Family intervention for neglect are poorly defined, needing clarification.
Significant concerns exist with services provided through the Differential Response pathway. This is the most common intervention for child neglect.	Monitoring Differential Response outcomes is important to establishing the effectiveness of child neglect interventions in New Zealand.
Many children entering Child, Youth and Family care do not have access to a health and education needs assessment.	National roll out of an agreed health and education needs assessment programme could be considered.
Significant concerns regarding access to secondary intervention services exist, but access is not formally monitored.	Monitoring of access to secondary intervention services for child neglect is needed. Barriers to access also require further clarification.
Children not in care but who are long-term clients of Child, Youth and Family are likely to have high health needs and be at risk of long-term impairment.	Monitoring of access to and outcomes of medical, mental and developmental health needs assessments for high-needs Child, Youth and Family clients not in care could be undertaken.

## 4.6 Services to prevent long-term impairment from neglect

There is no policy guidance or descriptive summary of statutory services provided to children to prevent impairment from neglect. Interviews with professionals highlighted access to behavioural and mental health services as key areas of importance in preventing long-term impairment from neglect.

Professionals from all agencies discussed the difficulty of accessing mental health interventions. Respondents spoke of the absence of a mental health early intervention service, long waiting lists and difficulty gaining access to services. Health professionals also spoke of missed opportunities for mental health referrals among children in care. Referral of children at 12 years of age, when they had been in care since 3-4 years of age was not uncommon.

*Mental health services for youth have changed significantly, you need to refer within the band of accepted cases*  
(Education sector)

One mental health professional talked about the limitations placed on them by the Mental Health service specifications. The specifications exclude children (and adults) who have needs 'solely orientated' to: conduct disorder, anti-social behaviours, violence and anger, sexual abuse, relationship issues, and parenting difficulties (Ministry of Health & District Health Board New Zealand, 2009). This group of exclusions intersects with neglect related adverse mental development and mental health outcomes in the early years.

Another health professional commented:

*In my experience there is rarely 'pure' conduct disorder, so few kids are kept out of our service due to anger, violence etc.*

However, the professional also noted:

*I would say people tend to use the exclusions so they don't have to see people that are very complex and change is unlikely. Who diagnoses them in the first place though? There are huge gaps in services around kids with ... severe behaviour and I'm not sure who should see them either.*

(Health professional)

Responsibility for providing services to prevent long-term impairment in neglected children with severe behavioural problems requires clarification. Behavioural problems are a common and early adverse outcome of child neglect. In the outdated memorandum of understanding the Ministry of Health is responsible for providing “services for the medical treatment of children or young people” (Children Young Persons & Their Families Service & Ministry of Health, 1997). Medical treatment is not otherwise defined in the memorandum.

Child, Youth and Family and health professionals spoke of the “somewhat pernicious”, unproductive and not uncommon practice in Child and Adolescent Mental Health of declining to accept a referral and work with a child until care and protection issues are addressed.

*I think the guiding philosophy for the health system needs to be see first and ask questions later*  
(Health professional)

Another respondent suggested that a solution could be therapeutic placements with multi-dimensional treatment foster care. This would facilitate immediate mental health engagement.

Finding	Comment
There is no policy guidance or descriptive summary of statutory services provided to prevent impairment from neglect.	Policy guidelines and information on the provision of statutory services to prevent impairment from child neglect is needed.

## 4.7 Primary prevention

Government agencies provide multiple services that are likely to impact on the prevention of child neglect. The primary prevention of child maltreatment is a prioritised area of focus for the Minister for Social Development and Employment and the Taskforce for Action on Violence within Families<sup>21</sup>. The purpose of the work for 2008-2009 was to enhance the contribution of the Health, Education, and Social Services sectors to prevent child maltreatment, understand better and take actions to reduce the incidence and prevalence of neglect, in particular of 0-5 year olds and strengthen effective community responses.

The Taskforce commissioned child neglect research in October 2008 to inform child neglect prevention in New Zealand. The report was to include:

1. a summary of the international literature on the definition of neglect, its nature, prevalence, and evidence-base for intervention and prevention; and
2. a research report on the approaches and responses to child neglect taken by New Zealand social services, education and health sectors.

The literature review has been completed but not yet published. Preliminary findings include:

- No common or agreed definition of child neglect in the literature;
- Severe, chronic and irreversible long-term impairment following systematic child neglect;
- Evidence on the best way to recognize potential harm and intervene with child neglect is limited. It is however a key issue; and
- Professionals interviewed for the research report recommended:
  - i. A common definition of neglect across agencies;
  - ii. Public awareness campaigns about neglect;
  - iii. Ongoing training on neglect for staff in agencies;
  - iv. Improving resources to Well Child and maternal mental health services;
  - v. Better co-ordination of the multiple services.

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<sup>21</sup> New Zealand has a Family Violence Ministerial Group, which is advised by the Taskforce for Action on Violence within Families. The 23 members of the Taskforce include Chief Executive Officers, decision-makers from the government and non-government sectors, the judiciary and Crown agencies (Ministry of Social Development, 2010).

The commissioned literature review identified the best investments for New Zealand to focus on for the primary prevention of child neglect as:

1. highest quality pregnancy and maternal care
2. highest quality early childhood education; and
3. highest quality health and social care, including education for professionals and paraprofessionals to identify neglect (Davies et al., 2009).

The Taskforce also commissioned a review of the health, education and social service sector contributions to child maltreatment prevention. The work was undertaken by the agencies concerned and the results presented to the Taskforce in April.

**Table 18: Summary of social service sector contributions to the prevention of child maltreatment and approach to future strengthening**

Strengths	Areas for strengthening
<ol style="list-style-type: none"> <li>1. Family and Community Services home visiting and parenting programmes Family Start and Parents as First Teachers</li> <li>2. Child, Youth and Family fund services for the secondary prevention of child maltreatment including domestic violence services, family wellbeing services (parenting and home visiting programmes, family preservation schemes and life-skills courses) and counseling and rehabilitation services.</li> </ol>	<p>For Family and Community Services funded interventions the following could be considered:</p> <ul style="list-style-type: none"> <li>• Development of direct and indirect measures of child safety</li> <li>• Strengthening the child maltreatment prevention focus in service specifications and programme manuals</li> <li>• Identifying opportunities to prevention related components of programmes</li> <li>• Strengthening provision of practical information on keeping children safe in situations of immediate danger</li> </ul> <p>For Child, Youth and Family-funded interventions the following could be considered:</p> <ul style="list-style-type: none"> <li>• Including data requirements in contracts (age and ethnicity)</li> <li>• Moving towards an outcomes-based contracting framework</li> <li>• Developing a purchase strategy</li> <li>• Embedding the Differential Response pathway</li> </ul> <p style="text-align: right;"><b>Cont...</b></p>

	<ul style="list-style-type: none"> <li>• Evaluating the All About Me programme</li> <li>• Piloting provision of Shaken Baby Syndrome information</li> <li>• Evaluating the impact of behaviour-management programmes on child maltreatment</li> <li>• Developing and evaluating a parenting programme for fathers</li> </ul>
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**Table 19: Summary of health sector contributions to the prevention of child maltreatment and approach to future strengthening**

Strengths	Areas for strengthening
<ol style="list-style-type: none"> <li>1. The Well Child Tāmariki Ora programme</li> <li>2. The Violence Intervention Programme</li> <li>3. The Family Violence Death Review Committee</li> <li>4. Child Protection Alert system</li> <li>5. Health and education assessments for children in care.</li> </ol>	<p>The health sector could consider strengthening the following areas:</p> <p>Child maltreatment activities within the Well Child Tāmariki Ora programme, including a new needs assessment and care planning process, currently underway, due for completion by May 2011.</p> <p>The child maltreatment aspect of the Violence Intervention Programme.</p> <p>Scoping opportunities for strengthening child prevention activities in other parts of the health sector particularly:</p> <ol style="list-style-type: none"> <li>a. improving pregnancy outcomes</li> <li>b. maternity workforce child maltreatment training</li> <li>c. improving access to adult mental health and addiction services and maternal and infant mental health services</li> <li>d. population based mental health, alcohol and drug-related interventions</li> </ol>

**Table 20: Summary of early childhood education sector contributions to the prevention of child maltreatment and approach to future strengthening**

Strengths	Areas for strengthening
<p>Provision of Early Childhood Education which improves positive self-regulatory behaviour, cooperation with and attachment to adults, positive peer relations, social skills, and reduced conduct problems.</p>	<p>For the education sector the following could be considered:</p> <ol style="list-style-type: none"> <li>1. Supporting and empowering staff with ongoing guidance including the Breaking the Cycle protocol</li> <li>2. Information to licensing staff to ensure conditions are met for the relicensing process</li> <li>3. Developing mechanisms to support local inter-agency relationships</li> <li>4. Supporting parents, families and whānau by supporting children’s development, facilitating social connections, providing education and information</li> <li>5. Engaging ‘hard to attract’ parents and encouraging participation in ECE services</li> </ol>

Within the social service review, the contributions of wider income, employment and housing interventions were not considered. More broadly, investment in early childhood in New Zealand was not examined.

## 4.8 Information for effective action

Child neglect, service intervention monitoring and intervention outcome information is not routinely made available in New Zealand.

While monitoring is commonly cited in child protection policies, most agencies and services do not in practice monitor the implementation of their child protection policy. Police, Plunket and Housing New Zealand Corporation were identified as currently recording and/or auditing Child, Youth and Family referrals from their service.

With the exception of Police, agencies reported that they did not receive information or feedback from Child, Youth and Family about referrals from their service. All agencies were unaware of the proportion of their referrals that required further investigation or had a finding of neglect or abuse.

### Monitoring of intervention outcomes to improve effectiveness of response

During interviews of South Auckland professionals the issue of monitoring the effectiveness of multi-agency centres as an intervention innovation was raised. The Counties Manukau Multi-Agency Centre, contains Police, Child, Youth and Family and Health services for victims of neglect and abuse. It aims to provide victims “the health, forensic and psychological support they need in a timely and co-ordinated way” (Colville, 2009). However, an evaluation of the centre has not yet started and the opportunity for obtaining baseline information is disappearing.

Findings	Comments
Child neglect surveillance, service intervention monitoring and intervention outcome information is not routinely made available.	There is significant scope for utilising service information to improve responses to child neglect.
Most agencies and services do not in practice monitor the implementation of their child protection policy	
The Counties Manukau Multi-Agency Centre is being implemented and evaluation is not yet underway.	An evaluation of the Mutli-Agency Centre could be progressed.

## 5.0 BEST PRACTICE RESPONSE

Child neglect and its consequences are a serious problem in New Zealand. While intervention is needed to prevent neglect and long-term impairment, there is a paucity of evidence on the effectiveness of interventions used internationally. Recognising the challenge of this situation, the World Health Organization and the International Society for Prevention of Child Abuse and Neglect (2006) have developed a best practice, systematic, multisectoral approach to addressing child neglect and abuse.

This best practice model aims to facilitate an evidence-based approach which also generates evidence for continual strengthening of the approach. The five key components of the best practice model are:

**DEFINITION:** Common conceptual and operational definitions of child neglect and abuse to enable case identification and recording.

**PREVENTION:** Policy and programme measures to address risk and protective factors.

**SERVICES:** Measures and mechanisms to detect and intervene in cases of neglect, and to provide services to victims and families.

**INFORMATION FOR EFFECTIVE ACTION:** Mechanisms to gather information through epidemiological surveys, facility-based surveillance, monitoring and evaluation.

**ADVOCACY:** to raise awareness of the need for investment in evidence-based prevention programmes.

In the absence of best practice guidelines specific to child neglect this generic maltreatment model has been applied with respect to child neglect only. Key features of the guidelines are identified and compared to the current responses by key government departments in New Zealand.

## 5.1 Definition

The various sectors involved in addressing child maltreatment need to develop a common conceptual definition of child maltreatment and common operational definitions to enable case identification and enumeration. They also need to have a common statistical approach to the problem, including standard indicators for measuring rates of maltreatment and the factors that increase the risk of maltreatment. (WHO & ISPCAN, 2006)

New Zealand lacks a common conceptual definition of child neglect at the legislative level. As indicated, this may change in the near future. A common conceptual definition at the interagency policy level is provided in the *Interagency Guide to Breaking the Cycle* (2001). This definition is commonly omitted from many intra-agency child maltreatment policies.

A common shared conceptual definition within the Interagency Guide could be strengthened with inclusion of the risk of harm, emotional and educational neglect, and reference to established standards of care. Following revision of the definition, it should be consistently used throughout agency child maltreatment policies.

This report also found that a common conceptual and operational definition of family violence is not used in New Zealand. Some definitions of family violence include child neglect and others do not. The literature advises that neglect of and violence against children, are different expressions of the same problem. Omitting child neglect from the definition of family violence reduces the strength of the response to family violence and child maltreatment.

A shared operational understanding of child neglect facilitates accurate case identification. A shared operational understanding of neglect does not exist in New Zealand. The most significant component of the understanding identified by professionals as missing is a shared understanding of the desirable standard of care for children in New Zealand. This lack of a shared operational understanding may be reflected in the low substantiation rate of professionals' notifications to Child, Youth and Family.

Professionals also recommended that the operational understanding of child neglect be commonly shared with the New Zealand public to facilitate understanding where intervention was required.

A common statistical approach is also central to a best practice approach to defining child neglect. This report found a dearth of child neglect epidemiology for New Zealand. There is no current mechanism for regularly measuring the prevalence of child neglect in the community. The Child, Youth and Family information included in this report provides an indication of the epidemiology of child neglect but with significant limitations. A range of agreed indicators for monitoring child neglect is needed.

## 5.2 Prevention

To prevent child maltreatment, policy and programme measures addressing risk factors and protective factors need to be implemented. (WHO & ISPCAN, 2006)

The best practice guidelines recommend a lead agency to prevent child maltreatment and a national child maltreatment prevention agenda (WHO & ISPCAN, 2006).

Practical steps suggested in the guidelines include:

1. nominating the single lead agency responsible for the prevention of child neglect and abuse;
2. assigning roles to collaborating sectors;
3. preparing a report on the current epidemiological knowledge and efforts across sectors to prevent it; and
4. developing a child maltreatment prevention strategy and action plan
5. including outcome evaluations within the plan of action

(WHO & ISPCAN, 2006).

The Taskforce for Action on Violence within Families has currently assigned the Ministry of Social Development the lead agency role with responsibility for child maltreatment. Each government sector has reported on their current work programme to strengthen the prevention of child maltreatment. However, a report on the current epidemiological knowledge of child neglect has not been undertaken. There is currently no systematic approach to monitoring or measuring outcomes of child neglect prevention programmes in New Zealand.

### **Prevention strategies for child neglect**

Best practice strategies for the prevention of child neglect should address the underlying causes and risk factors for child neglect at the individual, family, community and societal levels.

The Taskforce commissioned literature review on child neglect identified risk factors for child neglect (Davies et al., 2009). This information has not been supported by analysis of the prevalence of these risk factors in New Zealand families. Nor has the strength of association between identified risk factors and child neglect outcomes

been analysed in New Zealand. Such analysis could provide an evidence-base for funding risk factor interventions for the prevention of child neglect.

Current strategies for the prevention of child maltreatment (including neglect) by social services, health and education are summarised in Tables 18-20 (pp. 95-96). Following comparison of best practice guidelines and current strategies for prevention, the following opportunities for further strengthening have been identified:

1. Provision of information to parents through *Strategies with Kids – Information for Parents* on neglect, the impact of neglect and how to prevent it.
2. Ensure a common framework of outcomes for monitoring across prevention programmes including the Differential Response pathway and Te Puni Kokiri's Whānau Ora programme.
3. Ensure that reducing unintended pregnancies is included within the scope of Ministry of Health interventions to improve pregnancy outcomes
4. Review public health provision of preventive home visitation programmes. Evaluate the effectiveness of public health nurse home visitation interventions on child neglect and abuse outcomes, with comparison against populations who do not have access to this service.
5. Evaluate the impact of additional Well Child provider home visits on child neglect and abuse outcomes.

## 5.3 Services

A comprehensive response to child maltreatment involves putting into place measures and mechanisms to detect and intervene in cases of maltreatment, and to provide services to victims and families. (WHO & ISPCAN, 2006)

### **Intervention outcome studies to improve the evidence base**

Best practice interventions are grounded in appropriate theory and designed according to the best available scientific evidence. As current scientific evidence is limited it is important that interventions are evidence generating. Intervention outcomes should be measured to ascertain whether or not their intended effects have been achieved. In this way, outcome studies can improve the evidence base for intervention (WHO & ISPCAN, 2006).

Service surveillance and intervention outcome studies are particularly indicated in the areas of partnered response, Child, Youth and Family intervention services and interventions to address the health and education needs of children in care and children who are long-term clients of Child, Youth and Family. This is a priority area for advancement of effective child neglect interventions in New Zealand.

### **Responding to child neglect: detection, protection and prevention of impairment**

A best practice approach to detecting child neglect incorporates a focus on early detection and intervention and special training of professionals (WHO & ISPCAN, 2006). Where concerns have been identified, integrated health care and forensic assessment is needed. Children and families with multiple risk factors should be prioritised for intervention in a resource restricted environment (WHO & ISPCAN, 2006).

Following protection from neglect and other maltreatment, a range of interventions may be appropriate to prevent long-term impairment (Table 21).

**Table 21: Interventions to prevent long-term impairment following neglect**

- **Health interventions** – such as ongoing medical care; mental health interventions; trauma therapy; and individual, group or family counseling;
- **Social interventions** – such as respite care; assistance with everyday home tasks, including cleaning and preparing food; foster placement; and supervision by child protection services;
- **Educational interventions** – such as special schooling or training;
- **Legal interventions** – such as the prosecution of perpetrators; child protection; and measures to claim damages;
- **Financial assistance** – such as victim compensation funds to help with the above interventions.

Source: WHO & ISPCAN (2006).

Good practice includes clarity among all professionals with respect to their responsibilities and the protocols that they must follow. New Zealand professionals expressed clarity around the voluntary or organisationally mandatory nature of reporting concerns and the protocol that they must follow. However, professionals were unclear of the definition of neglect and when an assessment indicates sufficient 'care and protection concerns' to child protection services.

Best practice guidelines recommend prioritisation of cases where multiple risk factors exist in a resource restricted environment. This report has found inconsistent use of risk factors in policy and practice. The tools currently used by referring professionals do not significantly increase the sensitivity and specificity of the assessment beyond the referrals made by the general public.

A relative lack of discrimination in assessments places a heavier assessment burden on Child, Youth and Family. Strengthening of the *Interagency Guide to Breaking the Cycle* and subsequent training may improve the accuracy of assessment and referrals, thereby reducing the burden on Child, Youth and Family. Ongoing monitoring of the effectiveness of assessment tools is needed.

There is also some evidence that risk factor assessment in Child, Youth and Family requires strengthening. In some instances, referral risk assessment tools are more

detailed or coherent than the assessment tools of Child, Youth and Family. Furthermore, the application of tools has been reported as inconsistent within Child, Youth and Family. A recent review of selected Child, Youth and Family referrals found that statistical risk factor analysis was not possible due to the inconsistency of risk factor assessment (Kelly, MacCormick, & Strange, 2009).

Strengthening of policy from the definition and identification of neglect, to referral and provision of services to prevent recurrence and long-term impairment is needed. This should be supplemented by training to achieve greater clarity amongst professionals.

The *Interagency Guide to Breaking the Cycle* provides policy guidelines and child neglect and abuse information to guide all sectors in New Zealand (Child, Youth and Family, 2001). Areas identified in the report where guidance could be strengthened:

- a common shared understanding of neglect including guidance on the threshold for standards of care and the short and long term harms of neglect
- indicators of neglect and abuse, risk factors, red flags, and sample interview questions which are consistent with Child, Youth and Family assessment tools
- renotification advice,
- inclusion of the written referral form
- identification of the roles and responsibilities of core agencies and services
- advice on interventions for children of concern (beyond assessment and referral) and
- guidelines on intra- and inter-sectoral training.

Child, Youth and Family policy guidance could also be strengthened with:

- (a) description of the key risk and protective factors which must be recorded (as present or not present) in all children's records
- (b) the thresholds for Differential Response versus Child, Youth and Family intervention
- (c) the secondary child neglect interventions that should be accessible and indications for use and
- (d) the legislative responsibility to inform referrers of the referral outcome.

A Child, Youth and Family system for monitoring access to interventions following Child, Youth and Family referral is also needed.

## 5.4 Information for effective action

The best practice guidelines assert the need for population-based epidemiological surveys of child neglect and abuse:

Surveillance of reported cases of child maltreatment can point to trends in service provision and service utilization, but cannot give a proper overview of the problem. Wherever possible, surveillance systems should be supplemented by population-based surveys ... to remedy this.  
(WHO & ISP CAN, 2006)

The benefits of obtaining epidemiological information are described in Table 22.

**Table 22: How epidemiological information on child neglect and its consequences can contribute to prevention**

1. providing a quantitative definition of the problem that can be commonly used by a range of concerned groups and sectors;
2. providing ongoing and systematic data on the incidence, causes and consequences of child neglect at local, regional and national levels;
3. enabling the early identification of emerging trends and problem areas in child neglect so that appropriate interventions can be established before it is too late;
4. suggesting priorities for prevention among those at high risk of either experiencing or perpetrating child neglect, as well as priorities for addressing the associated risk factors;
5. providing a means to evaluate the impact of prevention efforts;
6. monitoring seasonal and longitudinal changes in the prevalence and characteristics of child neglect and its associated risk factors;
7. giving an overview of the geographic distribution of child neglect cases that can help in planning the location of future child protection services and other victim support services.

Source: WHO & ISPCAN, (2006).

Population-based epidemiological surveys of child neglect and abuse are possible but not currently conducted in New Zealand. This is a significant impediment to preventing child neglect. Action is required to establish regular or continuous child maltreatment epidemiological monitoring.

## **Case Information**

Collecting and sharing basic case information enhances the protection of maltreated children and contributes to the surveillance of child maltreatment. Even in communities where child protection systems are considered well advanced, the failure to communicate case information within and between service agencies regularly leads to the preventable suffering and death of children.  
(WHO & ISPCAN, 2006)

'Child or family previously known to social services' is a common indicator of neglect which professionals should be able to include as part of their assessment. Strengthening of education and health recording of concerns and referrals and information sharing by Child, Youth and Family services is needed to enhance the protection of neglected children.

## **Monitoring of child neglect cases**

The guidelines recommend monitoring of child neglect with recognition of its limitations and biases.

This report found that Child, Youth and Family monitoring information is not routinely made available with descriptions of the rate of identified neglect and disaggregation by age, sex, ethnicity, place of residence (Child, Youth and Family site), neighbourhood deprivation or maltreatment co-findings. Nor is referral monitoring information, including source of neglect referrals, referrals by geographical area, and substantiation rate by referrer, which all point to trends in the quality of neglect assessment. Monitoring information including number of referrals prior to a neglect finding, rates of neglect by Child, Youth and Family site and average weighted deprivation decile, and investigation outcomes also point to trends in service provision.

With all the limitations of monitoring data, it is currently the best available source of information which could be utilised for informing effective action.

## **Fatal child neglect**

Fatal child neglect could be monitored by the New Zealand Child and Youth Mortality Review Committee. However, such monitoring is unlikely to have a significant impact on the design of child neglect prevention programmes:

The view most countries have of deaths from child maltreatment is incomplete, and is likely to be biased towards cases that have been prominently covered in the media. Using such information to design prevention programmes for child maltreatment and victim services is therefore not recommended.  
(WHO & ISPCAN, 2006)

### **Feedback to agencies that provide information**

To improve the sustainability of surveillance systems for child maltreatment, agencies that provide the information should be given frequent feedback. This feedback should consist of regular reports with a basic analysis of the data received from each contributing agency. Such reports can help agencies manage their staff and other resources better and match the service they supply with the demands of users.  
(WHO & ISPCAN, 2006)

It is not current practice in New Zealand for Child, Youth and Family systems to provide frequent feedback to key agencies. However, capability currently exists for the provision of area-based and national summaries of child protection referral and referral outcomes for audit and monitoring purposes.

Recording of referrers is not sufficiently detailed to allow feedback to general practitioners, who have a specific abuse reporting protocol.

### **Using information to convince policymakers**

It is vital that data on child maltreatment are presented in reports dealing exclusively with the problem  
(WHO & ISPCAN, 2006).

The best practice guidelines recommend that child neglect data is presented with particular emphasis on the size of the problem in relation to other issues, its relationship with socioeconomic and environmental factors and the possibility to prevent child neglect.

Child, Youth and Family do not currently present child neglect data with any detailed analysis of the epidemiology or in association with monitoring of interventions to prevent its occurrence, prevent recurrence or long-term impairment. As the guidelines suggest, such a report could also be broadened to consider the size of the problem in relation to other issues.

## 5.5 Advocacy

Efforts to prevent child maltreatment should include activities to raise awareness among decision-makers and the public of the need for investment in evidence-based prevention programmes. Campaigning efforts should also focus on the adoption of non-violent social and cultural norms, especially as these relate to parenting.  
(WHO & ISPCAN, 2006)

Current efforts to prevent child maltreatment are focused on the prevention of physical abuse and family violence. The focus on physical aspects of maltreatment is reflected in child protection policies and practice. Public campaigns also focus on non-physical violence and have not addressed emotional abuse or child neglect.

Significant effort is therefore required to raise awareness among policy-makers and the public about the harmful long-term consequences of child neglect and the limited nature of current evidence on the effectiveness of interventions. The current family violence public campaigns could be expanded to include emotional abuse and child neglect.

## 6.0 RECOMMENDATIONS TO STRENGTHEN THE PREVENTION OF CHILD NEGLECT

Child neglect is a significant public health problem. While it affects only a relatively small proportion of the child population, the consequences can be severe: psychopathology, substance abuse, violent crime, heart disease, cancer and death. The consequences can also cycle between generations with neglected children more likely to neglect their own children as adults.

This report has examined the nature and consequences of child neglect, the prevalence of child neglect in New Zealand, and current policy and practice. It provides a description of the status quo and highlights challenges which hinder current responses to child neglect.

These challenges include firstly a lack of a shared understanding of neglect. Secondly, information on the prevalence of neglect is limited, and collection of this information is hindered by the lack of a shared understanding. Available information tells us that professional referrers are not accurately able to identify child neglect and abuse, and this again is related in part to the lack of a shared understanding, including the threshold for established standards of care.

There is an absence of information on interventions to prevent the recurrence of neglect, interventions to prevent impairment and information on the prevalence of long-term impairment from neglect to understand how this problem may be impacting on other social problems including violence, crime, and early death.

Finally, without this information it is difficult to meaningfully manage child neglect prevention interventions or make recommendations on the best pathway forward.

Respecting the best-practice advice given by the World Health Organization and the International Society for Prevention of Child Abuse and Neglect (2006) this report recommends that two key steps must be taken initially to strengthen the response to child neglect:

- **development of a shared understanding and policy guidance for child neglect interventions, and**
- **collation and sharing of information to inform action.**

Implementation of these recommendations will pave the way for identification of further mechanisms by which New Zealand's response to child neglect can be strengthened.

The following section elaborates further on means by which policy guidance and child neglect information management could be improved.

#### **A. Development of a shared understanding and policy guidance for child neglect identification and interventions**

A shared understanding of child neglect and the intervention pathway is central to collaborative efforts to prevent neglect from occurring and recurring. The shared understanding arises from shared policy, which leads to a consistent basis for training and action. A common understanding also arises from sharing child neglect information with the public. In order to move towards this goal, the report makes the following recommendations:

- 1. It is recommended that the Ministry of Social Development work with Child, Youth and Family, the Ministry of Health, Ministry of Education and Police to develop a shared understanding of child neglect and ensure that all child neglect and abuse policies contain the shared understanding, which should include the four common core elements of neglect and the category of emotional neglect. Policy definitions of family violence should also be reviewed to ensure inclusion of child neglect.**
- 2. It is recommended that Child, Youth and Family, in consultation with the Ministry of Health, Ministry of Education and Police, produce a revised *Interagency Guide to Breaking the Cycle* that includes the shared understanding of child neglect.**

In revising the *Interagency Guide to Breaking the Cycle* Child, Youth and Family could consider providing information on:

- the use of guideline indicators of neglect, risk factors, red flags, and sample interview questions. Child, Youth and Family assessment tools could be included to assist professional referrers in their referral decision making;

- indications for identified interventions to prevent the recurrence of child neglect;
- indications for identified interventions to prevent long-term impairment from child neglect with identification of the service responsible for providing the named interventions;
- the roles and responsibilities of core agencies and services;
- the legislative responsibility of Child, Youth and Family to inform referrers of the referral outcome;
- intra- and inter-sectoral training;
- inclusion of the written Child, Youth and Family referral form for professionals; and
- case scenarios that describe common neglect situations and suitable responses. This descriptive case series will support a shared understanding of child neglect.

**3. It is recommended that Child, Youth and Family develop practice material around the management of child neglect, as a source of reference for Child, Youth and Family social workers.**

Consideration could be given to locating this practice material on the Child, Youth and Family Practice Centre website and to including indicators of neglect, risk and protective factors, red flags, legislative responsibilities, case scenarios, the roles and responsibilities of core agencies and services, identified interventions to prevent the recurrence of child neglect or to prevent long-term impairment from child neglect.

This practice advice could be strengthened by including information on the key risk and protective factors that could be recorded (as present or not present) in all children's records, a discussion around the role of the statutory agency and examples of known child neglect interventions, to assist decision-making.

**4. It is recommended that Child, Youth and Family consider, with the Police, whether existing guidelines are sufficient to assist with the detection of neglect and serious willful neglect.**

Child, Youth and Family and Police have worked together to produce an updated Child Protection Protocol, which sets out each agency's responsibilities in cases of

abuse and neglect. This recommendation is asking that that Protocol be checked to ensure it covers sufficiently the areas of neglect and serious willful neglect.

- 5. It is recommended that the Ministry of Social Development consider providing information to parents through *Strategies with Kids – Information for Parents* and other strategies managed by the Ministry, explaining neglect, the impact of neglect and how to prevent it.**
- 6. It is recommended that the Ministry of Social Development consider reviewing all other child maltreatment information which the Ministry provides to the public, to ensure that information on child neglect is included, and that information is consistent with the shared understanding of child neglect and guidelines for referral.**

#### **B. Collation and sharing of information to inform action**

Routine collection and reporting of population-based survey information and Child, Youth and Family data are both needed to establish the true nature of child neglect in New Zealand, identify emerging trends, problem areas, and priorities for prevention as well as monitoring for the impact of interventions. Where child neglect has occurred it is important that referring agencies retain this knowledge, to help identify very vulnerable children who are at risk of recurrent neglect.

- 7. It is recommended that the Ministry of Social Development note that surveys designed to monitor child maltreatment are being used in the USA and the Ministry could examine options for collecting population-based measures.**

As part of this work, the Ministry of Social Development could work, with Child, Youth and Family, the Ministries of Health and Education and Police to identify a common, agreed 'dashboard of indicators' to monitor child neglect.

- 8. It is recommended that the Ministry of Social Development explore a child neglect research agenda, using the data available to it from Child, Youth and Family.**

An agenda could consider issues around strengthening the prevention of the occurrence, recurrence and impairment from child neglect. Areas for research could

include an examination of the strength of association between known risk factors and identified child neglect outcomes and/or an evaluation of the effectiveness of a revised *Interagency Guide to Breaking the Cycle*.

- 9. It is recommended that Child, Youth and Family consider auditing those 18 cases of child neglect with 15+ notifications identified in this report, identify barriers to earlier prevention and identification of neglect and use this information to advance practice advice and guidelines.**
  
- 10. It is recommended that Child, Youth and Family consider communicating annually with the Ministry of Health, Ministry of Education and Police, providing information to those agencies on numbers of referrals received from them, referral substantiation rates and referral outcomes.**
  
- 11. It is recommended that the Ministry of Health consider providing ongoing support for District Health Board development of the child protection alert system.**
  
- 12. It is recommended that the Ministry of Education consider reviewing the use of ENROL for child protection purposes and implement a plan of action for strengthening child protection alerts within the school system.**
  
- 13. It is recommended that the Ministry of Social Development note that some overseas jurisdictions are sharing information more freely amongst those engaged in child protection work and the Ministry could progress the development of a New Zealand model for information sharing.**

## Appendix 1: Methodology

This report examines the prevalence and prevention of child neglect and related long-term outcomes in the literature, New Zealand data, legislation, policy and government practice. A mixed methods approach was used for the report. The inquiry included:

1. A literature review
2. Analysis of Child, Youth and Family data
3. Examination of relevant legislation
4. Policy analysis
5. Stakeholder interviews
6. Analysis and integration of data collected to identify elements of best practice for further development.

### Literature Search Methodology

A literature search was performed of all English language review articles in the Ovid Medline, Cochrane and PubMed databases published during the 15-year period of 1996 – 2010. The search strategy used the keywords “child neglect” and “child maltreatment”.

Further articles were obtained by searching the reference lists in relevant articles. The following websites were also accessed:

- [www.cyf.govt.nz](http://www.cyf.govt.nz)
- [www.who.int](http://www.who.int)
- [www.nzfvc.org.nz](http://www.nzfvc.org.nz)
- [www.cdc.gov/ViolencePrevention/childmaltreatment](http://www.cdc.gov/ViolencePrevention/childmaltreatment)
- [www.childwelfare.gov/can/](http://www.childwelfare.gov/can/)

A total of 70 publications were reviewed. Within the literature search, key documents which provide a framework and best practice approach for the prevention of child maltreatment were identified (MacMillan, et al., 2009; World Health Organization & International Society for Prevention of Child Abuse and Neglect, 2006).

### Analysis of surveillance data

A detailed information request was made to Child, Youth and Family for child protection services information. Section 20 of the Children’s Commissioner Act 2003

provides the Commissioner and specified employees with special powers to call for information or documents.

The data source and methods are summarised in the background of Section 3.

### **Average Weighted Deprivation Index score**

The New Zealand Deprivation Index (2006) describes general socioeconomic deprivation in small areas. It is a relative measure, and ranks all small areas of New Zealand from least (scale of 1) deprived to most deprived (scale of 10). The deprivation value derived for any small area is assigned to each meshblock in that area.

There may be one or two constituent meshblocks in small densely populated areas, but several sparsely populated ones in rural areas. Therefore, a small group of meshblocks with, say, scores of 10, in a neighbourhood of interest may simply reflect a sparsely populated region, which has been pooled into one NZDep small area, that scored 10 (Ministry of Health 2006).

Since meshblocks vary in population size, the deprivation index was adjusted for the population in that area (average weighted deprivation). Meshblock level deprivation and population were combined into Child, Youth and Family sites to calculate the weighted average population (adjusted for the total population in a particular site) for each site.

### **Examination of relevant legislation**

Relevant sections of the Children, Young Persons, and Their Families Act 1989, the Crimes Act 1961 and the drafted Crimes (Offences Against the Person) Amendment Bill were examined with respect to the definition of neglect, willful neglect and child protection service responsibilities.

### **Policy analysis**

Policies were obtained from Child, Youth and Family, Police, the Ministry of Health and Ministry of Education. Policy analysis was conducted using the policy guidelines provided in the *New Zealand Standard NZS 8006:2006: Screening, Risk assessment and Intervention for Family Violence including Child abuse and neglect (Standards New Zealand, 2006, p.27-29)*. Only a summary of the core policy components is included in this report.

### **Stakeholder interviews**

A total of 47 interviews were conducted with 121 professionals from health, education, Police and Child, Youth and Family. Some stakeholders were interviewed as part of Office of the Children's Commissioner site monitoring visits. These visits included brief discussions regarding neglect with lawyers and non-governmental organisation employees.

Interviews were limited to professionals in Auckland, Wellington and Dunedin areas.

Seventeen health interviews were conducted with 58 professionals including paediatricians, hospital social workers, public health nurses, plunket nurses, child and adolescent psychiatrists, DHB child health managers, and Ministry of Health child health and family violence professionals.

Twelve education interviews with 37 professionals included principals, teachers and administration staff from the ECE, and primary and secondary school sectors as well as from the ECE section of the Ministry of Education.

Six interviews were conducted with 10 police staff including child protection/child abuse team police officers and National Police crime and social policy professionals.

Twelve interviews were conducted with 16 Child, Youth and Family professionals including Child, Youth and Family practice leaders, differential response coordinators, managers, Child, Youth and Family social workers in hospitals and national agency staff.

Interviews were carried out face to face with the exception of three telephone interviews. Interviews were semi-structured and based on the following interview guide:

1. How do you define child neglect?
2. What are the most common types of child neglect that you encounter in your work?
3. In the past, have you referred children to Child, Youth and Family because of neglect?

4. How do you decide whether a child and their family should be referred for risk or harm from child neglect? (Or for Child, Youth and Family, in what circumstances does neglect become a 'care and protection' issue?)
5. Does your service have a policy for responding to child neglect? If yes, to what extent does policy guide the practice?
6. Can you tell me about your experiences of the response process after a referral has been made?
7. How can the current system of responding to child neglect be further improved?

Interviews were either recorded or a written record was taken during the interview. Relevant excerpts were extracted and a representative sample of excerpts is included in the report.

## Appendix 2: Summary of key policy findings

ORGANISATION	INTERAGENCY	MINISTRY OF HEALTH	DHBs	PLUNKET	GPs	SCHOOLS	ECEs	KOHANGA REO	POLICE
Policy / Protocol	Interagency Guide to Breaking the Cycle	Family Violence Intervention Guidelines: Child and Partner Abuse	Generic Management of Child Abuse and Neglect Policy	Family Violence Prevention Policy and Protocols (inclusive of Child Abuse and Neglect Prevention) July 2008	Recommended process for General Practitioners: Suspected child abuse and neglect.	Reporting of Suspected or Actual Child Abuse and Neglect, Protocol between the Ministry of Education, the New Zealand School Trustees Association and Child, Youth and Family 2009	Template Child Protection Policy	Kohanga Reo and CYF Protocol for Protection of Mokopuna 2009	Child Protection Protocol
Definition of child neglect	Child neglect is defined with some components omitted (see general findings below).	Child neglect is defined in the glossary with some components omitted (see general findings below).	Child neglect is defined in Appendix 1 and 2 with some components omitted (see general findings below).	Child neglect is not defined.	Child neglect is not defined.	Neglect is defined briefly as medical neglect, abandonment and neglectful supervision.	Child neglect is not defined.	Child neglect is not defined.	Serious wilful neglect is defined. See Section X
Clear explanation of how screening and/or risk assessment are to be approached	Limited range of screening risk factors identified. Signs of abuse and neglect are provided. Interviewing is not recommended so questions for child or caregiver are not provided.	Tools provided include: High risk indicators associated with child abuse. Signs and symptoms associated with child abuse and neglect. HEADSS Assessment and (abuse focused).	Risk indicators, risk assessment, and red flags are provided. Risk assessment refers to clinical signs and symptoms of CAN in Appendix. Neglect section would benefit from detailing common signs and symptoms of neglect.	Uses Manitoba Risk Assessment Model. No physical and behavioural / developmental signs of child neglect. Questions that can be asked where there is suspected abuse/neglect are not provided.	One page summary of history (including risk factors) and signs of child abuse and neglect are provided.	High risk indicators and signs and symptoms of neglect are not included in the protocol. The policy recommends that the child is not formally interviewed but rather that what the child says is accurately recorded and claimed where necessary.	Template suggests that CYF resources are used to develop policies.	Advises that knowing the child and being aware of changes in the child is the best way to recognise abuse. Staff are referred to the Interagency Guide.	There is no test for seriousness of wilful neglect. Test for seriousness of physical abuse is provided.
Documentation	Clear documentation of observations and interviews is advised with clear quotes of what was said and details of who, where and when.	Section 1.5 details documentation requirements - slightly more detailed and technical than Interagency Guide. Appendix D contains the Body Diagram Sheet.	Documentation requirements as per interagency guide. Less detailed than the MOH FVIG. Health record also to be created.	Requirements as per interagency guide. Body diagram provided. Health record also to be created. NON-NOTIFIED CASES TO HAVE RISKS DOCUMENTED.	CYF referral facsimile sheet and body diagram sheets enclosed.	Information required for reporting is specified.	Template recommends inclusion of "appropriate record-keeping procedures"	Reference is made to a referral / report of concern form for Police / CYF (not supplied). A form is also provided for Te Kohanga Reo records.	Information fields for documentation are specified.
Outline of referral process	An outdated information / notification form is provided on page 31. Useful section explaining CYF processes.	Appendix F contains an outdated referral form for CYF. Section 1.6 outlines other support services.	Procedure for responding to actual or suspected abuse is provided. CYF report template is separate to the policy.	Provided on p. 17-22. Includes consideration of conditions where a repeat referral is appropriate.	Provided. Useful section on page 8 which explains the CYF process.	Referral guidelines are provided.	Template directs inclusion of referral guidelines	A flow diagram for the referral process is provided.	CYF and Police advise each other about the report or concern they have received and make a Child Protection Protocol complaint.
Agency monitoring and review plan	Guidelines recommend establishment of evaluation procedures to achieve service excellence for clients and staff.	Appendix P: Creating a Model Response to Child Abuse asks services to consider evaluation of the quality of assessment and documentation completed through a review of medical records.	The policy outlines monitoring actions and allocates monitoring responsibility to the Child Protection Co-ordinator. Implications for discharge diagnoses / ICD coding not discussed.	Regular start feedback on policy implementation. Inter-agency feedback when policy is reviewed, and policy reviews as necessary. National and regional reporting processes is described.	Monitoring and review not discussed in the policy.	No outline of monitoring and school review.	The template does not include monitoring and review issues.	Protocol does not comment on systematic monitoring or review of referrals, but a form is kept for service records.	Both CYF and Police will each put in place their own monitoring, reporting and assurance systems.
General Findings									

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