Australian Association for Infant Mental Health Inc. QLD Branch

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

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Queensland Child Protection Commission of Inquiry

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Background

Affiliated with the World Association for Infant Mental Health, the Australian Association for Infant Mental Health Inc (AAIMHI) is a national organisation of professionals from many fields who work with infants and their families. Our mission is to work towards improving professional and community recognition that *infancy is a critical time for psycho-social development*. This submission is from the Queensland Branch of the Australian Association for Infant Mental Health Inc. Our underlying position overall is that the current Queensland Child Protection Commission of Inquiry needs to give full consideration to the best interests of infants living in Queensland.

In the 2010 -2011 year, across Australia children aged less than 12 months of age were most likely to be the subject of substantiated abuse and neglect (12.0 per 1000 children). This pattern is consistent in Queensland (9.3 per 1000 children). In Queensland, children aged 1-4yrs of age made up the next highest group of children where abuse and neglect were substantiated (5.7 per 1000 children).

Together children aged 0-4yrs made up 40.93% of children who were the subject of substantiated abuse and neglect (AIHW 2012: 12; 52)

In this same year, in Queensland the number of children aged less than 1 yr and 1-4 yrs admitted to out of home care made up 43% of all children in care (468 infants or 17.7% and 668 young children or 25.3% respectively). (AIHW 2012: 66). While the majority of this group were placed in home-based care as at 30th June 2011, there were also a small portion who were placed in residential care (2.5%) (AIHW 2012: 70).

The vulnerability and needs of infants entering the child protection system can not be underestimated. Infants and toddlers are the age group most vulnerable to abuse and neglect and its aftermath. Infants suffer from the impact of abuse & neglect from the time it occurs. In other words there immediate effects, such as changes in feeding/digestion or sleeping, as well as enduring effects

Research has given a clearer understanding that infants (and foetuses) exposed to abuse and neglect warrants the greatest concern, in particular with regard to their neurological development. Brain development is at its most dramatic during the first three years of life. Crucial pathways needed for neuropsychological processes such as attention, learning, memory, affect recognition and regulation, impulse control and speech and language. Connections and pathways between neurons develop in response to stimulation and sensory input and are experience- dependent, both positive and negative experiences input into development. (Mares et al 2005)

Early and sustained exposure to high-risk factors such as neglect and maltreatment can influence the physical architecture of the developing brain through mechanisms such as neurotoxic effects of cortisol, dysregulation, disruption of the limbic system and effects on neurotransmitter systems. These physical alterations can result in difficulties in tolerating stress, managing emotions and impulses, regulating mood states and interpersonal functioning. (Mares et al 2005). On a social and emotional level, this can impact on the infant’s ability to process emotional information and learn the complexities of emotional interaction. These infants and toddlers will struggle with poor self-esteem, forming trusting relationships, relating to others and

development of empathy for others. (Cohen et al 2011; Shonkoff et al 2000; Mares et al 2005).

Taylor et al (2008) identified a range of pathways linking child abuse with adult physical health outcomes. These include smoking, substance abuse, overeating, high risk sexual behaviour and suicidal behaviour. Other physical health problems associated with a history of child abuse and neglect include chronic pain, gynaecological problems, irritable bowel syndrome, diabetes mellitus, arthritis, headaches, cardiovascular disease and chronic fatigue syndrome (Draper et al 2008). A study conducted by Centre for Disease Control and Prevention and Kaisers Permanente Health Appraisal Clinic in San Diego assessed associations between childhood maltreatment and later life health and wellbeing found that as the number of adverse childhood experiences increased the risk for health problems such as smoking, alcoholism, heart disease, liver disease and STD's also increased in a graded fashion. This research was further supported by a Dunedin Multidisciplinary Health and Development study which involved a 32-year prospective longitudinal study of a representative birth cohort. Findings from this study show that children exposed to adverse psychosocial experiences have enduring emotional, immune, and metabolic abnormalities that contribute to explaining their elevated risk for age-related disease.

Relationships with caregivers are the context in which this early development occurs. **The quality of the caretaking relationship is crucial.** Sensitive care promotes growth and development. Infants and toddlers rely on their closest caregivers for security and comfort. **Those who are able to develop secure relationships are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments (Shonkoff et al 2000). They also show a greater capacity for self-regulation, effective social interactions, self-reliance, and adaptive coping skills later in life (Goldsmith et al 2004).**

It is not surprising that researchers have found that approximately 82% of infants who have experienced maltreatment or abuse by their caregivers show disturbances in their attachment to their caregivers (Goldsmith et al 2004). It is important to remember that the trauma experienced by infants may be both direct and indirect. Indirect exposure is common and may include exposure to conflict and domestic violence. **Indirect exposure to trauma can have as significant effects on the infant as direct exposure. (Mares et al 2005). These disruptions within the attachment relationship are a predictor for ongoing developmental problems, behavioural and emotional disturbances and future mental health difficulties.**

Research confirms that the early years present an unparalleled window of opportunity to effectively intervene with at-risk children and their families (Shonkoff et al 2000). To be effective, interventions must begin early and be designed with the characteristics and experiences of these infants, toddlers, and families in mind.

Intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behaviour, welfare dependence, and substance abuse (Cohen et al 2011). Solid evidence points to the negative effect or harm caused by abuse and neglect on infants and children's physical, neurological, cognitive, social and emotional development. Developmental delays are four to five times greater for abused than non-abused children and along with a higher incidence of behavioural problems and higher risk for mental health problems in later life (Osofsky 2011: 2). There is also strong evidence that the social

and emotional consequences commence in early infancy and can continue on a trajectory throughout the development of child that results in later social, behavioural and emotional dysfunction and distress. (Osofsky 2011: 3).

1. Reviewing the progress of implementation of the recommendations of the *Commission of Inquiry into Abuse of Children in Queensland Institutions* (the Forde Inquiry) and *Protecting Children: An Inquiry into the Abuse of Children in Foster Care*

Recommendation 4 from the Commission of Inquiry into Abuse of Children in Queensland Institutions (the Forde Inquiry)

> *"In real dollar terms Queensland's actual expenditure for 1997/98 was $91.072 million, of which $80 million was spent on child protection services. Of this amount 88.75 per cent ($71 million) was expended on child protection intervention services, with few resources (11.25 per cent, or $9 million) for prevention and family support services."…..*
>
> *Recommendation 4*
> *That the Queensland Government increase the budget of the Department by $103 million to permit it to meet the national average per capita welfare spending for children, and agree to maintain the increase in line with the national average. The additional resources should focus on the prevention of child abuse through supporting 'at risk' families, respite care, parenting programs and other early intervention and preventative programs for high-risk families.*
>
> (Forde 1999: 118)

Infants, because of their particular vulnerabilities, require an immediate response to child protection reports or notifications. However, the need for tertiary level intervention such as out of home care can be reduced by a service system that values public health and a population health approach to health and disease prevention. These systems will encourage and support vulnerable families earlier, in order to be able to provide optimal outcomes for infant development. Primary preventative services such as community awareness regarding infant needs and development, ante and post – natal social and emotional health services, maternal and child health services; early child care and education and policies that support family-friendly work-place practices can help families universally and prevent difficulties arising. For some families, secondary services such as home-visiting, therapeutic and infant-sensitive adult support services can provide an additional opportunity to address presenting risks and prevent more serious difficulties (Jordan and Sketchley 2009). Given the innate vulnerability of infants and the fact that infants are the largest client group (by age) of child protection services, there is a need for services to actively address the specific needs of infants and young families at all levels. There are a number of evidence based programs overseas which target high risk families which have led to significant improvement in terms of outcomes. (For example Olds et al 1986 and 2010, Slade et al 2005).

Economically, investment in prevention will reap rewards. Taylor et al report on their research into the economic costs of child abuse and neglect. Their finding indicate that in Australia the annual cost of child abuse and neglect in 2007 (ie. the cost of abuse and neglect that occurred in 2007) was between a lower bound of close to $3.5 billion and an upper bound of over $5.5 billion. The best estimate of annual costs was approximately $4.0 billion. The burden of disease adds a further $6.7 billion to the best estimate (lower bound $1.6 billion and upper bound $25 billion).

(Taylor et al 2008: 135) For Queensland, this cost amounted to $789 million dollars based on productivity losses calculated for all children abused or neglected. (Taylor et al 2008: 136).

There are also tertiary level interventions in situations where abuse or neglect has occurred. These programs are multi-faceted, multifocal and resource intensive.

Not all families/parents are amenable to early intervention, support or treatment. Some parents are not going to change in time to be an effective or safe caregiver. We have to be realistic about the capacity of some parents to change to be good enough carers in time for their infants. This can occur particularly with parents who have a childhood history of complex developmental trauma become parents and have not completed their own childhood or development or processed their trauma. The needs of infants in foster care are discussed in more detail in Section 3.

Recommendation: Investment in the early years of children's lives should focus on attachment-informed interventions provided to families using a public health model with primary, secondary and tertiary preventative programs in place.

Recommendation: Where infants are identified as being at risk of harm in the care of their parents, intensive and timely intervention with parents and their infants should be offered with clear goals for the parents to achieve in a set time frame. This should be concurrent with specialised support and intervention if necessary with the foster carer and infant. This would allow determinations to be made regarding permanency while maximising the chance of reunification if appropriate. To facilitate this:

1. The best interest of the infant is the deciding factor in decisions rather than a high focus mainly on re-unification.
2. Thorough parenting capacity assessments occur leading early on to an intervention treatment plan that is very individualized, specific, accountable and enforceable.

2. Reviewing Queensland legislation about the protection of children, including the *Child Protection Act 1999* and relevant parts of the *Commission for Children and Young People and Child Guardian Act 2000*;

Under the Queensland Child Protection Act (1999), a child is defined as an individual under the age of 18 years. While this definition is easy to understand, more difficult are the definitions around *"What is harm?"* Under the Act, harm is defined as

"any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing." (Part 3; Div 1 Section 9)

The emotional, behavioural and physical responses to trauma vary tremendously depending on the child's capacity to comprehend and internalise his or her experiences, both of which depend on the cognitive and emotional development of the child. An infant's experience of an event will be very different to that of a child or adolescent. Infants, due to their level of development are less able to comprehend and integrate the experiences that they have, it is for this reason that they are highly sensitive to the adults in their environment and that their reactions and behaviours resonate with those of their caregivers.

Dissociation refers to the neurologically based protective mechanism of withdrawal or distancing from a traumatic experience. Infants and the young of many species are known to respond to trauma with a dissociative response (Mares et al 2011). Infants exposed to traumatic experiences may become emotionally flat, withdrawn, unresponsive and interact poorly. (Mares et al 2011). On many occasions within a out of home care situation, infants seen to be playing quietly or not reacting to a situation may be seen as “resilient” and not affected by the trauma occurring around them. This interpretation of their behaviour fails to recognise that a quiet or withdrawn infant is an infant at risk.

For infants entering the Queensland Child Protection system, the current definition of ‘harm’ provided by the Act is open to wide interpretation. Legal definitions of a child in ‘need of protection’ set the legal threshold at which sub-optimal parenting or circumstances become abuse or neglect. With the current legal definitions being open to varying interpretations, infants are reliant on Child Safety Officers having adequate knowledge and skills to be able to make this decision. Consideration not only needs to focus on the current implications of abuse and neglect but also the long term implications for infants experiencing trauma. Without additional support for Child Safety Officers, the documentation available does not adequately support an informed decision to be made about whether or not an infant is in need of protection.

Domestic violence can negatively impact on mother-infant relationships. Research indicates that the risk of domestic violence increases for women during pregnancy and following a birth (Taft 2002). Furthermore, women with children are three times more likely to be subjected to domestic violence than childless women (Humphreys 2007a).When affected by domestic violence; a mother may have difficulty empathising with or delighting in her infant, or be unable to provide her infant with a secure base or a safe haven. Research shows that domestic violence is known to directly compromise infant mental health and wellbeing. Living with domestic violence impacts the infant’s development with social, emotional and behavioural consequences. (Buchanan 2008)

Emotional maltreatment is not easily defined and delimited. Overseas jurisdictions have considered the following parameters:

1. Whether the parenting leads to actual harm or whether it puts child at risk of emotional harm
2. Giving specific examples of indications of emotional harm e.g.:severe anxiety, depression, withdrawal, self-destructive behaviour, or aggressive behaviour towards others, or any other severe behaviour that is consistent with the child having suffered emotional harm
3. Defining actual parenting behaviours that are considered emotionally maltreating, including indifference, denigration, emotional rejection, isolation, threat.
4. Specifically naming interpersonal violence, including domestic violence, as causing emotional harm. (Trocméa et al 2011)

Recommendation: Clear definitions and descriptions of what constitutes harm in infancy, in particular emotional harm and neglect, should be included in the Act to ensure Child Safety Officers have a clearly defined reference point for assessment and recommendation.

3. Reviewing the effectiveness of Queensland's current child protection system

a. Infant focussed Workforce Development for Child Safety Officers

The effectiveness of the Child Protection system is dependent upon an adequate number of appropriately trained staff. The complexity of families involved within the child protection system suggests the need to provide staff with continuing education programs, clinical supervision and other appropriate staff support mechanisms.

The ensure appropriate staff are employed the child protection services use of evidence-based recruitment and retention strategies such as providing clinical placements for undergraduate students, including entry-level positions, encouraging rotations of staff from other areas of the child protection system and supporting education, clinical supervision and research opportunities.

The development and implementation of a Workforce Development Framework focussed on infant wellbeing can

- create a shared understanding and common 'language' around the importance of the experiences infants have during the early years of development (including during the in utero period).
- enhance workforce capacity by providing ongoing education, training, professional development, supervision and support to child protection service providers.
- establish a sustainable system of care and protection.

Ongoing workforce development is required to support Child Safety Officers develop the ability to understand and define the concept of harm for infants and toddlers.

Recommendation: Development and implementation of a workforce development framework focussed on perinatal and infant mental health which will aim to create a shared understanding and common 'language' and provide the basis for supporting ongoing education, training, mentoring, supervision and staff support.

b. Intensive support for foster parents to provide attachment informed developmentally appropriate therapeutic placements

It is well documented that there is a dire shortage of foster carers in Queensland. Foster carers, both kinship and non-relative take up the role for a range of reasons. They also bring with them a range of experiences and skills. There are many challenges for foster carers including navigating medical, educational and mental health systems; negotiating the child protection system; addressing developmental, behavioural and psychological problems that the children are experiencing and managing the general demands of being a foster carer (Heller; Smyke and Boris: 2002).

For infants, negative foster care experiences may extend and compound the negative effects of the experiences that lead them to enter out of home care. Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that may have precipitated out-of-home placement, can leave infants and toddlers dramatically impaired in their emotional, social, physical, and cognitive development (Lieberman and Van Horn: 2007). Research evidence demonstrates that infants require the commitment of foster carers to establish an attachment relationship with them in order to thrive (Jordan and Sketchley 2009). In a

study of 84 caregiver–child dyads, it was found that commitment (defined as the extent to which the carer had a strong emotional investment in and was motivated to have an enduring relationship with a particular child) was the strongest predictor of placement stability (Dozier & Lindhiem: 2006 in Jordan and Sketchley 2009).

It is important to recognise that infants are acutely sensitive to the adults in their environment; they look to them in order to make sense of and understand their experiences. Early experiences take place in relationships; infants rely on their closest caregivers for security and comfort. Supporting responsive, secure bonds between infants and their foster carer is critical. For infants in out of home care, this means ensuring a stable placement in which foster carers are trained and supported to promote the infant's ongoing social, emotional, physical and psychological development. It is therefore vital that in order to support infants in out of home care, that the system provides intensive support to foster parents. This in turn will enable them to provide an attachment informed, developmentally therapeutic environment in which infants can recover from the trauma that they have experienced through abuse and neglect.

The importance of a high-quality of attachment relationship on an infant's development has a strong evidence base over many decades of developmental research. This knowledge should inform the design and implementation of out of home care for infants and young children (Zeanah et al 2011).

An infant's attachment relationship with different caregivers will vary dependent on the kinds of experiences that they have with each caregiver. An attachment relationship with one caregiver may be of high quality, while with another the quality may be somewhat lower. Infants and young children need caregivers to behave in nurturing and sensitive ways while committing to them as individuals in order to develop a secure and healthy attachment relationship. It is through experiences in relationships that infants and young children develop expectations about the dependability of attachment figures to provide comfort, support, nurturance and protection when it is needed. These expectations and experiences affect how children respond and behave in close relationships both now and in the future. For infants and young children in out of home care as a result of abuse, neglect and negative relational experiences, special efforts are needed to help facilitate the development of secure attachment experiences with their foster carers. (Zeanah et al 2011) Ordinary good enough care as provided by foster parents with their own children is likely to be insufficient with this population of children, particularly in infancy where their cues may be so difficult to read or interpret (Dozier et al, 2002)

Recommendation: Development and implementation of a foster carer's education framework focussed on infant mental health which will aim to create a shared understanding and common 'language' and provide the basis to create specialised attachment informed out of home care for infants.

Recommendation: Out of home care should be child-centred with an infant's need to form an attachment relationship with a primary caregiver as critical. Care should be informed by attachment principles and evidence-based knowledge including the importance of foster carers as primary attachment figures, stability of placement to allow such attachments to form, and training and support of foster carers to provide the specialised care these children need.

c. Permanency for infants

Multiple moves while in foster care are a particular concern for infants and toddlers. When a baby faces a change in placement, fragile new relationships with foster parents are severed, reinforcing feelings of abandonment and distrust. Even very young babies grieve when their relationships are disrupted, and this sadness adversely affects their development (Cohen et al 2011). In Australia, recent analysis suggests that nationally, at 30 June 2011, around four in five children (82%) had been in their current out-of-home care placements for more than 1 year (AIHW 2012: 33). Analysis of the age and number of moves that a child has had during out of home care was not provided in this report. Qualitative data does indicate, that in Queensland, while infants may not experience as many moves as older children, there is still small percentage of very young children shifting from home to home. These multiple moves place children at an increased risk for poor outcomes with regard to social–emotional health and the ability to develop secure healthy attachments (Gauthier et al 2004).

When harm persists and an infant or young child is removed, developmentally informed foster care is the goal (Zeanah, Shauffer & Dozier, 2011):

- Children's needs for forming attachments to caregivers seen as critical.
- The foster parent must become the primary attachment figure for the young child. This requires substantial emotional investment in the child by the foster parent.
- Special training may be required to assist foster parents in learning how to respond effectively to challenging behaviours and to help them become more securely attached.
- Stability of placements must be valued and maintained.
- Visits between biological parents and young children should be seen as collaborations between biological parents, foster parents and child protection. Foster parents should be present if possible. Biological parents may need support as they face the realization that their child is attached to someone else.
- Transitions – gradually build attachments to the new caregivers and maintain contact with the former caregivers even after transition, when possible.

Research around the positive effect of secure attachment relationships has demonstrated the importance of an infant's need for security, sensitive care and continuity in order to develop to their full potential. The need for sensitive, attuned care and a stable relationship is especially crucial for infants who have experienced abuse and neglect.

Research supports permanency planning for infants and children in the child protection system. Development during infancy lays the foundation for the child's future. As described by Bemporad "infants can't wait" (1995), meaning that infant development is such a critical time that to leave an infant in a high-risk environment in which the parent is unwilling or unable to provide adequate care and support condemns the infant to a range of potential difficulties throughout their lifetime.

Behavioural outcomes of infants who have been left too long in high-risk situations can include

- Attachment disruption, distortion and disorder
- Externalising behaviour problems
- Chronic depression or anxiety

- Failure to meet physical, cognitive and emotional developmental milestones. (Mares et al 2005)

It is a common misunderstanding that infants are adaptable and can manage moves from one foster carer to another, or can manage moves between home and foster care during times when reunification is trialled. The disruption of relationships constitutes a severe trauma that reinforces feelings of abandonment and can trigger short term reactions such as anxiety, clinginess, regression of development, behavioural changes, angry outbursts (Jordan and Sketchley 2009). These experiences are cumulative, so with each move, infants experience more difficulty in managing the transition. Transitions are experienced as a loss for the infant and their capacity to adapt and adjust and start to develop new trusting relationships is compromised (Jordan and Sketchley 2009).

As an opportunity to ensure stability for infants in out of home care, reduce the number of placements and avoid the negative implications of multiple moves and transitions it is argued that child protection services should engage in timely concurrent planning for permanency rather than planning in a sequential manner while parents attempt to address their difficulties in providing "good enough" care (Jordan and Sketchley 2009).

When considering the needs of infants in the child protection system looking through the dual lens of attachment & trauma is relevant. In practice this is particularly relevant to contact visits with biological parents.If a parent has been abusive to an infant and the infant is traumatized then contact with the abuser is likely to be terrifying/re-traumatizing for the infant. Contact should not be regarded as a right in such circumstances. It should occur based on the best interests of the child which in turn is based on assessment.

Recommendation: Permanence in placement for infants entering out of home care should be promoted through concurrent permanency planning and expedited permanency hearings.

Recommendation: Visits between biological parents and young children should be seen as collaborations between biological parents, foster parents and child protection. Foster parents should be present if possible to provide support for the infant in needed.

3. Reviewing the effectiveness of the monitoring, investigation, oversight and complaint mechanisms for the child protection system and identification of ways to improve oversight of and public confidence in the child protection system

Data and Research

Over time, child protection policy and practice have not been well informed by research. An important first step in ensuring developmentally appropriate care for infants and toddlers in the child protection system is learning more about who they are, where they are, what their needs are, and how those needs are currently addressed and can be better addressed by the system. Staff and others respond when they see the data and research outcomes. Such data and research are essential to shaping appropriate services and support for these children and their

families. The needs of infants and toddlers must take priority in child protection administration systems. (Cohen et al 2011)

One of the difficulties in comparing child abuse and neglect reports is that statistics are rarely presented with enough detail. Collecting data that is accurate, useful, timely and detailed also allows for a data surveillance system to be utilised. The purpose of a child maltreatment surveillance system is to provide data on a timely basis in order to inform all interested stakeholders about trends and risks impacting children and families. An effective identification system provides the ability to develop the tools to make strategic funding decisions and target interventions. (Fallona et al 2010)

Successful reform and improvement of child protection services requires strategies to enhance the capacity of the child protection service system to make greater use of research findings to create an evidence-based response to infants (and children) that enter the child protection system. Data collection that is designed to support appropriate planning, program development and implementation for the needs of infants, toddlers, and their families known to the child protection system is needed.

Recommendation: Development and implementation of an evaluation and research framework within the Child Protection system which can be used to evaluate service development initiatives as well as actively support systems to coordinate, support and transfer knowledge about infant needs within the child protection system.

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