



Understanding the potential impacts of Early Childhood Adversity with a focus on Neglect

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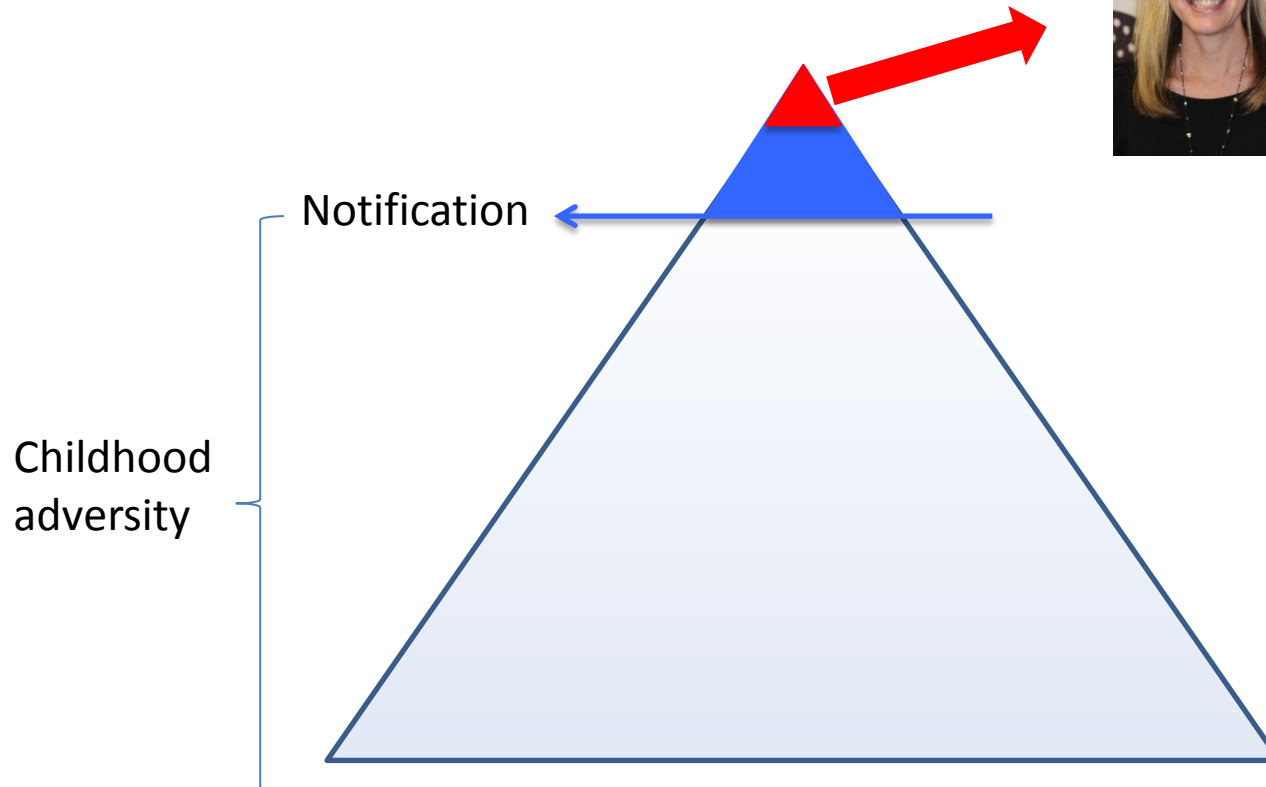
Case scenario to consider

- A 3 month old baby girl is referred to Paediatric OPD by a home visiting nurse.
- Background Information- Full term pregnancy. First baby to young mother. Concerns about possible Domestic Violence by current partner (not father of the child)
- At last home visit two days ago the baby's weight has dropped from the 50th centile at birth to the 10th centile. Nurse concerned that the mother is not following her advice to supplement breast feeding.
- On medical assessment you can find no medical cause for her poor weight gain.

What is your response?

Disclosure - Potential Conflict of Interest

- I am a forensic Paediatrician!



Pediatricians and Childhood Adversity/ Neglect

- 1. Recognition** that adversity is present and having an impact or potential impact on the child's health and or wellbeing in the context of a presentation to an outpatient clinic, emergency department etc. This role includes decision making with regards to when to notify and also about how to engage the family with appropriate services either pre-notification or in conjunction with notification
2. A Forensic Neglect **Assessment** following notification for the purpose of informing statutory bodies, Police, Courts as to the impact/harm/risk to the child(ren)
3. Out of Home Care Assessments, Child Psychiatry and other settings- Evaluation of the impact of neglect on a child's physical and mental health and the introduction of appropriate **Treatment**

Childhood Adversity/Neglect - Essential Understandings

1. Terminology
2. Prevalence
3. Evidence for the harmful effects when a certain threshold is crossed (ACE studies)
4. Mechanisms by which this harm is caused is increasingly understood
 - Neurobiology/Toxic Stress/ Endocrine System/Epigenetics
5. Child Protection is everyone's business -Think beyond notification

1. Terminology

- Child's Rights/Autonomy
- Child Wellbeing/ Needs
- Vulnerability
- Adversity
- Child Harm/ Cumulative Harm
- Child Neglect/ Forensic Assessment of

A SIMPLIFIED VERSION OF THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD.



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The Convention on the Rights of the Child (1990) has 54 articles. Articles 43-54 are about how adults and governments should work together to make sure that all children get all their rights.

CHILD'S RIGHTS

The Convention changed the way children are viewed and treated – i.e., as human beings with a distinct set of rights instead of as passive objects of care and charity.



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Child Wellbeing

The 6 wellbeing domains are

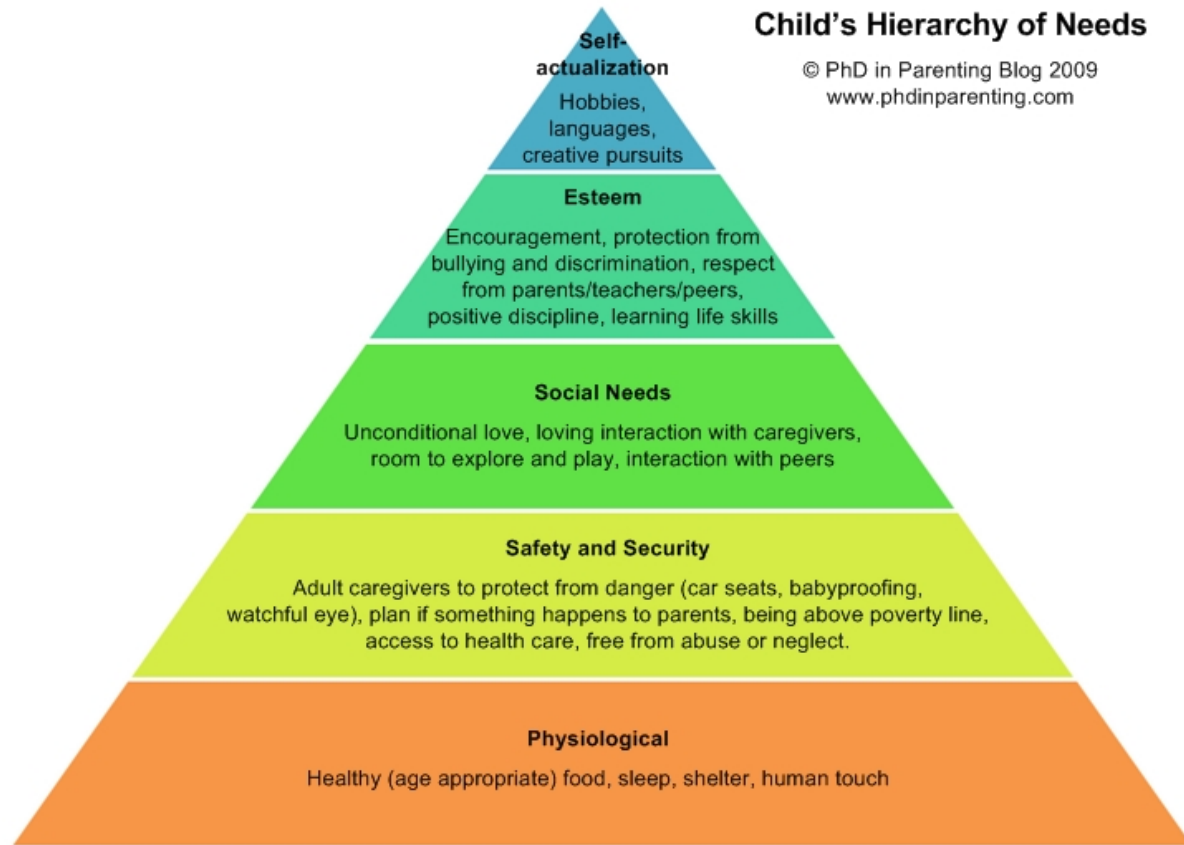
- Physical health
- Mental/Emotional Health
- Relationships
- Material wellbeing
- Learning and development
- **Safety**

The table below shows how the overview of child well-being has been constructed and sets out the full list of indicators used. The score for each dimension has been calculated by averaging the scores for each component. Similarly, component scores are arrived at by averaging the scores for each indicator.

Dimensions	Components	Indicators	Figure no.
Dimension 1 Material well-being Figure 1.0	Monetary deprivation	Relative child poverty rate	1.1a
		Relative child poverty gap	1.1b
	Material deprivation	Child deprivation rate	1.2a
		Low family affluence rate	1.2b
Dimension 2 Health and safety Figure 2.0	Health at birth	Infant mortality rate	2.1a
		Low birthweight rate	2.1b
	Preventive health services	Overall immunization rate	2.2
	Childhood mortality	Child death rate, age 1 to 19	2.3
Dimension 3 Education Figure 3.0	Participation	Participation rate: early childhood education	3.1a
		Participation rate: further education, age 15–19	3.1b
		NEET rate (% age 15–19 not in education, employment or training)	3.1c
	Achievement	Average PISA scores in reading, maths and science	3.2
Dimension 4 Behaviours and risks Figure 4.0	Health behaviours	Being overweight	4.1a
		Eating breakfast	4.1b
		Eating fruit	4.1c
		Taking exercise	4.1d
	Risk behaviours	Teenage fertility rate	4.2a
		Smoking	4.2b
		Alcohol	4.2c
		Cannabis	4.2d
	Exposure to violence	Fighting	4.3a
		Being bullied	4.3b
Dimension 5 Housing and environment Figure 5.0	Housing	Rooms per person	5.1a
		Multiple housing problems	5.1b
	Environmental safety	Homicide rate	5.2a
		Air pollution	5.2b

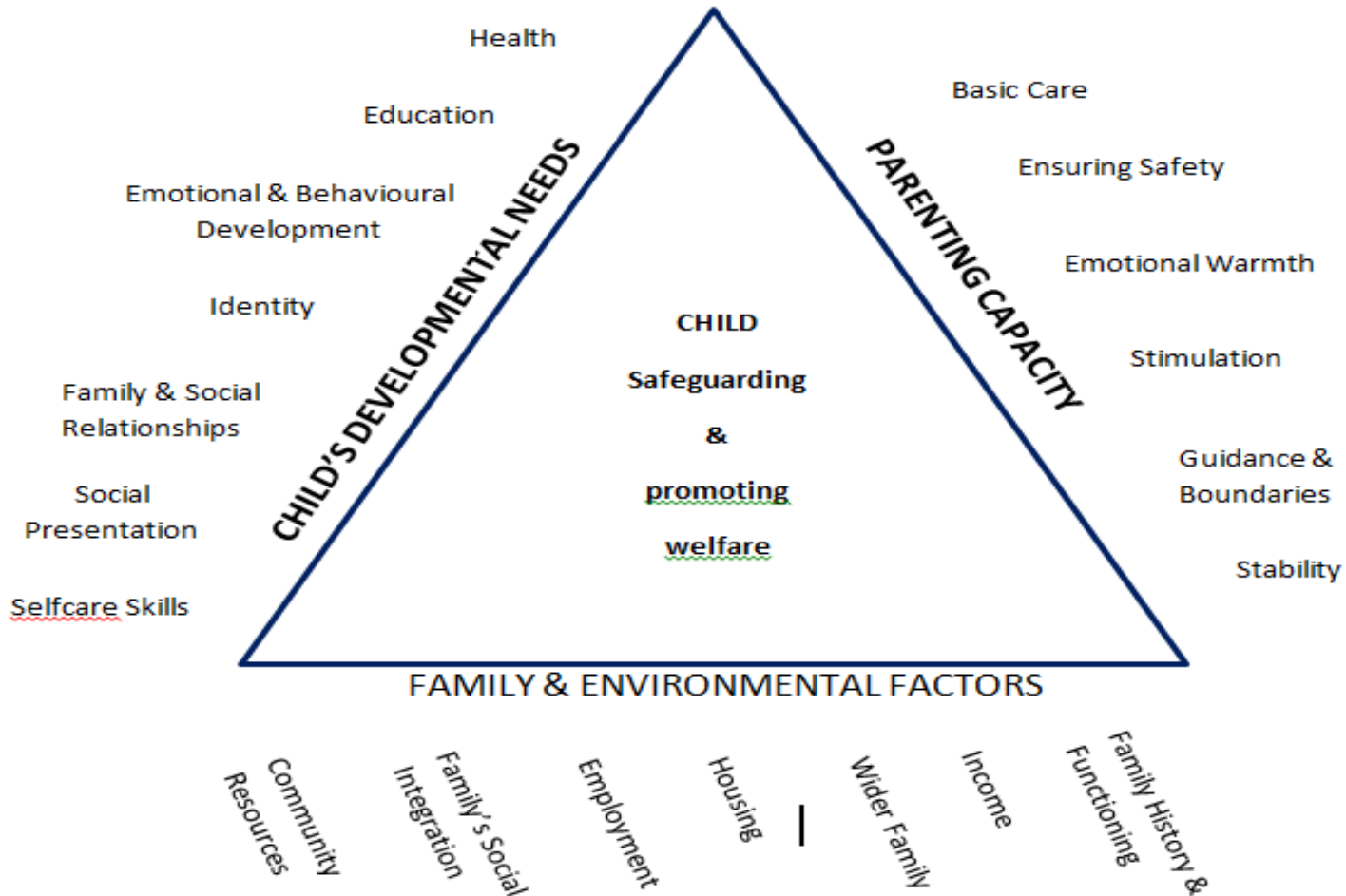
Child's Needs

- Adequate food
- Clothing
- Health Care
- Supervision
- Protection
- Education
- Nurturance
- A Home



Child's Needs

Bentovin's Assessment Framework



Vulnerability

- Vulnerable children are those who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs.
- Important to identify and address factors that make children vulnerable before they escalate to child abuse
- Adversity leads to vulnerability

Adversity

- Exposure to adversity impairs a child's capacity for optimal development and wellbeing.
- Adverse factors can be internal(chronic disease,disability)
- External adverse factors to which a child may be exposed include
 - Poor maternal health/behaviour in pregnancy
 - Poor parental mental health
 - Parental intellectual disability
 - Parental alcohol and substance misuse
 - Parental antisocial or criminal activity
 - Poverty/unstable housing
 - Impact of parental exposure to childhood maltreatment/trauma/adversity
 - Family violence

Active Adversity

Support Services

None

Statutory Response

Minimal harm and adversity

abuse causing harm with minimal underlying adversity

Child Harm

None

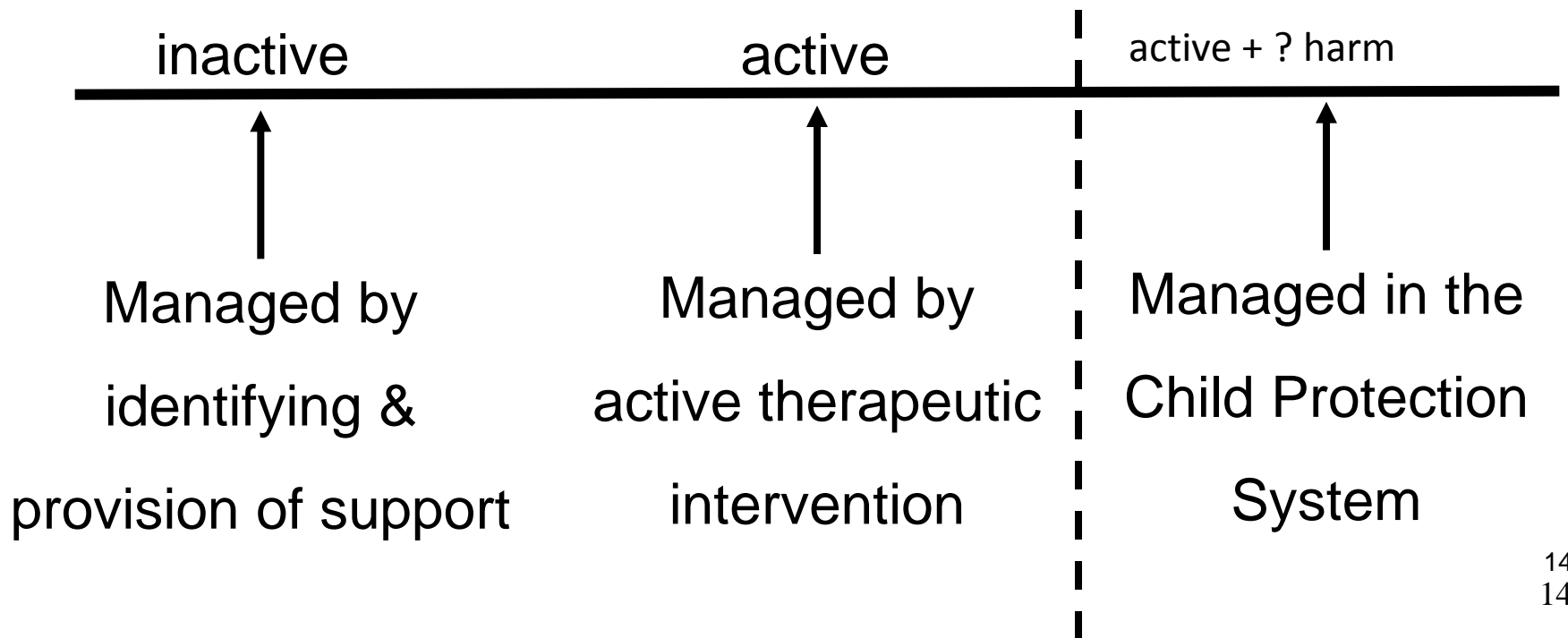
A lot

Vulnerability is buffered
minimising child harm ie
involvement of family,
friends, engagement with
appropriate services

Persistent/pervasive Adversity
Severe Harm
NEGLECT
EMOTIONAL ABUSE

A lot

The spectrum of adversity



Child Harm

If there is a belief /suspicion of reasonable grounds of child harm according to the following state definitions then mandatory reporting is required

- NSW “A child or young person is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm”.
- NT “Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child”
- QLD “Significant detrimental effect on the child’s physical, psychological or emotional wellbeing”
- SA and TAS “Any sexual abuse, physical or psychological abuse or neglect to the extent that the child “has suffered, or is likely to suffer, physical or psychological injury detrimental to the child’s wellbeing; or the child’s physical or psychological development is in jeopardy”
- VIC “Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type

Cumulative Harm

- Most Child Protection Systems based on the concept of incidents of harm that are notified
- Hence chronic adversity/cumulative harm/neglect often hover beneath the threshold until a serious event pushes them over the threshold and often this is after a child is significantly harmed
- SA Child Protection Act amended April 2016 inserted the following *“for the purposes of this Act, regard must be had to not only the current circumstances of the child's care but also the history of the child's care and the likely cumulative effect on the child of that history”*

Examples of Harm experienced by children who experience childhood adversity/neglect

Emotional development

Anxiety including PTSD

Unhappiness

Depression

Low self-esteem

Lack of empathy

Lack of affect regulation

Behavioural problems

Oppositional/Antisocial

Hyper arousal/ Aggression

Unpredictable

Withdrawn(internalizing)

Drug/ alcohol misuse

Eating disorders

Interpersonal relationships

Insecure attachment

Social isolation

Low empathy

Physical symptoms

Inadequate Growth

Fecal soiling

Non-organic pain

Learning/Development

Low IQ

Diminished executive functioning

Educational underachievement

Delayed Developments exp speech

Child Neglect

- **Neglect:** any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It includes physical neglect, neglect of supervision, medical neglect, abandonment.
- Severe neglect can negatively impact on all of the **child wellbeing domains** which explains the extreme harm child can experience as a result
- Child Neglect occurs when a child's **basic needs/rights** are not adequately met resulting in actual or potential harm

Forensic Medical Assessment of Neglect

- The point of this presentation is to define adversity and harm to allow for it's recognition to protect children and improve their wellbeing and emphasize the importance of an engaging and collaborative approach to working with families NOT to blame parents.
- HOWEVER when a child is suspected to have been harmed as a result of neglect the purpose of the forensic medical assessment is to establish whether parental omissions can be directly linked to evidence of child harm. This needs to follow forensic principals of objectivity in opinion formulation based on comprehensive information gathering to assist Courts and Statutory Bodies in determining what is in a child's best interests. In some instances of severe neglect it assists Police in prosecuting parents for the Neglect of their children.
- Hence a forensic medical assessment can also be seen to be promoting the Rights of the child, the right to be safe and protected, the right o have their basic needs met and the right to have those have harmed them held to account.

The spectrum of Childhood Adversity and the association with Child Neglect

- There is no cause-effect relationship between the presence of adversity and the certainty of a child being abused (harmed by carers).
- However adversity needs to be identified early to reduce the likelihood of child harm
- Issue is to identify harmfulness that may be linked to parental behaviour (notification)
- Issue is not to prove intent to harm



Herein lies the “ Adversity/Neglect Assessment Confusion”

- Medical Assessment of Neglect- should be considered a forensic assessment because if there is evidence of serious harm as a result of suspected neglect the threshold for mandatory notification?
- BUT Neglect itself is seen as a spectrum – should mild neglect be better referred to as Adversity and the term Neglect reserved only for significant harm?
- But what about if you don't know if the harm is “serious” or significant enough to notify ?
- What if it is vulnerability or adversity you have identified in a child's family do you do an assessment or refer to services ie go straight to intervention
- BUT if you don't do an assessment how do you know what interventions are needed and how do you know whether in fact there is serious harm requiring notification.
- WHERE do you start when you are trying to do an ASSESSMENT/What do you need to know/ Who should do it//is it worth the time and effort?

Trauma Informed Care

- Trauma- Informed Care and Practice is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of Trauma and interpersonal violence and the prevalence of these experiences in people who attend for health care.
- An underlying principal of trauma informed care is that there is a system wide understanding of the impact on an individual's development and capacity to cope. This understanding validates the person's experience and means that the meaning of behaviours can be re-defined
- As pediatricians this applies to your interactions with both the child and their parents/carers

Trauma Informed Care

- By incorporating the concept of trauma into the foundations of your clinical practice, trauma becomes a potential consideration for all consumers
- Ask about Trauma/Adversity consider the use of questionnaires/standardised approach ie CARRS
- Validate their experience and any reactions they may have/demonstrate understanding & non-judgment
- Establish current safety

Prevalence

- Whilst data on substantiations of Neglect are available how do we measure the prevalence of adversity within our population?

Synopsis

This report presents an accessible overview of the main concepts behind early child health and development. We summarise the goals of child healthy development in the concept that we call '*Five by Five*'. We describe the 5 basic developmental domains that are achieved in 5 stages.

We describe a child centred system that supports the *Five by Five*, ranging from parenting to the main service support systems (health, schools, child care and early learning, child protection, and non-government organisations).

Finally, we describe different barriers to effective parenting that may be experienced by caregivers, and provide a general introduction to the types of service responses that might better support achieving *Five by Five* for all children.

The *BetterStart* Child Health and Development Research Group is a group of inter-disciplinary researchers from epidemiology, public health, nutrition, paediatrics, biostatistics, and psychology who are trying to better understand how to ensure infants and children have the best start in life that will enhance their health and development over the life course.

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<https://health.adelaide.edu.au/population-health/research/grants/echdrg.html>

Five by Five

A Supporting Systems Framework for Child Health and Development



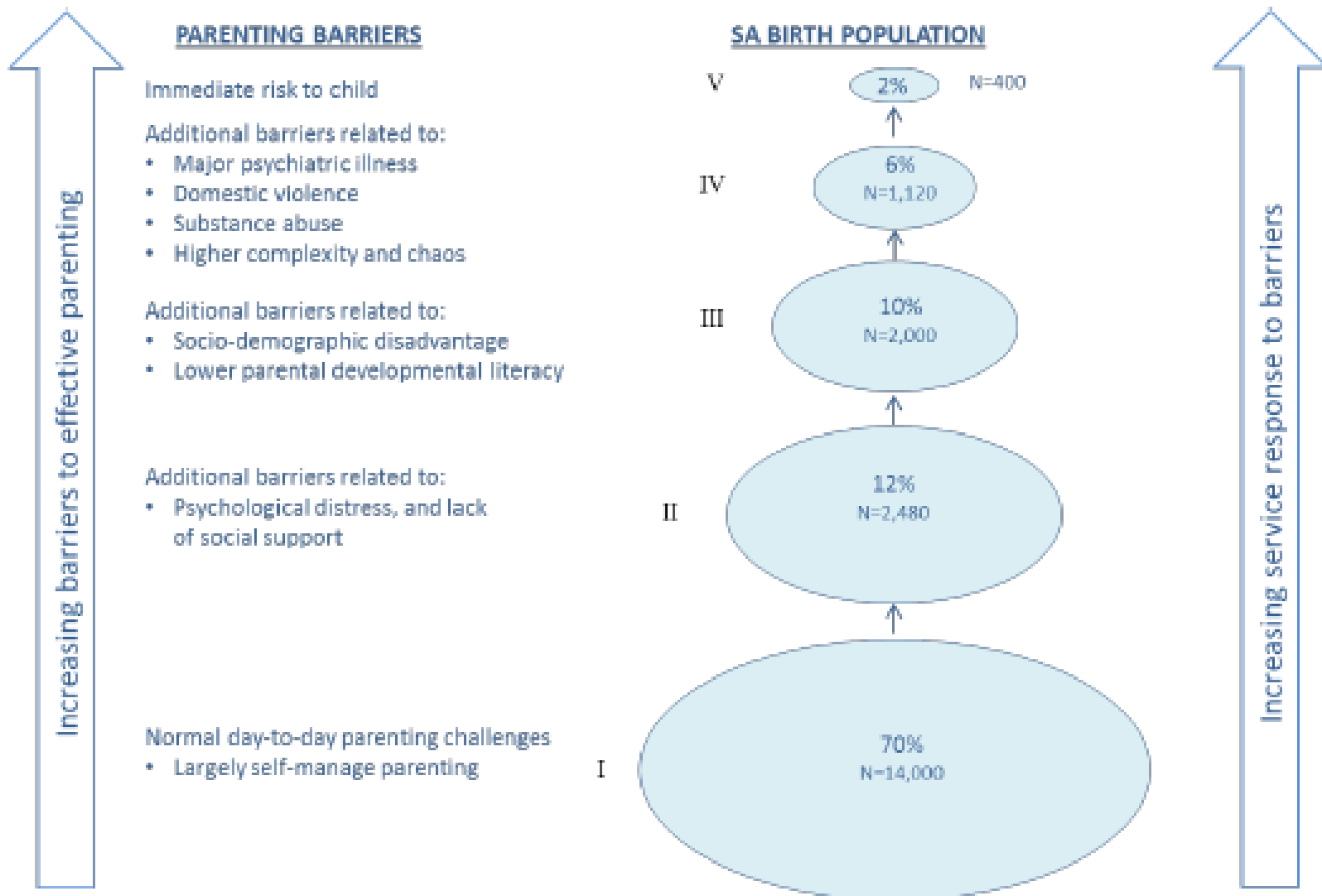


Figure 5: The distribution of the population according to increasing barriers to parenting.

Australian Child Wellbeing Project (ACWB) Feb 2016

based on interviews of children aged 8-14

Key Findings

- Most young people in their middle years are doing well. They report high average levels of wellbeing with respect to their objective circumstances, relationships and how they perceive their lives. They are effectively taking advantage of the opportunities available to them, for example in the space of education.
- However, a significant proportion of young people in their middle years have low wellbeing, and are missing out on opportunities at this crucial time. This is manifested in:
 - High levels of health complaints
 - Experience of bullying
 - Low levels of engagement at school
 - Low levels of subjective wellbeing
 - Low levels of social support
- Low wellbeing is concentrated in groups of young people who are recognised as marginalised - young people with disability, young carers, materially disadvantaged young people, culturally and linguistically diverse young people, Indigenous young people, young people in rural and remote Australia and young people in out of home care.
- Different forms of low wellbeing are linked – outcomes in one domain are often associated with outcomes in other domains. For example, high *pressure from schoolwork*, reported by 15% of boys and 23% of girls in Year 8, is related to high levels of health complaints, seen by experts as an indicator of stress.
- Almost one young person in five (19%) in the survey reported *going hungry* to school or to bed. These young people are more likely to *miss school* frequently.
- Both young people who go hungry and the one in ten who miss school frequently are likely to experience high levels of health complaints, frequent bullying, and low levels of engagement at school.

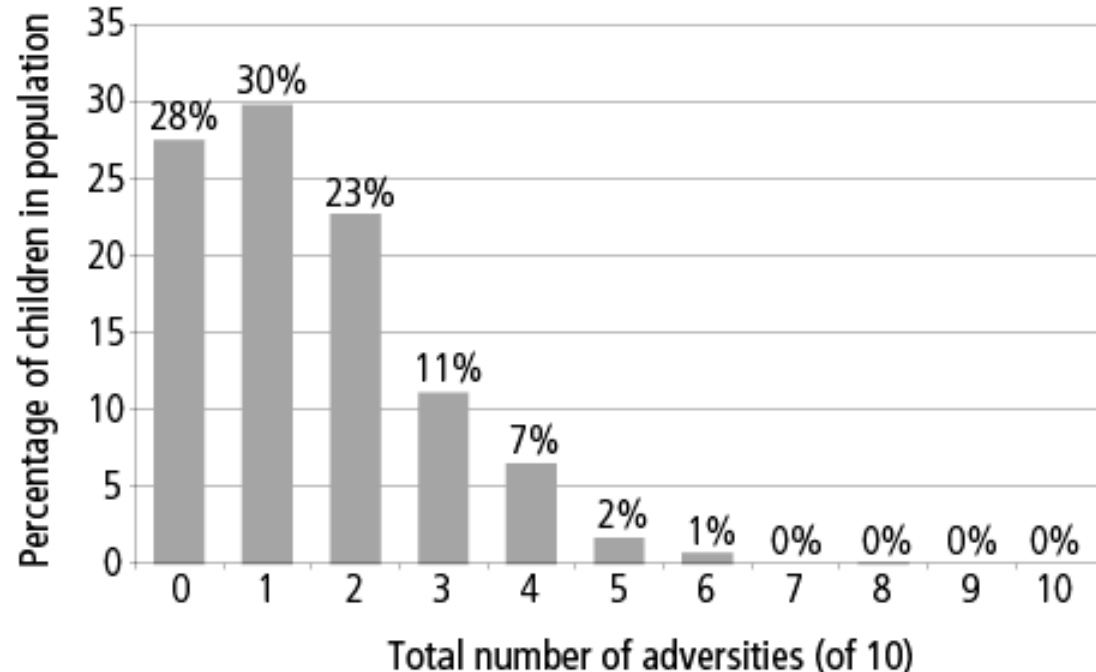
19% of children got to bed hungry

10% of children miss school frequently

Wave 5 (2005) Household, Income and Labour Dynamics Study (HILDA)

- “One-fifth of Australian children in our HILDA sample(sample size 3,506 children) had been exposed to three or more of ten parental and familial adversities we investigated. This is a conservative estimate given that a small proportion of surveyed parents did not respond to the adversity items and because we took care to exclude potentially redundant adversities.”

Figure 1: Number of adversities experienced by Australian children, of 10 non-redundant adversities



AIHW Child Protection Data 2014-2015

- **Notifications**

- 320,169 (cases)

- **208,111** (children), 39.2 per 1,000 (rate)

- **Investigations**

- 152,086 (cases)

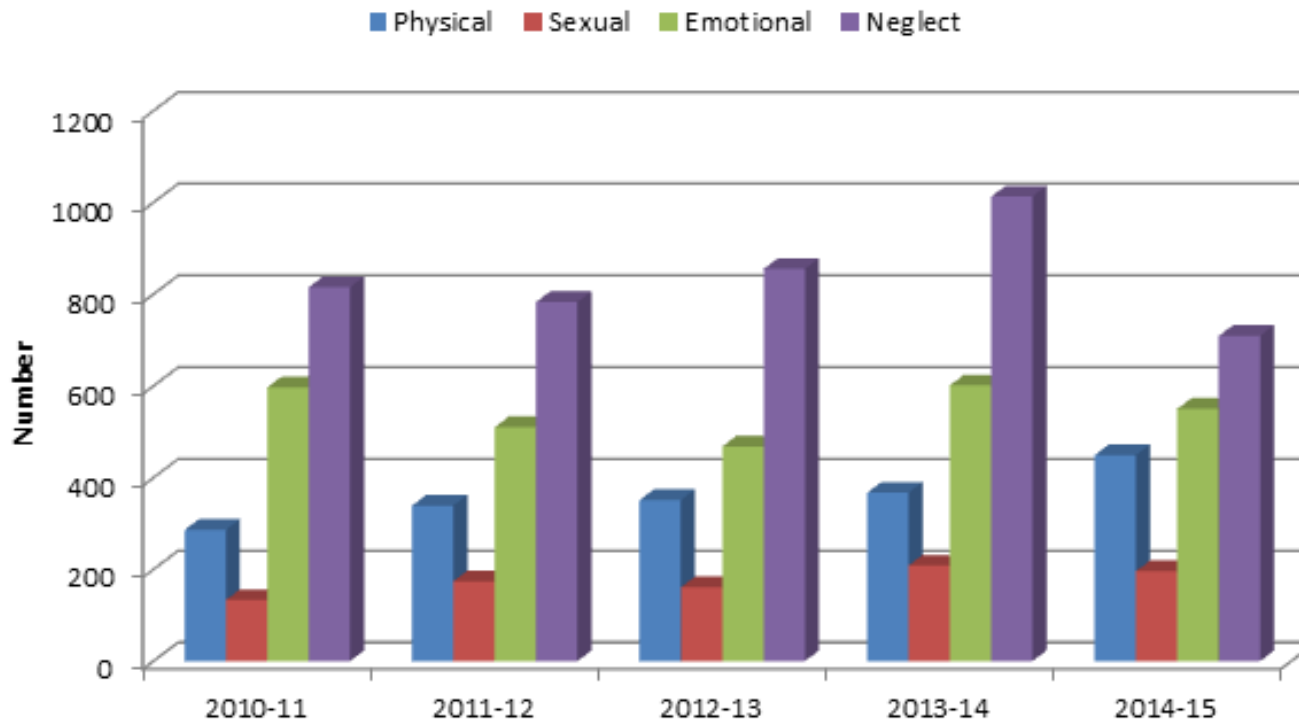
- **107,121** (children), 20.2 per 1,000 (rate)

- **Substantiations**

- 56,423 (cases)

- **42,457** (children) 8.0 per 1,000 (rate)

Children who were the subjects of substantiation by type of abuse or neglect



	2010-11	%	2011-12	%	2012-13	%	2013-14	%	2014-15	
Physical	286	15.62%	339	18.73%	351	19.12%	367	16.76%	449	23.53%
Sexual	133	7.26%	174	9.61%	161	8.77%	208	9.50%	196	10.27%
Emotional	597	32.61%	510	28.18%	468	25.49%	601	27.44%	550	28.83%
Neglect	815	44.51%	783	43.26%	855	46.57%	1013	46.26%	709	37.16%
Not stated		0.00%	4	0.22%	1	0.05%	1	0.05%	4	0.21%
		100.00		100.00		100.00		100.00		
Total	1831	%	1810	%	1836	%	2190	%	1908	100.00%

Table 2: Prevalence of neglect in contemporary Australian studies

	<i>N</i>	Age	Sample	Location	Definition of childhood	Measure of abuse	Rates %
Rosenman & Rodgers (2004)	7,485 (3,674 males, 3,809 females)	3 age bands: 20–24 years 40–44 years 60–64 years	Community– Electoral Role	ACT & NSW	“childhood”	“I was neglected.”	1.6%
Price-Robertson, Smart, & Bromfield (in press)	1,000 (390 males, 610 females)	23–24 years	Community– Longitudinal	VIC	<18 years	“the care taken of you by your parent/s was the right amount (e.g., they watched out for you, fed you properly, gave you attention)” (reverse- scored).	2.7%
Straus & Savage (2005)	270 (80.7% female)	Mean = 23.3 years	University	Adelaide	Unspecified	A range of questions measuring cognitive, emotional, physical, and supervisory forms of neglect.	12.2%

Ref National Child Protection Clearinghouse 2010

Evidence of the Harm from Early Childhood Adversity/Maltreatment

The ACE (Adverse Childhood Experience) Study

Conducted by the US Center for Disease Control & Kaiser Permanente

17,000 PARTICIPANTS SURVEYED

Female Participants:

13% emotional abuse
27% physical abuse
24.7% sexual abuse

Male Participants:

7.6% emotional abuse
29.9% physical abuse
16% sexual abuse



The ACE Study Findings

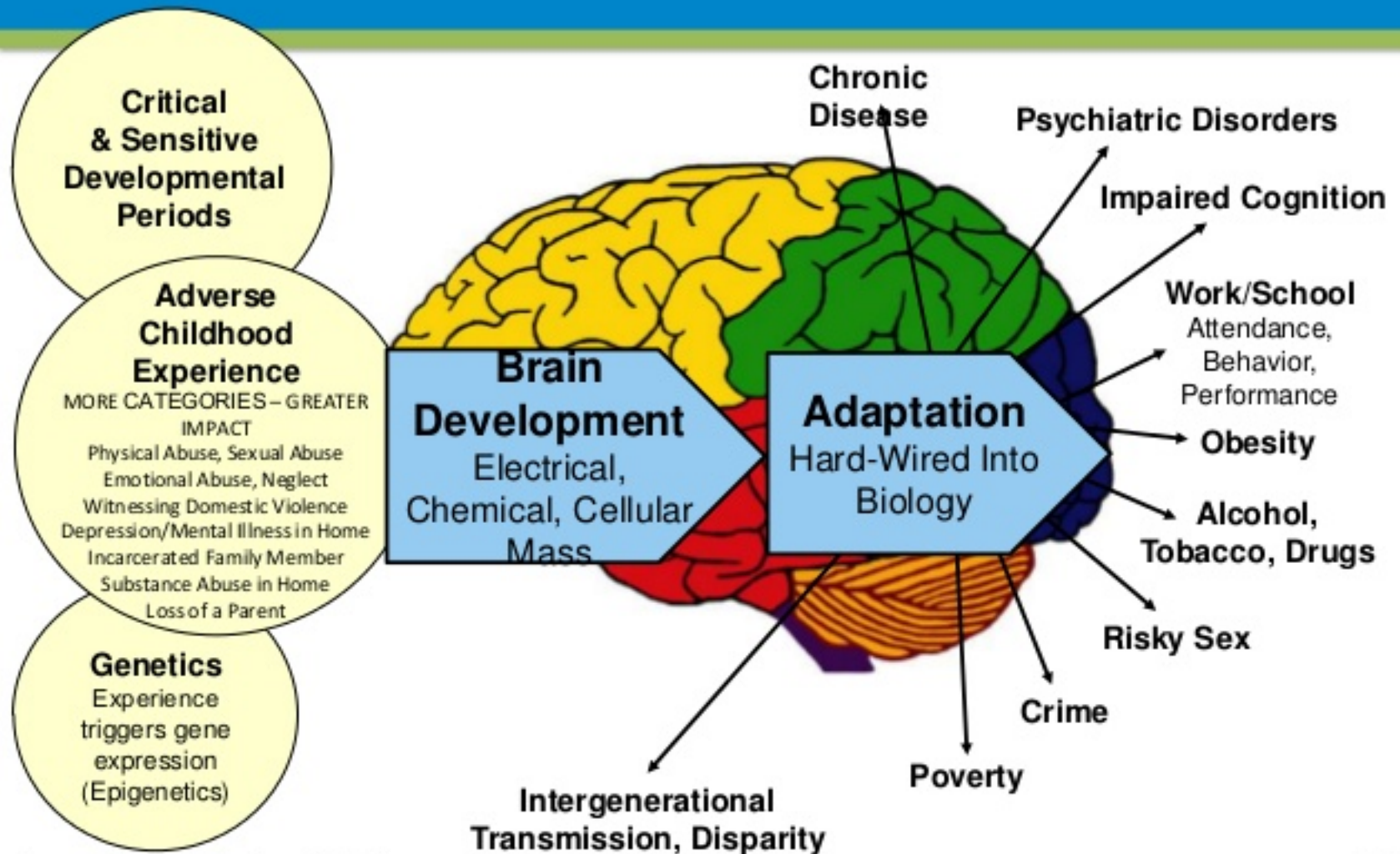
suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences.

Realizing these connections is likely to improve efforts towards prevention and recovery.



Lifespan Impacts of ACEs



Source: Family Policy Council, 2012

The Effect of Childhood Adversity on Adult Health

- Found a relationship between ACEs and medical disorders in adulthood including cancer, liver disease, chronic lung disease, immune disorders, ischemic heart disease
 - 4 or more ACE's twice as likely to get cancer
 - 6 or more ACE's shortened lifespan by almost 20 years
- Found a relationship between number of ACEs and negative lifestyle/mental health disorders including smoking, suicide, depression, obesity, illicit drug use, alcoholism, teen pregnancy, sexual risk behaviours and STI's

The Effect of Childhood Adversity on Child Health

- LONGSCAN (high risk population)
- 4 ACE's tripled the likelihood of childhood illnesses
- Further research needed to examine a link between ACEs and specific childhood illnesses
- Parental and familial stressors are consistently linked to poorer developmental, academic and health outcomes during childhood as well as later in adulthood

TOXIC STRESS



POSITIVE

Brief increases in heart rate,
mild elevations in stress hormone levels.

TOLERABLE

Serious, temporary stress responses,
buffered by supportive relationships.

TOXIC

Prolonged activation of stress
response systems in the absence
of protective relationships.

4. Mechanisms of Harm – Brain development

- Factors in environment affect pre and post natal development of the brain
 - **Prenatal**
 - Maternal stress
 - Maternal drug/Etoh use
 - **Postnatal**
 - Poverty
 - Poor nutrition
 - Educational opportunity/Healthcare availability
 - Stress, extreme deprivation, maladaptive experiences
- Via effects on myelination and synapse development
 - Abnormal synaptic pruning
 - Inhibited neurogenesis
 - Delays in myelination and inhibition of white matter formation
 - Decreased brain size and cerebral volumes
 - Decreased corpus callosum volume – arousal, emotion, higher cognition
 - Decreased hippocampal volumes - learning, memory
 - Chronic amygdala activation - emotion in response to threat

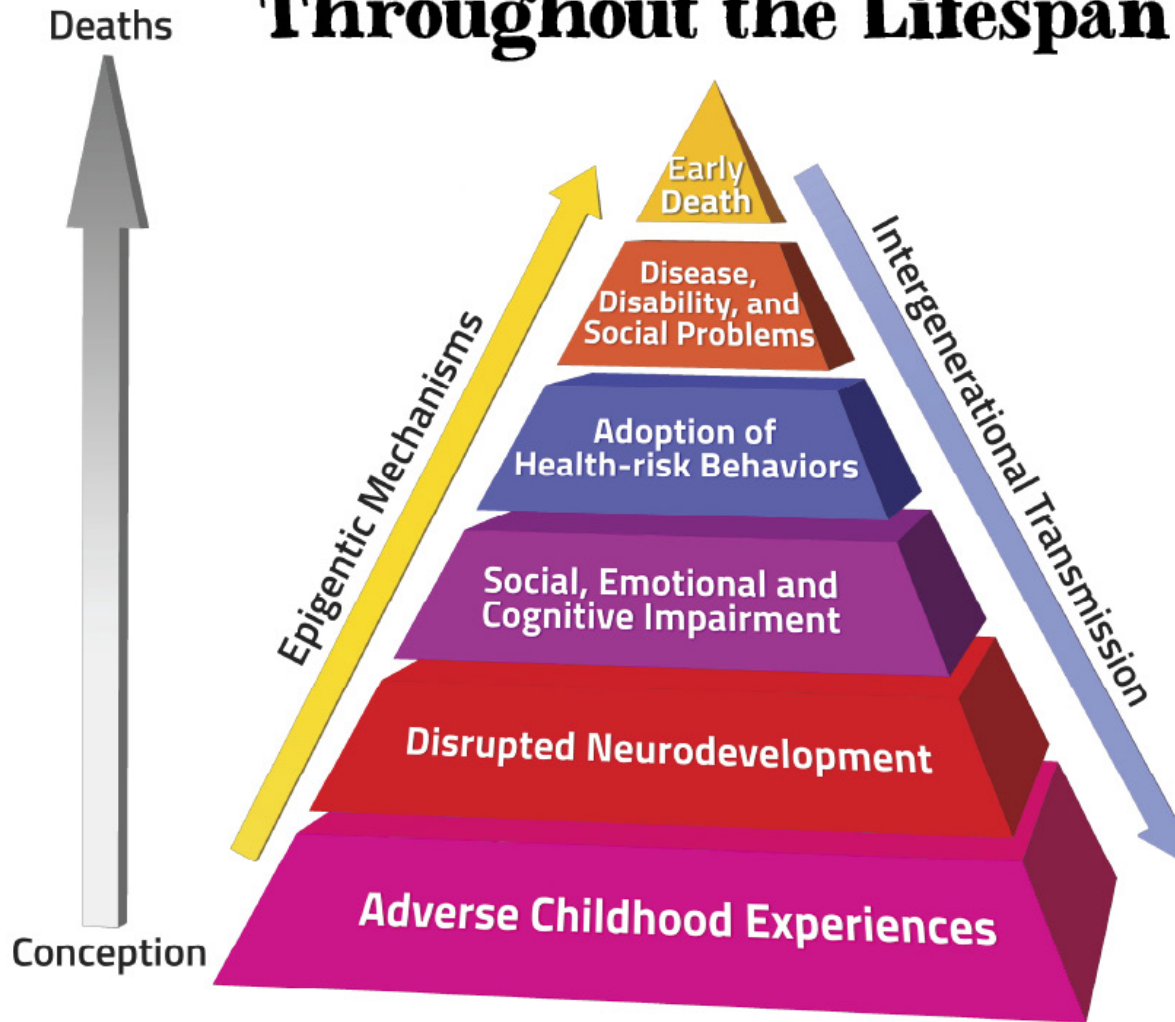
4. Mechanisms of Harm – Effects on the Endocrine system

- Stress-induced remodeling of structure/connectivity in
 - Hippocampus
 - Amygdala
 - Pre-frontal cortex
- Alters behaviour and physiological responses
 - Anxiety
 - Aggression
 - Mental inflexibility
 - Memory
 - Other cognitive processes
- Maltreated children – cortisol abnormalities

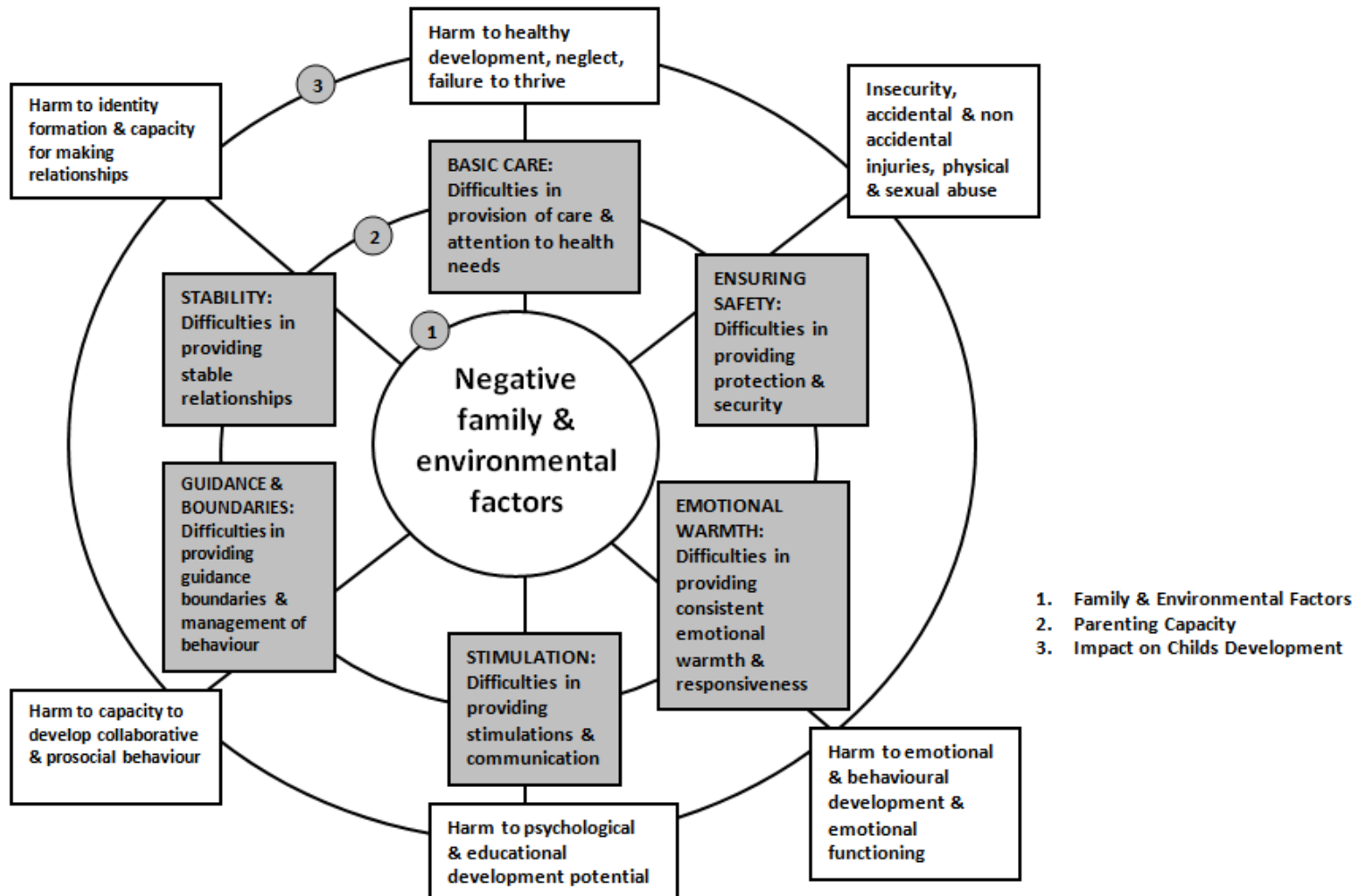
3. Mechanisms of Harm - Genetics and epigenetics

- Chemicals attach to genes and affect gene expression
- Alters methylation levels in gene promoters
- Affects gene expression in brain cells, can be passed on to children
- Chemical changes initiated by life experiences
- PTSD - maltreated group - 12 times more epigenetic changes
- Emotional/behavioural/psychological difficulties then become 'inheritable'

Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



4. Mechanisms of Harm Parental Difficulties and Harmful Impacts on Development



A Basic conceptual Approach

- Based on work of Danya Glaser
- Tier 0 Family and Social Risk Factors
- Tier 1 Parental Risk Factors
- Tier 2 Parent- child interactions
- Tier 3 Child's functioning
- If concerns in on one Tier look for concerns in others

5. Child Protection is Everyone's business- thinking beyond Notification

- Be trauma informed and develop a standard approach
- Be alert to indicators of adversity/ child harm
- Be thorough and always elicit a detailed psychosocial history
- Be curious and utilise Information Sharing Guidelines
- Be aware of services in your area and how to refer to them
- Be engaging, non judgmental
- BUT when the child is exposed
 - to high levels of active adversity
 - and/or is suffering significant harm as a result
 - and engagement/intervention can't be established sufficient to mitigate against this harm
- THEN an objective detailed notification encompassing all relevant information must be made AND all attempts made to continue relationship with the family

Applied to Case Scenario

- Concern is child's weight gain likely due to inadequate intake – establish why this might be happening and urgency of management
- Are there any other concerns for the baby – development, hygiene, injury etc
- Take a comprehensive Psychosocial History/consider need to seek information from other services/professionals to establish whether there are additional concerns/adversity in the family/ home environment and whether they are impacting on the care of the child
- Observations of parent- child interactions
- Is the family willing to engage in appropriate services? Identify any barriers to engagement and seek assistance to overcome them
- Decide has the child been significantly harmed or is she at risk of imminent significant harm?
- Is notification the next step or not?
- Develop a clear agreed plan with the family and facilitate review

Childhood should
be carefree,
playing in
the sun:



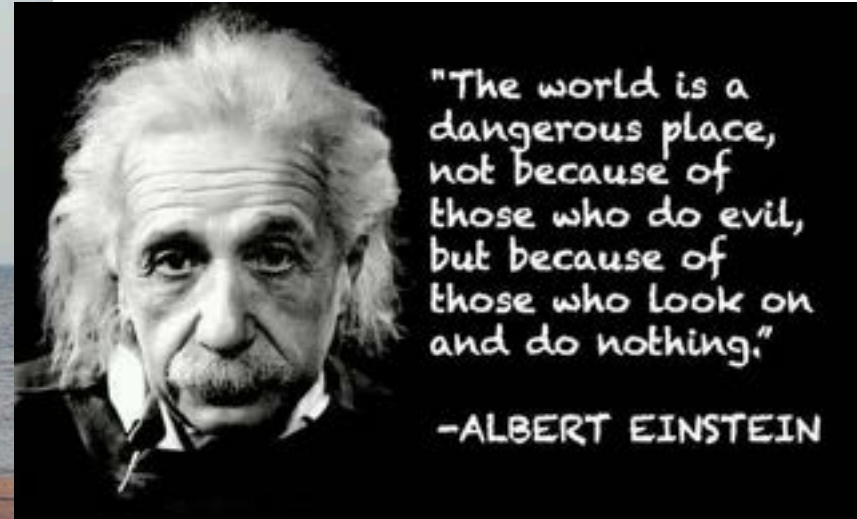
not living a
NIGHTMARE IN
the darkness
of the soul.

- Dave Pelzer
A Child Called "It"

Being ignored by
someone who means
the world to you is
the worst feeling.

THANK YOU

If you can help a child,
you don't have to spend
years repairing an adult



"The world is a
dangerous place,
not because of
those who do evil,
but because of
those who look on
and do nothing."

-ALBERT EINSTEIN