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# TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

MS K McMILLAN SC, Counsel Assisting
MR M COPLEY SC, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

BRISBANE

..DATE 8/11/2012

Continued from 7/11/2012

..DAY 33

THE COMMISSION COMMENCED AT 10.05 AM

COMMISSIONER: Good morning everyone. Ms McMillan?

MS McMILLAN: Thank you. Good morning, Mr Commissioner. The first witness we have is Dr Elisabeth Gudrun Hoehn.

**HOEHN, ELISABETH GUDRUN** affirmed:

ASSOCIATE: For recording purposes please state your full name, your occupation and your business address? ---Elisabeth Gudrun Hoehn. I'm a child psychiatrist and I work in a community mental health setting in Nundah.

COMMISSIONER: Good morning, doctor; welcome?---Good morning, commissioner.

Yes, Ms McMillan?

MS McMILLAN: Yes, thank you. Firstly, just before I start with Dr Hoehn I seek to tender the annual report Deaths of Children and Young People Queensland 2011-12 prepared by the Commission for Children and Young People and Child Guardian which was tabled in parliament this week. The parties have only just been given copies of it but I understand there's no objection to that tender.

COMMISSIONER: The annual report of the Commission for Children and Young People and Child Guardian will be exhibit 120.

ADMITTED AND MARKED: "EXHIBIT 120"

MS McMILLAN: Thank you. Could Dr Hoehn just be shown her statement, please, that I tendered yesterday?

Dr Hoehn, is that a copy of your statement?---Yes.

All right. Are the contents true and correct?---Yes.

All right, thank you. I might just have that back. Do you have a copy with you?---Yes.

Can I just ask you, have I pronounced your surname correctly, Hoehn?---Yes, that's correct.

All right, thank you. If you could just keep your voice up a little, that microphone doesn't amplify your voice? ---Okay.

Dr Hoehn, your position is Children's Health Queensland Hospital and Health Service. You provided this statement in your role as a consultant child psychiatrist and program director of future families which is the Infant Mental Health Service of Children's Health Queensland Hospital and

Health Service?---That's correct.

Child and Youth Mental Health Service - so it's part of the umbrella, if I can put it this way, of Child and Youth Mental Health Services?---That's correct.

All right. You also provide this information in your role or supporting the line management and program development of the Koping Program. Is that the correct pronunciation? ---Yes.

A framework for service delivery for Children of parents with a Mental Illness and the parent aide unit, a volunteer home visiting program to support families at risk of child protection issues. As well you provide leadership to the Queensland Centre for Perinatal and Infant Mental Health. All these programs are co-located at Nundah. Correct? ---That's correct.

Quite a bit on your plate by the sounds of things? ---They're a bit interrelated.

You have a degree of a bachelor of medicine and surgery from the University of Queensland. You're a fellow of the Royal Australian and New Zealand College of Psychiatrists. You hold a certificate in child and adolescent psychiatry and you are a member of the faculty of Child and Adolescent Psychiatry. You've practised as a child and adolescent psychiatrist and you've held the position of full-time consultant psychiatrist in your current role since 2007? ---That's correct.

Prior to that for 16 years you held the position of visiting medical officer in child and adolescent psychiatry at the Royal Children's Hospital, Child and Youth Mental Health Service Brisbane working in various community mental health teams. Correct?---Yes.

All right, thank you. You obviously hold relevant registration with the Australian Health Practitioner Regulation Agency?---Yes.

All right, thank you. Now, if I could take you to some specifics - I should say you were also one of the authors of the submission in relation to infant mental health that was provided to the commission. Correct?---Correct.

Thank you. As I understand it, some of your statement reflects the contents of it and in other parts which I may well come to you've referred specifically to that submission?---Yes.

All right, thank you. Can I take you to page 5, please, of your statement about midway down, the developmental imperative of the early years of a child's life. Now, could you perhaps summarise why it is that these early

years, zero to three, that you identify are just so vital in a young child's life?---Probably the most crucial part of what happens at this point is that this is the point in which the brain actually organises its pathways. So we are born with a genetic complement and neurones already in place but most of the connections and wirings still need to be developed and that happens in relation to some pre-programmed pathways within the genetic material but also the experience that the child has becomes a particularly relevant part of that experience. So the environment in which the infant finds itself and the young child then becomes extremely important because it actually provides the context for organising the development of the brain.

So you say, for instance, that in the first year alone the infant brain more than doubles in size?---Yes.

Is that if it's in a secure and appropriate environment? ---Yes, that's in a health context. We know that if children have been exposed to excessive alcohol, if they're exposed to severe trauma and neglect, then their brains will ultimately end up smaller than what you would expect for the average child.

Indeed, you say the human brain experiences a growth spurt from late pregnancy until about 24 months of age with five-sixths of this growth spurt occurring in the postnatal period?---Yes, and that's why the environment that the child is in is such an imperative part of that experience, because it directly influences how the brain will ultimately look, how it's wired, which is also what makes us each unique, because we each have those different experiences.

You say further down that page, "Connections and pathways between nerve cells the brain neurones develop in response to stimulation and sensory input and therefore experience dependent both positive and negatives input into their environment," so that you say, "Therefore the experiences of the child will influence the development of the child's brain impacting which neurones survive." So is it the case that if a child is in an abusive or neglectful environment in zero to 24 months, some of these neurones won't survive?---Yes.

So can you just explain a little bit more about that? ---There are certainly particular parts of the brain that are very sensitive to the impacts of stress so when there's stress - and trauma and neglect are part of that that promotes that stressful experience - you get hormones released and you get neurotransmitters released that will have an impact on what's happening. So you've got areas of the brain that are genetically programmed to start developing and they proliferate neurones and connections, but if essentially the substrate in which that's happening is then adversely impacted so that you have chemicals

around that, for example, that are potentially destructive, then you actually get damage and death of cell material. Some areas that are particularly sensitive, for example, are the hippocampus which is involved in our memory functioning. There are other areas that are very sensitive, particularly in that sort of period eight to 18 months, which lie at the underneath surface of the front part of our brain, so basically it sits over the top of the eye area. They're very much involved in our capacity to regulate our emotional life and they actually require relationship to develop effectively. So you actually need positive interrelated experiences for that aspect of the brain to actually develop properly and if that doesn't happen, then those cells will die and won't develop in the same way, and we can actually see that in - a lot of this work came out of the Bucharest Early Intervention Project because they actually were doing scans on the brains of the children who were in institutions and those scans showed significant absence of activity in those key areas.

In fact, it almost looked like there were black holes in those areas on the scans where they just hadn't developed pathways appropriately.

So can I just ask overlaying on that, if you have a child who's born, say, with foetal alcohol symptomatology, what parts of the brain are affected by that for starters, and then the next part of my question is if they are then exposed to an environment which is neglectful and/or abusive, what further happens in relation to their brains? ---I think our understanding is that a lot of those pathways that I've just talked about that you would have affected by maltreatment and trauma are also affected with foetal alcohol syndrome or the spectrum of disorders. One of those things is that the period of development, particularly where the alcohol seems to have an impact, is when we're developing our facial structures and the front part of our brain. So you get that effect where it effects the frontal lobe, which is where a lot of our executive functioning and planning and the way we regulate ourselves, our capacity to do things in sequence, to think of cause and effect and consequence; all of those things happen in that part of the brain. The development of that is actually affected in utero. That is also the part of the brain that struggles in its development if you have chronic exposure to neglect and maltreatment. So that further exacerbates what would already be a very vulnerable structure for that child.

That's what I wanted to ask you, is it different or does it exacerbate? What's the position?---No, I think it exacerbates it on top of that.

Right, thank you. Now, in terms of page 6 of your statement, you say that, "The expanding brain is directly influenced by early environment enrichment and social experiences." You say that for instance these positive experiences, without them a brain doesn't develop, and the rules of relationships obviously don't develop either, or capacity to feel worthwhile. Now, are those more attachment issues rather than brain development issues? ---That's where our understanding now in the research is, that you actually can't separate the two.

Right?---That in fact attachment relationships are integral to brain development, so the two sit together. Increasingly now people see attachment theory as in fact a regulation theory, that you need those relationship experiences to actually develop your capacity to relate, to become empathic, to be compassionate; all those things that happen within our relationships.

All right. And you say that:

> *Brain imaging research has identified identical areas of infant and caregiver's brain are activated simultaneously when they smile at each other. In this way interpersonal relationships affect the structure and functioning of the brain and in turn help shape a person's emotional and social and mental functioning.*

There's not only the obvious benefit for the infant, but also for the caregiver?---Sorry, could you repeat that.

There's a benefit obviously clearly for the caregiver's brain as well?---Yes.

And that's in, clearly, an intact and appropriate relationship?---Yes.

So that for instance an absence of affection or attention to a child can clearly - one would extrapolate from this - impact. On the brain?---Yes. So you don't then develop those pathways in the way we would like to see them develop.

And if there's some difficulty in the caregiver, either through mental health issues or perhaps a substance abuse, they may not necessarily have that beneficial effect in their brain imaging. Would that be right?---Yes. So they wouldn't actually be - that part of the brain wouldn't be lighting up. They would have other parts of the brain that are predominating or having a negative impact.

And I take it that what studies have shown, that that activation in the caregiver's brain ordinarily also would form a protective aspect to that relationship, wouldn't it?---Yes. We're wired that way.

Yes?---So we acquired to bond to our children and to attend to their care needs, just as our children are wired to want to look at ours. So they're wired to look at faces, absolutely. And so that's how the system is intended to work.

And that is present in appropriate, love and relationships? ---Yes.

And you say that there is a distinction, obviously, in relationships which are characterised by abuse or neglect? ---Yes. An important part of the process is our capacity to repair, so the system is not set up to work perfectly because none of us can do it perfectly, so we sort of have a 30 to 50 per cent rule that's required for this positive interaction. If you have a rupture because you don't have that positive interaction, then healthy relationships will repair that. One of the very significant things that you

get in trauma, if you've got perinatal and mental health issues, is you lose the capacity to repair and so the child is left with a rupture and holding the rupture in the relationship with no capacity to actually repair that and come back to a more positive experience.

So just so I can understand that, are you saying that if that's ruptured because of maltreatment or the absence of their primary carer, for instance, they're not then given an opportunity because of that to be able to repair that rupture?---Yes, if that persists.

If that persists?---There is actually a YouTube clip that you can look at called Ed Tronick still face, which is an experimental video where a - it's an experiment where you get a mother and an infant together, they have a few minutes of play, then the mother turns away and she is required to come back with a still face, and that lasts for two minutes, but you can actually see in that particular one how distressed that infant gets just buy two minutes of not having the mother available. At the end of that the mother then comes back and repairs and you can see that the infant then calms down again and relaxes. That's the normal sort of thing, you know, we leave the room, we go to the toilet, we answer phones, we're not always available, but we come back and repair that relationship in a healthy context. What these infants and young children are experiencing is that they're left holding is really just distressive experiences and they don't have that experience of repair which allows the stress system come back to a baseline.

I was going to ask you about that because you then go - at the bottom of page 6 you talk about:

> *Early and sustained exposure to high risk factors such as abuse, neglect and traumatic experiences can result in the strong and prolonged activation of the child's stress management system in the absence of consistent supportive relationships to help the infant cope and bring the psychological stress response back to baseline.*

Which is really what you were just saying?---Yes, that's what I just described.

"This can result in persistently elevated stress hormones and altered levels of key brain chemicals which can alter the architecture and functioning of the developing brain." You talk about, "It's mediated through the neurotoxic effects of cortisol," which you say can reduce the overall brain size. So is this correct, that where it's prolonged it's in effect that the infant child is in, like a flight-type situation - - -?---Yes, that's right.

- - - where it's elevated because it's obviously quite

appropriate times for all humans to experience that flight response?---Yes.

Because that might ensure safety?---Yes.

But what you're saying is it's clearly inimical to their development if it's prolonged and sustained?---Yes, that's right. So we're wired to have this fight flight response because at all costs human beings are wired for survival, as are other animals. So that's how our brains developed. In the context of this sort of chronic stress we don't actually come back to baseline so the whole sort of homoeostatic level in the body is set at a much higher - well, they're running at a higher point of anxiety. The levels actually at which they go into that state has dropped. They've got a much lower threshold to get into that stress state. We sort of have a window of comfort where our body sits in a homoeostatic position, which is where we want to be. In that state we're relaxed, we have a capacity to relate to people, we can digest our food and we're rested. If we have a stress experience that takes us outside of that window then we get into a state where we have both physical responses in our body and psychological responses in our brain which are all geared for our survival. And so we shut down non-vital organs, for example, in that case, such as our digestive system. We get a dry mouth, we don't use our saliva, our bladder doesn't contract. So there's physical experiences that happened. And again, they will have a long-term impact if you stay in that state, both physically and psychologically.

You say on a social and emotional level it can impact on a child's ability to process emotional information and learn the complexities of emotional interaction. There are obviously issues, you say, that they suffer with poor self-esteem, forming trusting relationships, et cetera, but at other levels you say the physical alterations to the brain result in difficulties in learning, memory, tolerating stress, managing emotions and impulses. Is what you also say then, because their tolerance, if you like, is lowered, therefore it's generally accepted, isn't it, that young children, certainly less than three, usually need stability to feel secure?---Yes.

So that if there are further changes of carers, for instance, or experiences which may well cause stress in a young infant, their tolerance to it is much lower than a child that's been in a healthy relationship with their carer?---Yes. If you've had a secure experience, particularly in those first three years, while it doesn't protect you against everything and forever, it certainly acts as a buffer to building resilience.

I want to come to this later. So if you're looking at permanency placement and if a child is removed because of child protection concern, and Dr Connors' evidence, and Dr Stathis, was that it's best to give them that chance of permanency in that zero to three years, you should not attempt continuing efforts at reunifications in that important period. Would you agree with that?---I think you have to look at each individual child. I think that you need to do an absolutely thorough assessment. I think there are situations where families can be reunified, where one of the difficulties is that the biological parents lack resources, they lack education, they themselves haven't had good experiences, yet there are numbers that I've worked with who are actually quite resilient and with a lot of support and therapeutic intervention in fact can shift and make quite a significant change. So I think that we need to actually look at the relationships, we need to look at all aspects. So we need to look at the child. We also need to understand what's happening for the biological parents and see which ones we can actually proceed down the pathway of some reunification attempt and which ones we wouldn't even start that process.

Perhaps if I put it another way, that prominence shouldn't be given to attempts to reunify over the child's interests in terms of security and stability?---No.

Would that be a better way of putting it?---Yes, that's absolutely correct.

Right, okay. Now, can I also ask you, because we don't seem to have heard much evidence about this, that exposure - on page 7 you talk to early adverse experiences can affect the child's immune system and other metabolic

regulatory systems in the child's body so resulting in permanently lower threshold for activation of the immune system. So that obviously has implications, I would imagine, for fighting infectious diseases and other illnesses that obviously your immune system needs to be able to function for. Does that work into adulthood as well?---Yes. So what we can see in the infants and small children is that you get a picture of what is sometimes called failure to thrive and we call it non-organic failure to thrive, so there's no biological reason for that. So it's actually impacting on the capacity of the infant to grow physically effectively. Cortisol is actually an immunosuppressant which we use in treating disorders where our immune system is over-responsive. So if you've got high levels of cortisol it will have that depressant effect. There have been studies that have been done in the US within the health care system there which has looked at, interestingly, the impact of adverse childhood experiences on adult health and they've actually had quite phenomenal outcomes in that when they've looked at that.

So which study or studies were these?---Can I refer to the document?

Yes, please?---So the adverse childhood experiences study was conducted to assess the associations between childhood maltreatment and later life health and wellbeing. It was a collaborative study done between the Centres for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego. Over 17,000 Kaiser patients were participating in routine health screening and were asked whether they would be interested in volunteering in this particular study. They actually gave consent for a comprehensive physical examination and provided detailed information about their childhood experience of abuse, neglect and family dysfunction. Out of that they looked at seven categories of adverse childhood experiences. There was emotional abuse, physical abuse, sexual abuse, violence against a mother, so domestic violence, household members who were substance abusers, household members who were mentally ill, household members who were suicidal and household members who were imprisoned. Almost two-thirds of study participants actually reported at least one of those adverse childhood experiences and more than one in five reported three or more. They found that the short and long-term outcomes of these childhood exposures included a multitude of health and social problems. What they did was created an ACE score. An ACE score was how many of those factors that you actually had. As the number of the ACE score increased the risk for health problems also increased in a strong and graded fashion. There were things such as alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, foetal death, health related quality of life, illicit drug use, ischaemic heart disease, liver disease, domestic violence, having multiple sexual partners, sexually transmitted diseases, smoking, suicide

attempts, unintended pregnancy, early starting of smoking, early starting of sexual activity and adolescent pregnancy. They actually found there was a cumulative effect of the ACE factors on health. So if you had four of those factors, which many of the children and young people who come into care have experienced, you actually have a 260 per cent increased risk of chronic obstructive pulmonary disease, a 240 per cent increase in the risk of hepatitis, a 460 per cent increased risk of depression and a 1220 per cent increased risk of suicide attempt. So they really had a profound outcome in this study and what they actually looked at was the fact that you seem to have these adverse childhood experiences that happened very early in life. They had then the social, emotional and cognitive impairment that we've been discussing. That led to an adoption of health risk behaviours and out of that you ended up with earlier disease and disability and an increased incidence – and in fact early death.

That was a cohort of some what, 17,000?---17,000, and that was a retrospective study done - - -

When was that, doctor?---Sorry?

When was that study done?---Actually, I can't answer that question.

Right?---I'd have to go back and check that.

Perhaps would you mind giving that information to us later? ---Yes, I can forward that information.

Thank you?---There has also been a 32-year prospective longitudinal study done in Dunedin called the multi-disciplinary health and development study with a birth cohort that they followed through and they found very much the same thing, but that was a prospective study. I can provide you with the information on both of those.

Yes, please, if you would, thank you. So there appears from those studies to be, one would think, fairly unarguable evidence that there is a much greater risk of not only mental illness issues but also physical impairments?---Yes.

I take it these were self-reports of abuse and neglect? ---Yes. That's the difference between the two studies. The American one was a self report and it was looking back, whereas the Dunedin one was actually following the cohort forward.

All right, thank you. Do their results nonetheless mesh? ---Yes. They had similar outcomes in what they found.

So just onto page 8, is what you're depicting there down to the early intervention heading that as these children

progress chronologically they're often labelled disruptive, defiant and poor learners?---Yes.

So is that when they're progressing, after these very early years?---Yes. As they move into the schooling system one of the difficulties is that they do struggle with learning and how they process memories. So for us to function well in a school setting we have to be able to sit and attend, we actually have to be able to integrate language and emotion and put words to experiences. These children really struggle to do that. They are often quite aroused so they're outside of their window of tolerance that I discussed and once you're aroused and outside of your window of tolerance, you actually have a tendency to shortcut away from using the more thinking parts of your brain because you're down in that survival mode so they're constantly scanning the environment. It's a stress-provoking experience to be at school and so they really struggle to settle and learn unless they feel in a very safe environment which often they don't.

So for these children it's obviously very difficult because that's their perspective in terms of their approach at school, for instance, and other interactions?---Yes. So the early experiences that you have set internal templates and representations of how you see the world. So you'll have internal representations of how you see adults, for example, based on those experiences you've had with your early key adults. You'll have an internal representation of whether adults and the world value you and see you as a worthwhile person. If you haven't had that experience with those positive interactions, then you're sitting in a classroom setting, you will use that template to appraise the teacher who's an adult and you will be suspicious and threatened by them because your experience of adults is that they don't provide a safe environment and they don't think you're important or worthwhile.

Does that carry over then to, for instance, clinicians such as yourself attempting to work with these children?---Yes; yes, so you often get them as particularly in adolescence quite sullen and withdrawn and guarded. It's going to be very difficult for them to trust. It's also what foster carers struggle with. When children do come into care, foster carers are another adult and the child has no reason to necessarily trust them. Even if the environment is very loving and caring, it's going to take a long time because essentially you've got to create another template which you've got to build alongside of that. We create the templates and we create things by very repetitive experiences and one researcher in fact said that you have to repeat something 186 or 187 times until you actually get that brain pathway developing. So if you're trying to create a new template with a foster carer, they have to repeat that positive experience many, many times or you as a therapist need to repeat that positive experience many, many times until you have an alternative internal representation that the child can then use.

Children tend to learn generally, don't they, through repetition, particularly in early years?---That's absolutely how the brain is programmed to develop.

Like language and all of those sorts of issues?---Everything, yes, learning to walk; everything that an infant or a young child does they have to repeat. Our brain is programmed to grow with patterned repetitive experiences.

So further up that paragraph you say that children - even if they're not actually threatened at this stage, their bodies act as if they are in a constant state of alarm and their brains are endlessly vigilant?---Yes, because it's actually very difficult for us to understand what their perceiving in their environment because we don't know the detail of the experiences they've had. One of the tricky things is that early - for the first two years our right

cortex and right brain is the predominant developing part of our brain. From two to four years we switch over to our left brain. Our language development sits with our left brain so our early experiences that we lay down the memories for are laid down in a sensory context. So all the information coming in from our body and from our senses is how we lay down those memories but they're fragmented memories. Our capacity to actually - it's what we call procedural or implicit memory. The memory we think of - when we have a continuous sentence, we use our brain to recall information like I'm trying to do here in this setting. That uses our explicit memory and language is attached to that. It's a capacity to sequence information. With our right-brain memory it's laid down as fragments so it might be, for example, that the teacher that the child has in the classroom wears the same perfume that the mother wore when she was hitting the child, for example. I mean, that's a very basic example, but it means that the actual scent is what triggers in the child the anxiety.

So it's a little bit like post-traumatic stress disorder where a particular thing - - -?---Yes, can trigger it.

Sound or sight?---Yes.

Right?---The other side with that is then that if you don't have good explicit memory, the hippocampus which is a part of our brain that's very involved in sequential language based narrative memory that gives us a continuous picture is very vulnerable to the damage from cortisol and trauma. So if it's not working properly and you can't lay down good memory, move it from short-term to long-term memory, and you're relying on that fragmented memory, then the kids really struggle to learn, plus we don't know exactly what their triggers are to be aroused.

I was going to ask you: you wouldn't know as a clinician and the foster carer, for instance, wouldn't know either? ---No.

Because a child wouldn't be able to articulate it?---No.

Right. At page 20 and following you in your statement talk about the considerable international evidence providing targeted support to foster carers can have a significant positive effect and you refer to the United States has an attachment behavioural catcher, ABC, intervention?---Yes.

Would it from your knowledge, for instance, provide some of the information in an appropriate way that you've just been giving here why children who have been subjected to abuse and neglect behave in certain ways such as, you say, tending to push caregivers away when they are hurt or frustrated, needing nurture and care - that would seem to be a given - are often disregulated at behavioural and biobehavioural levels. So I take it that that's what that

program specifically targets?---Yes, and it certainly - in my own clinical practice when I worked with foster carers that's what I do. So I have a plastic brain but I basically explain the things I've put in this paper and the things we've talked about here in this room. I would explain that to foster carers and also to biological parents. So the parents I work with - I really try and educate them about what's happening internally for the child. Interestingly what I find particularly with the biological parents is that they suddenly have a light-bulb moment where they realise that's what actually happening in their brain and so really what you're trying to do is develop that understanding and I think if you get those light-bulb moments with biological parents, then there is a lot of capacity then to try and move forward and support those parents. So I think they're some of the things you've got to think about at an intervention level.

In your work with parents who have that light-bulb moment, have they themselves been subjected to abuse and neglect? ---Yes; yes, this is really an inter-generational pattern because we parent the way we were parented. As I talked about, we lay our experiences down as these internal representations and then when we come to have relationships with other people, we'll pull those out and so you have this hierarchy of templates of relationships that you have and those earliest ones are the most profound and entrenched. So when we come to parent, then we'll parent the way we had that experience and that's the difficulty. We're all programmed to bond with our children and care for them, but for many of these parents they've had so many negative experiences themselves - I like to think of it a bit as an onion. In the core of the onion you've still got that capacity but they have just got so much baggage around the outside that we have to sort of help them understand that so that we can get back to that core of wanting to actually care for their parents - for their children. I mean, it's my experience that even parents that have really been very neglectful or maltreating their child actually love their child and don't want to lose their child. There's something still in there that drives them in nearly all instances to want to care for that child.

This would come back to, I imagine - you've spoken of it previously this morning about the necessity of having a very thorough assessment early in a child's life if there's some sort of child protection concerns present?---I think if we had some way of having an holistic sort of centralised way of assessing the children at risk, that we have a central point of contact at which all children that are identified at risk - not just through the department but through health services and other services could refer children to and we could do a thorough assessment and then from there work out what would be appropriate pathways to take.

As a practical example at page 10 of your statement you refer to Future Families which obviously you lead.

It's a multidisciplinary child and youth mental health team including child psychiatrists, infant mental health clinicians, including social workers, psychologists, nurses, speech pathologists. Now, I take it in that setting you're already providing a comprehensive assessment, aren't you, for a child who's referred to you, and that child can be referred by general medical practitioners?---We get our referrals from a diverse range of people, so from GPs, from child health nurses, from youth services that work with young parents, from adult mental health services; whoever sees parents and infants and identifies that the parent isn't coping and developing that relationship.

Do you think that it is feasible that that team, if it was properly funded, could provide the sort of early assessment - comprehensive assessment - that's needed to make a decision about a child where there are child protective risks identified?---Yes.

Because as I've just ask you, you obviously have to perform some assessment yourselves because you need to do that in order to know how to treat and work with the child and their family, clearly to provide an assessment may be utilised for a decision about perhaps removal of a child or how the child's needs may best be met is different to some degree, but do you consider that your team would be well-placed to do that sort of assessment?---Yes. My team would have the experience to be able to do that assessment. There is a model like that, the Interlay in the US where they have an infant mental health team that do that assessment, so in that particular county any child who comes into foster care is actually referred to that team and they do very comprehensive assessments and offer specific interventions to try and move things along. I think if you were going to set something like that up you'd want to broaden it out to make sure that you have health services involved, so paediatrics, which we don't have in our team because we're specifically a mental health team.

Yes?---But you'd want to be working quite collaboratively with child health and paediatricians to make that complete comprehensive assessment. Because as I said earlier, these children often have failure to thrive in numerous developmental domains.

All right?---But having something like that, which is a central point of contact and a thorough assessment team who could then also go on to provide appropriate interventions or direct pathways, so it's really about having that triage experience, being able to do the assessment and then be able to decide which pathway to go down. Because in some cases you might go down the total child protection pathway when you're going to remove the child and you make that decision then fairly early to find an alternative placement; in other cases you might say, "Well, I can see that this parent has some capacity to think about this child, is these it as independent from themselves, has taken on some information. I think it's worth trying to do some work here," and then you were trying to intervene. That might be while the child is in a supportive foster placement, but you would also - one of the things we do with some of the families we work with is we work with both foster carer and the biological parents and we have both of them come to the clinic and try and support the infant to actually have a better relationship with their parent. That works sometimes, it doesn't always work.

And I take it that's at your discretion - the treating practitioner's discretion, whether that works or not - whether you bring them together?---Yes. Sometimes we do get referrals from the department. It's difficult for us to, say, work the biological parent if they have very little contact with the child, so if there perhaps in a process of attempting reunification but the parent only sees the child half a day a week or a day a week, it's

actually very difficult for us to become involved therapeutically. But in cases where we can see that we can actually provide something, we might actually have that contact happen in the clinic, for example, and actually see whether there's any value in continuing with that reunification process; how can that parent make use of this experience?

I was going to ask, and no doubt do you provide some educative assistance in the sense of explaining to a biological parent why, for instance, their very young child may have difficulty moving from, say, the foster carer to them in terms of - - -?---Absolutely, yes.

- - - leaving the primary carer for that child at that point in time, and why a child might behave in that way? ---Absolutely. And it's also important for the foster carer, because they often don't understand what the transition experience might be like for the child, so is equally important there.

So in terms of other service delivery options, you've listed a number of them in your statement, such as children and parents with mental illness, there's a triple P parenting program, nurse home visiting programs; so there the sorts of pathways that, for instance, you might prefer parents or the family to. Correct?---Yes. Some of those are universal population interventions, and I think one of the things - like, we now have a national framework around child protection and it really is about the fact that it really is the responsibility of all of us to look at that at multiple levels. So you really need to start with child protection at that universal whole population level, you know, around things like the impact of alcohol in pregnancy; supporting our young adolescent parents or trying to prevent that; you're trying to do preventive things; providing input into, for example, antenatal classes about the importance of these early relationships and what you can expect and how you can build them. So you're trying to do something for the whole of the population to prevent child protection issues. Then you're really looking at a group that are a selected population of at-risk people where you're trying to intervene early. So some of those would be pathways that you were direct into programs which the department has some programs of already that of listed, and then you're really trying to work intensively in the third sort of tier with those families where there are serious child protection issues and you're really looking to see: well, can these families actually respond to intervention or does the child need to be removed?

In terms of these other selected population interventions such as early parenting centres, family support services; in your experience does the Department of Child Safety link into those well?---Yes, I think the department links - I'm

not so sure about the early parenting centre, but I think - and that's because we don't actually have one in the catchment that I work in. There is one at Redcliffe-Caboolture. I certainly know that health services that work with these families try and link the families in and work with the child protection services as well. Some of the services in some areas only take referrals from the department. Some of these early intervention programs initially were set up like that and then broadened out their intake criteria so that other services could refer in. My experience is that it's like there's lots of these things out in the community but it's very hard to pull them all together in a coordinated sort of way. And even within health you get a very shotgun approach where you might refer one family to three or four different services to try and have a similar sort of experience or wrap protection around them but they're not coordinated with one department receiving this referral and someone else getting this on someone else getting that, and it's the same with child safety services. We really need to work within an interagency coordinated framework if we are actually going to effectively support these families because you've got to wrap services around them. And my belief is that the child needs to be at the centre. We sometimes lose focus about what we're trying to do is about the child, not just about the parent. And so we need to child at the centre and we need a coordinated way of wrapping things around a child.

So the team that you work within, do you think it would be benefit in having formerly, for instance, a member like a child protection liaison officer sitting within your team? How do you see it as being much better coordinated than it currently is?---I think if you set up a team like my team to do this, so you had paediatric involvement, you might have someone representing education or the childcare sector, you would need someone representing child safety in some way, whether that's a liaison officer or someone from the department, and you'd want the non-government sector represented as well because they run a lot of these early intervention programs of the communities.

So you would say do it district wide. For our district you would get a representative from each of those key non-government agencies that provide services, the department, health representatives, mental health representatives, someone from the early childhood sector, come together and then assess these intakes and what is required so that you have a holistic approach.

So obviously to practically work you would have those members who might – a bit, perhaps, like a SCAN team, meet together about what might be the best outcome, but would it be predicated on the team, say such as yours, with a paediatric involvement, doing an assessment first, "Well, these are the risks to the child and this is the current functioning of the parents," for instance?---Yes. I think you would have referrals come in to a central point.

Yes?---They would meet and assess them and triage them and then say, "We need a mental health assessment, we need a paediatric assessment, we need to look at educationally what – an assessment, perhaps, how this child is functioning in a child care centre." There are multiple levels of observations that you need to make to actually be able to make a comprehensive assessment.

Does your unit work after hours?---No, we work 8.30 to 5.00 in the clinic. We are supported by the extended hours service of the hospital.

Well, I was going to ask, there must be, I imagine, some emergency support if necessary?---Yes. In this age group you don't get a lot of that happening. Sometimes general practitioners ring us and need some urgent assessment. Generally, I think, people as yet don't really identify that infant and early childhood necessarily are people that you would involve us in urgently.

Right?---It tends to sit – if there are urgent issues they tend to sit within child safety and crisis care.

Or the emergency department of a hospital?---Yes, that's right.

Because in the submission that you co-authored, the one I referred to, the Australian Association for Infant Mental Health, the submission, page 2, indicated that in 2010-11 across Australia children aged less than 12 months of age were most likely to be the subject of substantiated abuse and neglect. So it's a very high risk category, isn't it?---It's huge.

The pattern is consistent in Queensland with 9.3 children per 1000 children. In Queensland children aged one to four of age made up the next highest group of children where abuse and neglect were substantiated at 5.7 per 1000 children. So together you say zero to four years made up

40.93 per cent of children who were the subject of substantiated abuse and neglect. Those figures, if anyone is seeking the source of them, is the Australian Institute of Health and Welfare 2012. It's clear that they make up almost half of the children in Queensland's population where abuse and neglect were substantiated?---Yes, and very few of those come through for therapeutic intervention.

They're mainly seen at the tertiary end, either child protection or emergency, for instance, departments of hospitals?---Yes, and they're even not coming through to our Evolve services, which have been trying to build that relationship so they get the children younger, but the department hasn't really prioritised them to send them through. So it's been a difficult issue that we've been trying to work. Again, I think this is where a lot more training and education actually has to go into the staff who work in child protection sectors around the sorts of information that we're talking about.

So that access to primary and secondary services. There needs to be better education, if you like, of the child safety workers about what options are available?---What options are available, but also - - -

And intervening - - -?--- - - - theoretical underpinnings of why you might actually refer them on to treatment, what is actually happening in transition, what they need to look for. For example, often the child safety officers are actually supervising contact. They might pick the child up from the foster carer, take it and meet the biological parent and supervise contact but they don't also - they don't have the understanding necessarily of what they need to look at in that experience between the child and the biological parent, what it means if the child, you know, backs into the parent rather than wants to cuddle the parent. I think they need to gain a lot more understanding of this whole area, I think, to actually effectively impact.

How best do you think that could be done? Do you mean formal study through their university studies or postgraduate level or do you think and in addition there should be the sort of education that I think you spoke of at page 19 of your statement?---I think it has to happen at multiple levels.

Yes?---I think we've been advocating to get it into curriculum and in some areas it has gotten into curriculum. We have a role, I think, in providing that, potentially, and there are opportunities where - for example, I might do a presentation and child safety officers are present. In the past I've actually directly been involved in providing training. There was a period of time in the mid 2000s where the department would bring all new staff for the department down to Brisbane and orientate them and we would

provide training and they would get outside people in to provide specialist training. That really ceased and doesn't happen anymore.

Do you understand why that occurred?---I think it was probably the expense of bringing people down. I think they moved to online training and it was pulled back into the department, which we struggled to understand and although we tried to have a dialogue around that that's just how it ended up happening.

So in fact you talk about at page 18 that a memorandum of understanding has been signed between child and youth mental health services and child safety services. There's goodwill to implement it but a holistic and collaborative framework of practice does not exist between the services. You say that similarly, despite the existence of child safety directors and the child protection partnership forum, these collaborations do not filter down readily to the coalface where service delivery frequently remains in silos of practice. So is that what you're talking about, that it was drawn back into the department, the training? ---Yes, and I think at a corporate level following the last inquiry, the Ford inquiry, these child safety directors were placed in - set up in departments and at that higher level they meet and they discuss things. I think you need to replicate the model on the ground. So from about 1997 I worked at Pine Rivers in the child and youth mental health service there. At that time we actually set up a new service and part of that was we actually set up an inter-agency forum between education, ourselves as mental health and child safety, where we actually worked together to meet the needs of the high risk kids. So it was actually a forum where we would bring the children each department was concerned about and work together to actually find solutions for these children and support interventions for them. On top of that was another layer. So there as a reference group that met higher at a manager, executive sort of level, which supported the work that we did. At the moment we have that higher tier but it's not happening really readily on the ground. The Evolve interagency way of working, they do have that interagency meeting, but generally that's not happening. We tried early 2000s to replicate the model we used in the Pine Rivers catchment in the greater part of North Brisbane but it didn't work effectively there.

Was there a particular reason for that?---I think at that time Pine Rivers was a much more defined community and there was a lot of goodwill amongst the people. It was sort of an evolving new thing that was happening. I think there is a lot more entrenched practice, you know, in all the departments in the more central Brisbane area and it was more diverse and disperse. So you had a number of child safety offices, a number of education offices. It wasn't as easy to actually bring people together. It

really needs to happen around that community of service providers that the family finds themselves in the centre of.

Will that be made, do you think, easier or more difficult now with the changes to Queensland Health going to regional areas?---I don't think – I mean, over the time I have worked there have been changes in boundaries multiple times for child safety, for education, for health. It's a moving feast from that perspective, but people still live in communities. So I think it really requires the people on the ground who support the people in the community to get together. In some cases that might be half of a Child Safety region, half an Education region and, you know, three-quarters of a Health region maybe, but outside of Brisbane, outside of the - going out further I think that's easier to do because there's a bigger overlap of what happens in other areas of the state. It's somewhat harder in the central part of Brisbane, but it needs to happen around the child.

You talk about as a further challenge the high turnover in staff within Child Safety prevents the formation of close and informed working relationships that are able to support vulnerable families. So you say, "For families where relationship and their predictability and continuity should be at the centre of healing and repair for children this can have a significant impact"?---It has a huge impact. It has a huge impact for us to know who to work with, to support, but it has a huge impact on the child. I'll be working with a foster carer or a family who has a child safety officer. That child safety officer is the person that transports the child; picks them up at the foster carer; transports them; is there for the contact visit, for example. If that person changes every three months, that in itself is an enormous stress for the child who's relying on that person being their secure base in what is already a very difficult transition and a different experience of moving between foster carer and perhaps going to see the abusive parent. If they don't even have a secure base within the department to be able to refer to, that has a profound impact. It has a profound impact on the foster carers who also need that. The whole thing with attachment relationships is it becomes this multi-tiered sort of thing. I as a clinician act as a secure base for the parent that I'm working with and you're trying to give them a reparative relationship experience. You are then asking them to do it with their child. You're asking the foster carer to do a reparative experience but they have to be held as well and it's really - the department's role is to hold them. Unfortunately with that change there's no-one holding and that becomes very difficult and for us as clinicians - you know, we'll think we have been working with someone and we'll, you know, provide them with information or express concerns if we want to make another notification and then suddenly we find out that they're not there any more and they've left and there's someone else, but we also haven't been notified even though we may have already been partnering with the department that they're leaving and that makes it very tricky when you're really trying to wrap services around a child in the centre.

COMMISSIONER: It's even more complicated in that on a monthly basis because on top of the CSO and any clinicians they're seeing the children also have a visit from the community visitor at the end of every month and the representative of the service provider to check that things are going according to their standards?---Yes.

So at the end of every month there are three adults intervening in the child's life that other children don't have to bother about?---Yes, and a month is an enormously long period of time if you're little; like, if you're under three, a month is like an eternity. We all remember how long a year seemed to be when we were at primary school, you know. That's even longer when you're smaller and then so these people are essentially strangers to them when they

turn up each month. That's very stressful for someone who's already primed to have a heightened stress response.

Especially if the person keeps changing?---Yes.

MS McMILLAN: Also, if they themselves have been subjected to abuse in the past, and you've indicated that one of the issues as they come through and chronologically mature is suspicion and issues of self-esteem, et cetera. So does that have an impact on them in terms of these changing faces to deal with in Child Safety?---It's huge. I mean, we work with quite a lot of young women who themselves have been in the care of the department, have just graduated from that process, who have had a baby and are essentially repeating that, so they're repeating it for themselves. They don't have that sense of stability. They're themselves transitioning out of care and they have these changing faces and I think, you know, the whole system - the way we're wired is based on predictability; stability; security; knowing to feel safe. If you don't feel safe, then you actually can't get on and master your world because that system actually requires a sense of safety and you need to switch off your attachment system. If you can't do that, then you really struggle with actually working effectively in the world.

All right. Future Families - at one stage you provided some training to the One Chance at Childhood initiative which is a department one?---Yes.

You say that that occurred and that in fact your team received a Child Safety Australia Day award for contributions made, but this great relationship has gradually broken down. Again, do you understand from your perspective why that broke down?---I think a large part of that was that the initial people that were involved in setting up that we worked with to deliver the training and supported them in setting the process up - they actually left. One of them had a baby and then someone else left so new people came in.

Yes?---As often happens in the department, the program was reorganised. The regions changed. They did something different with it so all of this - to actually effectively be able to do this work is built on relationship. It's no different to what you're trying to do with the families themselves. For us to work most effectively we need good, positive working relationships with people we know and that we trust and feel safe with. One of the things we really tried to support was they had a permanency panel, a planning panel, and they had the capacity to have expert witnesses come and so we were trying - we were hopeful and trying to build that relationship so that if we were already involved with a family or had input, we would actually be able to come along and have some input based on our assessments and our experience, but we never actually

received an invitation despite trying to make that happen and I'm now not even aware whether those panels are still in place.

I see; so they are called what, permanency?---They were panels. So the idea was to actually - the One Chance at Childhood was really looking at children up to the age of four years and so it was really trying to address having these multiple placements, trying to reduce that and really looking at running permanency planning in parallel to other things the department was doing initially, so putting it on the agenda much earlier, and so they were trying to pull together a panel of people to - and they were largely people within the child safety officers.

Were they more experienced?---Generally they were, yes.

Now, what is it about the South Australian government's Every Chance for Every Child policy that you think might be helpful to perhaps translate here?---I think it's early days, the South Australian model. They've put in place a framework. I think what they've done is put the child in the centre. So the premise is that every child in South Australia has a right to grow up in the best way possible to be protected and so they started with actually wrapping department around the child. So they've brought together in one department a whole lot of different areas and looking at trying to pull them together that way but - I mean, it will be interesting to see whether they can translate that actually down to the coalface. There's a lot of things already happening in South Australia that do that. They have much more extensive health home visiting than we do, again much more extensive infant mental health and perinatal mental health services, so that's already happening, but their view is really that from a whole department point of view right down we need to wrap that around the child and the child needs to be at the centre which is every child, every chance that they can possibly have to have the best outcome. Really economically for this country that's imperative because we have an ageing population. We have a negative population growth. In reality we actually need the best possible outcome for every child that we have so that we continue to have a productive society and have young adults who are able to care for our ageing population. So I think it is - economically it's imperative that we have a look at that and - - -

Also, isn't it, too because the evidence we heard from, for instance, Dr Stathis yesterday is that these children who are victims of abuse or neglect have a lot of contact throughout their lives with other governmental agencies - - -?---Yes.

- - - and often Youth Justice offending and mental health providers?---Yes.

So there is a tangible benefit, if I can put it that way, economically, isn't there, for trying to engage therapeutically very early?---Yes, it's a smaller percentage of the population that's really using a large percentage of the resources.

Are just in terms of working particularly with mothers, at page 22 you talk about the Tulane Institute of Infant Mental Health and talk about the intensive mental health assessment of the child, which we were discussing in terms of what your team does, but, "Intensive infant-parent psychotherapy to provide biological parents with a highly supported opportunity to change their parenting skills, and obviously there is a parallel with foster parents receive training and skill development." So from what you're saying, that's obviously a good model because it works with parents and also foster carers?---Yes.

And then you say that, "Staff at Louisiana State University have worked with judges to develop a protocol were young mothers are given the opportunity for intensive parent-infant psychotherapy." So is that where they're given an opportunity and there's some report back to the court of how that therapy is progressing?---Yes. They've actually set up an infant court, so it also has a Head Start Program attached to it and the therapeutic intervention. They've done a lot of work on educating the judges and the people within the legal system over there, so they take - I've actually got a document with me that they developed, "Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System."

Are you happy to give us a copy?---You can have that, yes.

Thank you?---And so as part of that they set up this infant court, so they educated legal representatives, they have - when families come into this court system they then give them an opportunity to see if those that they feel that they can work with, they send the child to the Head Start Program, they have the parent working with the infant, particularly they focus on young mothers and trying to support them. If then out of that they don't make any progress or for example the mother doesn't turn up to appointments, she doesn't use that experience, then obviously that provides considerable evidence that helps the judges to make decisions about whether they should terminate parents' rights.

I see. Would you have any objection if we tendered that? ---No, it's fine. You can keep it.

Thank you. Mr Commissioner, I propose to tender that document. Is just being shown to the representatives so I'll come back to that in just a moment?---I think - - -

In terms of following on from that, the support for maternal mental health and infant relationship, page 23 records that you have one mother-infant the in-patient bed based at Prince Charles Hospital mental health unit. That's the whole state?---Well, they really only take admissions from the Prince Charles's catchment. We don't have any other dedicated public perinatal and infant mental health beds.

This would be where there was a particularly acute situation, that you would provide this bed, one would think?---Yes. So they use it if they've - more often, I think, if a mother is psychotic or acutely suicidal they would admit her to that bed.

And you say, "In other states, including Western Australia, South Australia and Victoria, there are established public mother-baby units. In Western Australia there is

significant investment in establishing perinatal and infant mental health responses." I take it that is that a little like what Riverton provided in terms of where they could be admitted together, it's not part of a hospital physically but they provide intensive support for mothers and babies? ---Yes. Riverton is now - it was previously at Clayfield, it's moved into the grounds of the Prince Charles Hospital, and with that had a name change, so it's now Ellen Barron family centre.

Sorry, I'm showing my age?---That's fine. But it's a parenting centre, so it sits within paediatric and child health, it's not a mental health facility. The units in other states are a similar sort of stand-alone facility. Most often they're attached or close by to adult mental health services. So for example in South Australia they have something called Helen Mayo House in Adelaide. You can go out of the door and across the corridor and you're within the mental health service. One of the things we had been trying to propose in Queensland is that we actually have a centre in the grounds of Prince Charles Hospital because you have the adult mental health service located there plus you have the Ellen Barron family Centre, so you have the parenting support.

Yes?---One of the difficulties with working with these families is that you have a number of different types of interventions. John Bowlby himself said that you have to kind of approach this in a multi-layered way. You need to develop therapeutic relationships with the parents that you're working with because you have to provide them with an alternative relationship experience, so you have to work at building a relationship, as we talked about. You also have to build their skills as parents. Many of them lack basic parenting skills, and that's where places such as the Ellen Barron family centre and so on, and triple P, those sorts of programs have a role. The trickier role which sits largely within more mental health framework is that you actually have to change those internal working models that the parents have, so there's internal representations that the parents have of the child, of themselves and how they see it. Because often parents project onto the child their own internal experience. Probably a simple one to think about is if the child is a product of a rape and that mother and projects onto the child the trauma of the abusive father, particularly that's a male child that child will be at risk. That parent will struggle to see that child as not responsible for that, as an individual separate person. You really, from a mental health point of view, are really wanting to work to change the internal representation. That's the bit that takes a lot more time.

So is that - and also like if a parent has - and we're using the example of mothers - very severe depression, then you need to work with that issue of her internal self-representations, as you say?---Yes.

In terms of assisting them to parent?---Yes. And with depression, particularly postnatal depression often has a very strong biological component, so you need to make sure that they get appropriate medications and that's managed. Underpinning that, though, you can then find there are these are the things that are going on that then need work. One of the advantages of having beds is that you can actually, while the mother is recovering, admit the infant and keep the relationship supported and going, so you have workers that actually support the mother to connect with the infant during that time where she is unwell.

And also some good evidence-based observations, I imagine as well?---Absolutely, yes.

Yes, all right. Just excuse me. Yes, thank you very much. I have nothing further with this witness.

COMMISSIONER: The National Council of Juveniles and Family Court Judges Assistance Brief will be exhibit 121.

ADMITTED AND MARKED: "EXHIBIT 121"

MS McMILLAN: Thank you.

COMMISSIONER: Mr Hanger.

MR HANGER: You said, doctor, "We parent the way we have been parented," and I think you were quoting someone there. But before the age of three we don't have conscious memories. Does that statement that you make, "We parent the way we have been parented," apply to the experiences we've had before the age of three?---Absolutely.

Yes?---We start to lay memories down even in utero, so when a child is born it recognises its parents' voices, it recognises the mother's smell, it recognises the rate of the mother's heartbeat. They're all experiences, so they're sensory experiences that have been laid down. So in those early years we continue to lay down memory, and it's experiential memory. It's a bit like learning to ride a bike. If I said to you - if you didn't know how to ride a bike and I said to you, "Okay, what you have to do is you straddle the seat, you put a foot on each pedal, and then you gradually push down each pedal and you move forward," if you get on a bike, no matter what I say, you're actually not going to be able to ride the bike. We've all had that experience. It actually takes that repetition of experience to be able to learn to ride a bike or drive a car. Once you've done that it becomes quite automatic, but it's laid down as a procedure. That's what our memory of relationship is like. It's an experience that we have and so we lay that down as an experience and we do that antenatally and then from birth.

Thank you. So taking that answer into account with your earlier evidence, those first three years are absolutely crucial - - -?---Yes.

- - - to the way that you're going to be a parent?---Yes.

Is there - - - ?---Unless you have corrective experiences along the way.

Coming to those corrective experiences then, it is difficult to correct the damage done by abuse to a young child, is it not?---It takes more time. The brain is wired for those pathways to be laid down in an – the way it's wired is it happens at that point in time. That's kind of a critical window in which that really happens. After that we can lay down new pathways and have corrective experiences but they take – they're harder to do and they take more time. So we have this sort of thing where the brain is wired to do it early but at the same time we have plasticity. But it just – you really – the other thing is when you're correcting it it's essentially like earning security. We talk about earned security. It's never exactly the same as having that secure experience when you're supposed to be having it. It's not – it's a different quality, but you have the capacity to earn security and some of us do it in our marital relationships, where we have a corrective experience. It's always there in life.

Following on from that parenting, the way you've been parented, what is the research, if any, on the topic of whether abusers were originally abused as children?---I think there's – I can't quote specific references, but we know when you go back into the history of many of these people that has also been their experience. In a way, I would anticipate – you get to a point as a clinician in mental health where what presents is a pattern of behaviour and you really – when you see a specific pattern of behaviour you're able to anticipate the background and the history. So patterns of behaviour present and then we would be specifically asking the mother or the father questions around their own background, whether they've been the victims of abuse, because that's what we would be expecting to find.

Is that likely to be connected with epigenetics?---Yes, and that's kind of - - -

Carrying on the trauma from generation to generation? ---Yes, and that's what the template is about, that you lay this down and you change the genetic material in the next generation that comes out. They have actually done very elegant studies in rats that are able to show that for multiple generations, and bearing in mind that our emotional part of our brain we actually share with mammalian species; we're wired in similar ways. So they look at licking and nurturing behaviour in rats. If you remove pups from – or if they have a parent that is neglectful and doesn't care for them properly and that continues, they're going to repeat that in the next generation. You can remove them and put them with super mum pups, with mums that would look after them, but the damage is still done and it takes several generations of good caring to actually repair that in the rat model.

We're actually able to identify now the genetic change, I think, from generation to generation?---Yes, they're starting to be able to do that.

Anecdotally I've been advised that sexually abused females tend to choose males who will abuse their children. Is there any work done on that?---I think that's not an area that I have a lot of specific information on.

Okay, thank you. Nothing further, thank you, Mr Commissioner.

COMMISSIONER: Thank you. Ms Stewart?

MS STEWART: Good morning. I've just got the one question. Do you have any particular knowledge about the Aboriginal traditional child-rearing practices more relevant in the early years?---In terms of - - -

Attachment and - - -?--- - - - and that in the community context rather than the - - -

Yes?---Not in any great depth.

Nothing further, Mr Commissioner.

COMMISSIONER: Thank you. Mr Capper?

MR CAPPER: I just have a short question. In relation to – you were asked some questions about people coming into and out of a child's life, particularly in relation to the CSO, once a month the CVs and perhaps service delivery personnel. In relation to that, when we're dealing – most of the evidence you're giving is in relation to zero to four. Is that correct?---Well, that's my area of expertise, yes.

Okay, of course, and certainly in relation to that, in relation to the presence of another person in the home – and from what I understand, your evidence is the stability needs to be around the foster parent and the person that's there giving the care to a child on a day-to-day basis. Would that be correct?---Yes. The child has to have a stable relationship and you want at least one intimate sort of relationship, one close relationship, for that to happen.

Yes, and in relation to the CSO and the need for stability of that CSO, that's more to do with making sure that we can maintain continuity and stability in knowing the knowledge and the background and what the child's been through, where they're going, what the plan is, making sure that that's followed through and that we don't lose sort of information as we go if that keeps changing. Would that be right? ---Yes, there's an element of that, but if the CSO, I

think, is actively involved in supporting that infant or that young child and is doing things like taking them to contact visits, then I think you need some continuity. It's a very frightening experience and a stranger is frightening.

Most definitely?---So, yes, it depends really on what the role of the CSO is in that context, but maintaining that historical context of information becomes important.

So that's particularly relevant for the CSO where they're taking the child away from the carer. Would that be right? That becomes a particularly concerning issue?---Sorry, can you just clarify what you're asking?

Well, the concern that you've raised by that comment, as I understand, is that the concerning prospect – we put them with the carer and we need to be very careful to ensure that they maintain that attachment and that relationship, and to remove them from that carer, placed with a CSO to take them off somewhere else, that's the frightening aspect. Would you agree with that?---Yes.

So that's where the harm could be caused. Would that be right?---Of having multiple CSOs.

Of multiple CSOs or multiple strangers, as the child would see it?---Yes.

But it's the removal from the carer, not the presence of a stranger, would that be right, if the carer remained present?---Yes. If the child – the way the attachment system works, and this is what you can look at. The whole stranger situation, laboratory paradigm, is based on this.

Yes?---If a child has a secure relationship with the person who is the primary person looking after them, if you introduce a stranger then that child's attachment system will be activated, because the stranger is seen as a threat to their survival.

Yes?---Once you activate that system the child should be using their secure base. So their main person, they should be using them to manage their anxiety in the face of that stranger. One of the things that often happens is that the foster parents don't seem to have a role say in supporting the child to go to contact. You have this thing where the CSO might come and take the child away.

That's right?---So you're actually not allowing that secure base to come with the child to support that contact visit and really support that child to manage both the stranger of the CSO but also these very stressful people that they have traumatic memories about.

Most definitely?---So you take away the secure base out of

that picture, and I think we need to think about how we can actually much more support contact and reunification processes in the interests of the child, because I think often we think about them from the interests of the parent, they need to have contact or they want to be reunified, but the way we set our processes up we don't have the child in the centre. They're not focused around the child. It's not like we have the foster parent who is their secure base, the biological parent and the CSO maybe all sitting down on the floor on a rug with toys so that the child can use the foster parent to try and then explore relationships with these other people that they don't know very well or are scared of.

Yes?---I think if we could think differently about how we use foster carers to support even looking at reunification - it's a bit like having a grandmother supporting mother, I think.

I guess what I'm trying to differentiate is the idea that we're going to take the child away with a CSO, with a stranger, as the child is concerned is to - the concern in part, and I guess we need to - I guess what I want to clarify is do you understand that in terms of the community visitor, for example, that a community visitor visits the home, the foster carer is present, particularly in this nought to four-year-old they talk to the carer more so than the child, they obviously don't interact so much with the child. Do you acknowledge that?---I don't know a lot about the community visitors, but I imagine it would be like any household where you have a visitor come into it. It's really how you structure it. I mean, most of us would say to our children, "Such and such is at the door. They've come to talk to me." You would provide context and information around that.

Yes?---One of the difficulties, I think, for children that have been traumatised is that they have this heightened arousal about adults or strangers and their first response would be, "Is this person a threat?" So it would be different to say, perhaps, our children, when we have a strange come to the house, who have a much more secure base and wouldn't necessarily find adults or strangers to be such a threat. So they need a lot more scaffolding and support around that process, plus you can do a lot to manage that sort of thing. You know, you can have a board on the fridge, for example, that has a photo of the community visitor and the child gets an explanation and they know that this is a person that's going to come and why they come. Even small children you can explain those things to. So it really is about how we structure all of that to maintain that sense of security.

Okay, certainly. So in relation to that, I mean, I guess it terms of that the community visitor comes in once a month, which is obviously not frequent in terms of a

child's life but certainly enough to raise concerns, from what you've said. So the issue is about making sure that they understand the role of the community visitor, which is there to advocate for their interests. So that needs to be - you're saying even in young children that could be brought to their attention or explained to them in a way that they would understand in some circumstances?---Yes. I think that you can explain that.

Do you agree that the role of community visitor being there to look after the child's interests, to advocate on the child's behalf in relation to ensuring that they receive the care that they need whilst in care, do you agree that that's a valuable exercise or certainly a safeguard for that child whilst in care?---Yes, I do.

Thank you. In relation to that, once they get beyond that age, beyond that zero to four that the community visitors are talking to, certainly our data, certainly in the survey, suggests that almost 80 per cent like seeing their community visitors, enjoy their visits. In fact, 20 per cent want to see them more often. That's the survey data we're receiving. Would that make sense to you? ---Okay, this is with older children?

This is certainly beyond five. The community visitors certainly don't talk to the children below four. They focus on talking to the carer about their needs, but certainly from five on the community visitors talk to the children. Would that be an appropriate age and would they be able to extrapolate their opinions, I guess, at that point about their views and should their views be - can we give weight to that finding that they feel safe and comfortable in that?---I would think that there's a role for the community visitor to be talking to the child at any age, because if they're going to continue on then you really need to build that relationship.

Yes?---I work with four-year-olds who have had very traumatic experiences with their mothers, for example, who are incredibly verbal in being able to say, "I don't want to see her again for this and this and this reason. These are the things she did to me." So I think even at a younger age they have a capacity to actually know and, you know, form those relationships and be able to provide them with information. So I think it's a really important thing that they develop a relationship and that the child has a sense that there are people there that will advocate for them. Eventually that person will become another safe adult and it's another relationship that you can develop that's positive, because really the more of those that we can develop the better it is for the child. So I would be wanting those community visitors to start having a relationship even with the baby. I mean, they can talk to them, but you do that in the presence of the foster carer, as you would do in any normal family situation.

Similarly, we'd want stability in terms of the community visitor being regular and the same person wherever possible?---Wherever possible, yes.

That's the same stability month to month?---Yes, because that's what they need. They need these long-term positive relationship experiences that become reparative.

Yes?---Particularly if it's someone who is independent who they can learn to trust and if something does go wrong in the placement further down the track they at least then have a relationship that they can use to manage that.

Thank you.

COMMISSIONER: Ms McMillan?

MS McMILLAN: I have no re-examination for the doctor. Might she be excused?

COMMISSIONER: Yes. Doctor, thank you very much. You're excused?---Thank you.

Thank you for your time and your evidence. It's much appreciated.

WITNESS WITHDREW

MS McMILLAN: Could we just have a short break, say 10, 15 minutes?

COMMISSIONER: 10 minutes, yes.

THE COMMISSION ADJOURNED AT 11.39 AM

THE COMMISSION RESUMED AT 11.55 AM

COMMISSIONER: Ms McMillan?

MS McMILLAN: Thank you, Mr Commissioner. I call Dr Brett McDermott.

**McDERMOTT, BRETT MARTIN CHARLES** affirmed:

ASSOCIATE: For recording purposes please state your full name, your occupation and your business address?---Brett Martin Charles McDermott. I'm executive director of the Mater Child and Youth Mental Health Service at South Brisbane.

COMMISSIONER: Good morning, doctor; welcome. Yes, Ms McMillan?

MS McMILLAN: Thank you.

Dr McDermott, you have trained in psychiatry and child psychiatry in the United Kingdom and in Sydney?---Correct.

Your current appointments are the executive director of the Mater Child and Youth Mental Health Service in Brisbane, chair of the Queensland Child and Youth Disaster Response, professorial fellow at the Mater Medical Research Institute and associate professor at the University of Queensland. You're also a bi-fellow at Churchill College Cambridge University and a director of the Australian national depression initiative beyondblue. Your clinical and research areas of interest include children and adolescents with depression, post-traumatic mental health and child and youth mental health service provision. Have I left anything out?---I think that's enough.

That's about it. Doctor, can I ask you: how long have you been qualified as a psychiatrist?---I qualified in 1995.

Since that time, where have you been in terms of your vocational work?---Most of the time was in two positions. I was the professor in the University of Western Australia, at the Princess Margaret Hospital for Children and for the last 10 years at the Mater Children's Hospital.

Thank you. Doctor, did you prepare a submission for this inquiry which is signed on behalf of you dated November this year?---I did.

Are the contents of that true and correct?---They are.

Yes, I tender that, Mr Commissioner. I should just indicate Dr McDermott hasn't provided a statement as such. This will be the evidence he gives.

COMMISSIONER: All right.

MS McMILLAN: Doctor, thank you for making yourself available.

COMMISSIONER: The submission will be admitted and marked exhibit 122.

ADMITTED AND MARKED: "EXHIBIT 122"

MS McMILLAN: There's no reason why this couldn't be published on the web site, the contents of your submission? ---No, there's no reason at all.

All right, thank you. Thank you for making yourself available. I understand you have just re-entered Australia. Now, can I just ask you in terms of your submission, do you have a copy with you?---Yes.

You say that the brief submission is to ensure the inquiry is aware of the current neurobiological revolution. I take it inherent in the description of the revolution means that it's clearly something - this school of thought, if I can put it this way, is obviously revolutionary in nature?---I used that term to emphasise that biology in the last 10 years has had an order of change of several magnitudes. We can do things now that we could only dream about 10 or 15 years ago. It's been truly a revolution in technology.

Does that include, for instance, you have given examples understanding brain functioning with a functional MRI and, I understand, issues such as the decoding of the human genome?---Yes.

Are they the types of advances that you're talking about? ---Yes.

At the bottom of page 1 you've indicated the issues relevant to child protection about the evidence of structural brain damage in abused children and I take it that's a particular area of interest of yours of impact on the brain as a result of trauma?---That's correct.

Secondly, evidence of parenting affecting gene programming, evidence explaining how trauma-related biological functioning is passed on between generations and, fourthly, evidence that adverse child experiences also have a profound effect on later physical health. Now, doctor, I indicate evidence has already been given by Dr Stephen Stathis who you would know of - - -?---Yes, that's correct.

- - - and Dr Hoehn about structural brain damage issues and also profound impacts on later physical health, but can I ask you something about the evidence affecting gene programming. Could you explain a little more about that? ---Absolutely; and I've mentioned the words "the central

dogma". We thought for decades that genes caused the production of proteins in a very linear fashion. You have a gene. It does this job. It creates a protein which is kind of the building blocks of humanity. We now know that that's actually not true and that you can make genes work faster or in fact you can make genes work slower and the seminal studies have been done to show that in fact parenting, good parenting, make your genome work faster and be more efficient and make its stress responses better and you respond to your environment in a much more kind of, you know, rigorous and reactive way, whereas bad parenting in fact closes off your genome and makes the reactions much more all or nothing, much less regulated, much less sophisticated, and it's called "gene programming". It happens early in life. In fact it probably can happen in utero as well and it sets people up for a way of interacting with the environment for the rest of their life.

So postnatally, what is the critical time in your view for this gene programming to occur in a child?---Probably the first five years of life but very critically the first two years of life. In fact around birth if you understand the word, a synapse is a connection between two brain cells. At birth you're making 40,000 connections per second, okay. That is an astronomical number. I mean, basically that's filling the GABBA to capacity and shaking hands with the person beside you and shaking the hands of everybody in that stadium every second for three months, okay. That's the astronomical nature of brain connectivity in the first few months of life. If you want to wreck a human being, you actually damage that process in those first few years of life.

So those synapses, that is, the shaking of the hands, just doesn't occur?---Well, the architecture is less rich. The tree, if you like, is more bare. It has less connections.

I imagine it would vary from individual to individual about how much neglectful or abusive parenting would affect that? ---Yes, and there's now good - well, there's now emerging evidence that it's a dose response. So the cited paper on loss of brain volume with sexual abuse - it was correlated with the amount of sexual abuse so we think the correlation is with the amount of abuse.

And over a certain period or - - -?---Seems to be critical periods so again I think figure 3 of the submission shows that in terms of physical abuse around four years of age is a critical period and we have a suspicion that there's different periods for different types of brain functioning.

Just for those of us less adept at understanding this area, would I be right in thinking that there are probably critical ages that certain parts of the brain development occurs at that are impeded greatly if the child is subject

to abuse or neglect?---Absolutely.

So, for instance, it might be four, as you say, for the hippocampus, was it?---Yes.

That's a critical time?---Yes.

It might be younger in age that another part of the brain develops?---That's correct.

So I think Dr Hoehn - I don't know how much of her evidence you heard, but she talked about the frontal part of the brain developing in those zero to two years?---Yes.

And that being very impeded if the child was subject to either neglect or abuse?---Yes.

That part is higher functioning, isn't it, that front part of the brain in broad terms?---Yes, and I've alluded a little bit to that on figure 2. It actually is about physical abuse in the frontal lobe.

Yes?---These figures are - obviously they're too fine for you to actually get much out of looking at them. They are really rhetorical.

Yes, for those of us who don't have the skill perhaps to interpret them either?---That's right, they're rhetorical. And the point is that the executive function and decision-making part of the brain is the frontal lobe.

So this figure 1 reference is Tomoda. Is that a Japanese study?---Akemi Tomoda are a Japanese professor who hangs out in Harvard, so it's actually a joint US - - -

Right?---All of those are joint US-Japanese studies.

And this figure reflects that young women who have abuse histories as a child have on average an 18 per cent reduction in the volume of the visual cortex?---Yes.

So that is the part, is it, that is responsible for higher functioning?---That study is actually - that study is really just talking about the perception of visual stimuli.

All right. Okay, thank you?---And the second one is about the executive functioning. I mean, the important thing about that study, while we've just mentioned it, is that these are women who were 18 to 25 years of age so the key importance there is if you don't do something it seems as though this damage is with you, you know - - -

Into adulthood?---Into adulthood, and there's very little evidence - very little evidence that that's going to change once you're 25. You don't make grey cells in your brain when you're 25.

COMMISSIONER: So, doctor, am I right in thinking that your figure 3 shows that verbal abuse of a child at four or around that time will cause neurobiological changes for the life of the child?---All of these studies are in adults, so these deficits last into adulthood. What they've done is they've been very ethical, they've waited till people turned the age of 18 and they can give informed consent, so they don't MRI four-year-olds, so these are all in young adults. And looking back, they've correlated with when the history from the court or the personal history of when the abuse occurred, that correlated that to the brain findings.

So just as someone looking into the responsibility of the state for protecting children, if the damage is being done to them at around four by parents who are verbally abusive, how does the state exercise its responsibility of protection in that circumstance?---I think the take-home message from the neurobiology is that protection earlier is overwhelmingly better and that there are some groups that we need to have a special interest, and that's babies and pregnant women who have abuse histories themselves. These are extremely high risk groups for the offspring having brain damage.

So how do you positively identify them and avoid false positive recognitions?---At the moment that technology - I mean, the revolution hasn't got to the point of a biological test, although it is highly likely tomorrow we would have a biological test, but ethics lags 10 to 15 years behind science and the ethics of this, you know, is

difficult. So for instance, I mean, I can MRI a baby. Now, because that's magnetic resonance imaging there is no radioactivity, there is no radiation, it's actually an incredibly safe test to do.

MS McMILLAN: It's safer than CT scanning, isn't it? ---It's safer than a blood test, it's safer than everything. All you're doing is lining up your whole body, dipoles in a huge magnetic field, and then letting them turn back. It sounds frightening.

Can I ask how you keep a baby still, though?---Yes, that's true. There is a way of doing it. The problem is society is not ready for that, but I think that sooner or later we will be. The same with genetic tests, I could now say that there are some genetic tests would make you overwhelmingly more likely to become depressed and suicidal. Now, society is not quite ready - I can do that test for $2 at the Mater but we're not quite ready for that yet.

COMMISSIONER: And the purpose of doing it is to do something about it?---Well, the purpose for doing it for me would be to direct rare resources to those who really need it. So for instance if I found someone had a certain gene that make them a very low risk of depression I would say, "Off you go, Sunshine, go to this website. Do some on line psychoeducation and you'll be okay." But if you've got the high vulnerability gene I'd say, "Come here, I need to provide my rare resources to you." And I think in 20 years' time that's actually what we'll be doing.

MS McMILLAN: In fact does this perhaps tie in with the other area wanted to ask you about, the passing on of abuse experiences across generations?---Yes.

Can you explain little more about that, please?---Yes. There's now very good evidence that if you get abused your gene name is more tightly ravelled, it's actually physically tighter, and if your messenger RNA and you're trying to read that it's almost like a knot of wool. It's actually very hard to read. If you're not abused your genome is much more unravelled, it easier to read and it works faster. This is ravelling-unravelling process is passed through generations.

So that can you tell us a little bit about this study of Yehuda, working with women pregnant during the 9-11 tragedy in New York and what that indicated?---Yes. Well, Rachel Yehuda has had a series of studies and she's look also at the children of Holocaust survivors and found that the gene pattern of abused people is actually not randomly passed on, it's very specifically passed on to the child, so the degree of ravelling and unravelling of your genome, ergo the speed with which your genome works, it's actually passed through generations.

So - sorry, doctor, go on?---And she looked at people after 9-11, mothers who were pregnant and have different levels of exposure to that tragedy. The highly exposed, their genome was more ravelled and tighter and the genome of the babies was more ravelled and tighter.

And I suppose there were controls to obviously isolate whether that had other abusive experiences?---Yes.

COMMISSIONER: Doctor, when you say abuse, do you mean trauma?---In the Yehuda studies it was exposed to thinking you were going to die in 9-11.

All right?---So it was emotional trauma.

Emotional blow?---It was emotional trauma.

This is the sort of harm that I'm concerned with by the law: it is defined as, "Any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing." Now, that's what harm is and that's what the state protects a child from, that sort of harm. It doesn't matter how it's caused, but the trick of course is to identify the child who needs protection because of that harm and is otherwise unprotected by a parent. Identifying a significant detrimental effect on emotional wellbeing, how would you identify that without an MRI?---Sure. It depends on the age. This is where child and youth practitioners I think have a lot of expertise over adult practitioners. You have a different assessment process for a different age. When they're extremely young it's all about parenting and attachment, and I'm sure Dr Hoehn talked a lot about this, so it's about attachment behaviour. And in every animal on the planet there's actually secure attachment behaviour or anxious and insecure attachment behaviour.

Is this what Anna Freud called psychological parent?---It relates to that. It relates to that, and so for instance the baby - Anna Freud was talking about the baby has no interest in genetics.

Yes?---It has no interest in biology, it actually wants to know who loves them.

And doesn't care whether they're natural parents or not? ---Doesn't care at all. And frankly, nor do I.

Yes?---I'm interested in who is the psychological parent.

Yes?---So at the very young age I'm looking at the parenting ability, the parenting style, how abusive or neglectful the parenting is and how the baby responds to the parent. So for instance if I've just met a baby and they're overwhelmingly more interested in me and clearly are anxious or scared about that parent, who they've been

with for months, I'm immediately extremely worried.

Now, later on assessment can pick up more where the child is. You can actually pick up abuse and neglect symptoms from a four or five-year-old, from a six-year-old, and of course when they're eight or nine and 10 they can speak and tell you about post-traumatic stress disorder or they can tell you about, you know, various other mental health manifestations.

By that time it might be too late, really, to really protect them from the harm that we're supposed to be protecting them from, because there might be permanent damage?---Yes.

So if you were the one – just say you were a child safety officer and you've got to work out whether there's – you've got to balance two things. You've got to work out whether the state is going to actually intervene in family life here, which we're reluctant to do by tradition, and the softer the intervention, actually, the more intrusive it is, but we're at the point of coercive intervention, that is, it's involuntary, they don't want you there, and your call is has this child suffered relevant harm which for the purposes of the question is a significant detriment to their emotional wellbeing. What are you going to look for to make that decision?---Yes. I'm going to look for, generally speaking – in my clinical practice I do have some of these issues, and in my service wing. I would actually look for psychosocial impairment. I would look for at the age of the child, no matter what their age is, how, if you like – how many standard deviations less than the rest of people that age are they functioning in their personal abilities, in their abilities with peers, in their abilities at school and in their abilities with parents and society. So, for instance, are they two standard deviations more anxious, it's manifest at school by having peer problems, it's manifest at school by having problems sitting on their bottom in class and attending and they're generally slipping away from the cultural mores of society. So I actually don't base it on symptoms, I base it on impairment and how far their trajectory has deviated from other kids their age.

So you can measure that?---You can measure that.

The measurements will tell you whether the child has suffered that form of harm and then you can work out – and the cause, according to the law, is irrelevant, but would one of the causes for that harm be verbal abuse, for example?---It could be. Any of the abuses can cause most of these things. So what you do is you say, "This is an impaired child."

Yes?---If you like, the metaphor for a GP is, "This person is crook," okay, "This person has an issue," and then the next step is to work out if abuse and neglect is the most likely cause, because of course in my position I can't always say that.

No?---But on the basis of probabilities is that the most likely cause, and then, you know, I would intervene accordingly.

You would exclude a genetic or organic cause?---Yes, a medical – yes, absolutely.

That must be pretty hard. That must take you a lot of training and experience to be able to accurately measure those things?---Yes.

You're not likely to be able to do it as a CSO straight out of university, are you?---I think it would be impossible, and that's a problem with the system. I think that in health and child mental health we have very rapid recourse up the chain to a very senior clinician. So, you know, one night a week for the last 20 years I've been on the end of the phone to any of my staff, and that's a very quick way of getting up to someone who is at that level of experience, but of course in other systems that is not available, and that's a major flaw.

MS McMILLAN: _So – I'm sorry, go on.

COMMISSIONER: So if I was designing a system that was flawless in this respect and I didn't want to over-include or under-include an emotional harm to child, would I need somebody like you on the end of the phone before I made that judgment?---Well, it's the way we work in health. So, for instance, any child who comes in suicidal to the Mater accident and emergency, child accident and emergency, has to run their assessment past a senior specialist. That's actually our business process. The senior specialist knows that one night a week they have to be on their best behaviour and they're there by the phone and they're not allowed to go out and they will give that high level of advice to that person who has been trained up to make an assessment any hour of the day.

All right. Now I'm going to ask you a harder question. Say, for example, the child in question is an infant, newly born. The question is whether that child is at an unacceptable risk of emotional harm as being the reason for intervention. How could you safely tell without doing an MRI on that child?---We have a very clear protocol to err on the side of over-inclusion for - you know, the more defenceless you are the more we would over-include. So some of those kids we would actually put them in hospital. We would say – and we don't put them in a mental health ward, we put them in a paediatric bed, which is fairly acceptable in society.

So you avoid the – you err on the side of safety but it would be non-stigmatising?---Absolutely.

What about the attachment and bonding process?---Well, then we are very keen over the next 24 to 48 hours to watch every parent-child interaction. We have a consultation liaison team, which is a team of mental health professionals that works in the physical part of the hospital and they would be part of that care team and everyone would know what the issue is here. You might be in a medical bed for asthma but everyone would know that this is all about observation of attachment. Over 24 hours the decision becomes much easier.

Does it?---Absolutely.

MS McMILLAN: Because I take it you've got some very good evidence based observations of that baby and parents or other significant persons in that baby's life. Correct? ---Absolutely. You don't have a half an hour or a one-hour assessment, you might have a 36-hour assessment.

So you would be looking at even basic parenting skills, wouldn't you, like do they know how to pick up the baby, feed the baby, those sorts of things?---Yes.

But also those non-verbal interactions, all of those sorts of issues?---Yes.

Which I take it for highly trained clinicians are very significant?---Yes. You can objectify this quite well, and people who are very – I mean, and, of course, you know, you have to – you know, again, there is nuance and sophistication. You are allowed not to be a wonderful parent but there are some basics about parenting babies you have to do. You have to hold them in a way that won't drop them, you have to look at them, you know, you have to - - -

Yes?---You know, there are some basics that you have to be able to do.

Also whether the parent visits?---Yes.

That might be - - -?---Yes, and also the interactions between the parent and ward staff can be extremely telling.

Yes?---So if you are projecting anger or whatever relentlessly around those 30 hours when you're meant to be on your best behaviour, that can be very telling.

And it might be too - - -

COMMISSIONER: Are you – sorry. Are you doing this at the request of the department or off your own bat?---We would – well, both. Both. If I am concerned, if it's a baby, then I will say, "Gee, you know, I think they need a medical bed. I don't care what you call it. I don't care if you call it asthma, that kid needs to come in and we need to observe them."

MS McMILLAN: I take it other things you would be interested in, do the parents come together, are they supported by extended family. All of those sorts of things you would be interested in?---Yes, and it's quite a – well, the other thing we're very interested in is: is there any evidence of the parent withdrawing from substances, is there a substance abuse issue, those kind of issues.

How do you effect that training so that in effect your clinicians know all of these things to look for? I know that sounds a trite question, but how do you get that quality assurance, if you like?---Yes. I'm extremely

fortunate at the Mater. We have very impressive staff retention rates. The average age of the Mater clinicians is actually 47. So these are people who have got 15 years of experience.

What do you think is perhaps part of the secret of the staff retention, because obviously in the role that you and your staff perform, at times it would be confronting, distressing even, the type of experience that a lot of probably child safety officers in some fashion undergo? ---Because I'm the director of the service you probably should ask someone else.

All right?---However, I suspect it's good management.

All right. I just wanted to ask a couple of things while we're on the genetic issues. Is the interesting part about the genetic transition, if I can put it that way, between, say, mother and child of interest because, one, you're more likely to be able to pick up children who are going to be vulnerable to risk and so rather than stigmatise them you say, "Well, look, this looks like" - particularly combined with other factors you see a mother antenatally that they're going to need further support?---Yes. I think the issue about transition is kind of multiple so, for instance, it explains why some magistrates comes and tell me, you know, "It's strange that I had before me the mother. Now I have before me the child and I suspect I'll have before me the grandchild one day." These things run in families. It's partly environment but actually it's partly genetic, okay. The second thing is we can actually help clinicians move away from the behaviour so there might have been some assaultive behaviour and point out that this is partly caused generations past and this has been carried through. The third thing is if we actually treat the person - and there's a whole bunch of things we can do like delaying the onset of the next child, increasing education, doing a whole bunch of things - you can actually break this cycle.

Can you in fact alter - is there evidence to show that you can alter some of that ravelling and unravelling?---Yes. One of the fascinating studies was with little traumatised rats and if you adopted them very early, over time their genetic programming started to look much more like the good adopted parents as opposed to their biological ones.

That was my next question. Let's say you have a very young child under two. A decision is made to, say, remove them from that abusive environment. Is there evidence to show that if they're in a good, stable placement receiving appropriate parenting, that genetic programming, if you like, can be regularised, if I can put it that way?---Yes, that's the really crucial and exciting issue, that in animal models - because, of course, it's hard to show this in humans, although we're getting to the technology where we can. In animal models you can normalise their gene programming if you're exposed over several years to good parenting.

All right. So it sounds like getting it right in those early years is vitally important?---Yes.

Dr Hoehn spoke of her team that you no doubt know of that is comprised of multidisciplines, child psychiatrics, social workers, psychologists, making assessments in terms of what a child needs, what a parent needs and probably what a foster parent needs to support the child. Do you think when a decision is made (1) it needs to be made sooner than later in terms of trying to assist a child who may have been subjected to neglect or abuse but (2) that it

be an in-depth assessment so that it gets it right as far as possible early in that child's life?---Yes. I mean, the biology is very clear. Getting it early and getting it - obviously getting it right is helpful but getting it earlier is more helpful. We're not talking here about necessarily removal. It might be scaffolding parenting and I think, by the way, it needs to be at multiple levels. I mean, for instance, we have a national depression initiative beyondblue which has arguably changed the face of stigma around depression. We don't have a national parenting initiative and I would argue that it's - and this is from someone who is a beyondblue board member. I would argue that's more important than beyondblue.

Because it would encompass issues such as depression? ---Well, because if you get parenting right and you get gene programming right, you are less vulnerable to depression, anxiety and future abuse.

In fact, doctor, I want to ask you about some of your experience in practice but also in relation to your board membership of beyondblue. Now, I just want to work with some figures at the moment. This week two documents were tendered - tabled in parliament. One is the Deaths of Children and Young People, the annual report by the Children's Commissioner, and the second one is the Queensland Child Death Case Review Committee. Now, can I tender the second document now, Mr Commissioner? I tendered the first one earlier. Everyone has copies, Mr Commissioner.

In terms of children and young people the annual report indicates that in the last year children known to the child protection system died at a rate of 54 deaths per 100,000 compared with 447 per 100,000 for all Queensland children. Of the 486 children and young people whose deaths were registered in this last year 88 were known to the child protection system within three years of the child's death. Now, there were 20 suicides of children and young people during 2011-12. Six of those identified as Aboriginal and Torres Strait Islander, 14 were identified as having previous suicidal thoughts and/or behaviours, including ideation. 13 of them stated or implied their intent either verbally, online or via SMS. 10 of them who took their own lives were known to the child protection system. That was three times greater than for all youth in Queensland. Six Aboriginal and Torres Strait Islander children took their own lives at a rate of six times that of indigenous youth. Now, if I can just turn to then the Child Death Review Committee figures, suicide was the second leading external cause of death behind transport - I take it obviously road accidents, one would think - with six children suiciding. This is of the 73 cases that they looked at. Now, just in terms of those figures in terms of then the children who suicided, 20 suicides, it seems that 14 of them were identified as having previous suicidal thoughts or

ideations. Now, I take it in your practice - and given when you say you've been rostered on one night a week for the last 20 years, I take it a considerable proportion of those would probably be urgent questions about young people who express suicidal ideation or self-harming behaviour? ---Probably about 70 to 80 per cent.

All right; and I take it that that is - is it because of two things? One is the gravity of the risk posed and the need to access obviously expert assistance, but (2) because of the prevalence of self-harming and suicidal ideation of that cohort, adolescents?---I think both are correct.

All right; and in terms of those issues I take it you have no doubt given great thought to issues relating to children and young people who express suicidal ideation and self-harming behaviour generally. What is it that in your view is effective and what might be learnt in terms of assisting child protection workers to understand this particular problem?---Okay. In a suicide risk assessment there's - and we obviously train everybody in our service to do this. There are two aspects: one is an aspect around what they did and why they're actually in the accident and emergency department and that's all about the riskiness of what they did and the intent of whether they really, really wanted to die or not, and there's quite a lot of nuance and kind of training around that, but there are very clear guidelines about what's real suicide risk. So an example might be someone who takes an overdose 10 minutes before 5 o'clock with the rest of the family coming home at 5 o'clock every day for the last 15 years is not intending to kill themselves. The person who takes the overdose 10 minutes after everyone left anticipating no-one home for 10 hours is really very dangerous. So there's clear assessment sophistication around that, but the other thing is that I always say that there is cumulative risk and you need to do the assessment of what's happened now but you need to look at over time are there factors that increase the probability. The one factor that overwhelmingly increases the probability is if they've been abused or neglected or a proxy measure like in the care of the state and I would tell my junior colleagues that that increases the chance three to five times and that fits very nicely with the figures that you've produced there.

Knowing that those figures, by the way, are probably an under-report because some of the ones in the non-abuse group probably were.

Yes, and there's always an issue, isn't there, about trapping that data accurately. So in terms then of that, can you just indicate how is it that these children and young people are assisted in the health facility that you work within?---We make some - we have an algorithm that's pretty clear. If the risk is unacceptable they're briefly and overnight managed in a way that markedly decreases the risk. So if the parent - the best thing is if a parent is willing and able to sit with them on some rostered basis all night, that's actually the best outcome because the parents are empowered to do that and you can bring in uncles and auntie's and whoever. That's the best outcome. But if you can't achieve that outcome then we would put them into hospital for 24 hours just to circuit-break that incredible risk. If they're less risky we would send them home, and we actually send most home. I would send most people home and we follow them up with our extended hours service which would telephone them, you know, every 10 hours or whatever we think is appropriate and get them an emergency appointment into our care system, so they'd see a professional very quickly depending on their level of risk. So there is a risk response to different levels.

Is it your experience that for child safety workers there's not that level of ability to access a very senior, say, consultant level person such as yourself?---They have, I would suspect, almost no recourse to someone like me and I think that that needs to be changed.

Speaking obviously only for yourself necessarily, do you think that you would be prepared to work within a system that they could access a senior consultant if they were very concerned about a particular young person and what might be occurring, or to try to understand that behaviour in context? Do you think there's a facility, or would you be willing to work within that sort of system?---In a regional system - health works on a regional system - in a regional system it would actually be surprisingly easy to do this and we would be very prepared to do this. I mean, clearly there are some resource implications but I would remind you that early intervention overwhelmingly saves you money and eventually these kids might come to us anyway, so being able to intervene quicker and earlier would end up being cost-effective.

And just indicate, are the patterns of suicidal behaviour different for an adolescent, generally speaking, then for an adult?---Adolescent behaviour is generally speaking quicker and more impressive.

Is that because of their impulsivity, generally?---People who have complex emotional trauma, one of the issues they

have is they're - the technical term, and I think it's a wonderful term - is they're disregulated, so they're not able to maintain their mood within the confines that I might; they're not able to maintain their impulsivity in more regular confines, and their aggression, their behaviour. Disregulation means that problems happen quicker and they're more spectacular, and that's a feature of adolescence.

Okay. Now, in the child death review committee it identified in four of eight cases that the department - this is of child safety - "missed opportunities to provide ongoing support to the children and their families. Had the department focused on their core responsibility to provide a holistic child-centred service delivery and to identify and follow up with support options, it may have been a better place to address the mental health needs of the children." In particular it was observed that, "There was a lack of communication, information sharing, engagement and coordination of service delivery with other agencies, including child and youth mental health services, disability services, the child's school, and other support services." Bearing in mind probably you're best placed to comment on mental health services, what you say about that? Is that a fair reflection in your experience where there's been an adverse outcomes - if I can put it that way - for young people that you've had contact with?---Absolutely. I think there's lots of examples where the systems have failed young people, and this not only is child safety, this is health as well, but also the non-government organisational system. NGOs sometimes had been structured in a way that they find it very hard to intervene because of their internal business rules and, you know, various ways of acting that we don't have those issues in health. So there are issues within each system; there are very clear issues across systems. So one example is we've offered supervision and I've said, "We will provide for free supervision to your NGO around these children," and that's not a bad offer for a very senior clinician, and these offers haven't been accepted. It has got much better with the Evolve system - the Evolve system of care - but of course that only accounts for a very small percentage. And even then there are some issues accepting help in that system.

And can I just ask you, Dr Connor's evidence yesterday that it was her experience that adolescents are pretty much - fall between the cracks. That's my summary of it, that often there's an intervention with parental agreement, that things are termed as parent-child conflict rather than looking at the underlying causes and therefore treatment of them. Would you think about that?---I think - and this is in the process I shared last year, the Australian clinical practice guidelines for adolescent depression, it was very clear that in certain areas expertise around adolescent health was poor; the number of adolescence centres of

excellence were not very widespread; understanding of their differences in presentation of depression in adolescence was fairly poor. It's clearly something that some systems don't do well. Probably they do best children in the middle child years, and infants and adolescents they do more poorly, as a generalisation.

Another observation of that committee was that follow-up was, "Minimal by child safety service centre to ensure that referrals were being followed and to seek follow-up information to inform decision-making." Are you able to comment on that at all from your experience?---I think different services and different organisations have different standards. In health the standards I think generally speaking are in fact very high and if there's not follow-up of the child at risk that they have to come and see me and explain why that is and it's not pretty. So I think standards do greatly differ. If I hear a person from accident and emergency hasn't been followed up in a day when that was the agreement, I mean, that is a major problem. So I think the standards of professionalism and expectation to differ and that's something we could improve on.

And, "There was no collaborative or coordinated response by the department to the child's suicidal ideations, suicide attempts." Are you able to comment on that from your experience?---Certainly not on the individual case, but there are, you know, collaboration is - it's an interesting thing, really. We had a process in Brisbane probably eight years ago and it was kind of the - it was called the SLAO process, senior level action officers. These were people who were essentially head of department from health, child mental health, juvenile justice, then families and communities, child protection, and we would meet around a case. This was the most effective process I've ever seen, and around a particular case we could mount an extraordinary response. So for instance a young lady in care was attempting to hang herself at railway stations, and she done this three times, and I said, "If she presents at an accident and emergency anywhere in Australia we will fly her back to our unit. She likes our unit, she's attached to a unit. We will treat her well. And I don't care where she turns up." It was an extraordinary response. And that level of very senior executive support, and then of course people will say, "Well, if you're going to do that extraordinary response we will do this and we will put a special alert on the police assistance." It was a very coordinated response at a very senior level. For some very strange reason this process was ceased - - -

By whom?---By some former – I don't know, but we actually can do this well if the senior players are empowered to do this. We have done it in Brisbane before extremely well. That process doesn't exist anymore.

I take it from your answer that you think that would be very beneficial?---I think it would save lives, and I think also having – as a director of mental health, developing a personal relationship with the director of communities meant that that person rang me up and said, "Brett, I want a favour," to which I was defenceless to say no, because we had a personal relationship. I'd say, "What do you want?" and vice versa. I would ring up TAFE and say, "I want a special program for this kid, mate. Do I have to remind you of all the good things I've done for you?" "No." "Good." The system worked extremely well.

COMMISSIONER: How did it come – we don't know why it died out, but what was the impetus for this?---I suspect a child death. I think there was actually a very – at a senior level in premier's there was a person who had a project role who dreamt this up. It was a trial. It was a trial over two or three years and it was extremely successful. I could out of session provide counsel assisting - - -

MS McMILLAN: Yes, please?--- - - - with some information about it.

COMMISSIONER: Yes, that would be good, thanks?---It was extremely helpful.

MS McMILLAN: Now, I just want to ask you, lastly, could you tell the inquiry what is the Barrett Centre and where is it located?---The Barrett Adolescent Centre is located at the Park. It's been there for about 30 years. It's very unusual, because it's run by health but it offers an in-patient experience for sometimes nine to 18 months for some of our most traumatised adolescents. I call these kids eponymous legends, because everybody knows their name and they are so problematic across juvenile justice and health and child safety.

Let's just, if you can, approximate. How much in terms of percentage-wise would they be kids in care, or children at least in that context?---The director of the unit is a Dr Trevor Sadler, and he feels that 30 to 50 per cent are kids who have had abuse histories. Now, not all of those are formally in care.

Yes?---Some are still with kinship or other arrangements, but 30 to 50 per cent. 80 per cent have had extremely prejudicial parenting, which is related but slightly different. He thinks that more could be accepted from that system if the system had some, you know, better arrangements around stability of placement, but at least 30 to 50 per cent are abused children.

What do you understand as of this week is the fate of this centre?---Yes, we've been informed that the centre will close at Christmas. You know, I'd like to bring this to the commissioner's attention. This is a decision by adult mental health directors who in my opinion know very little about child abuse and neglect, who know very little about child protection, who judge the centre by adult metrics like occupied bed days and length of stay, when of course in a unit looking after schizophrenia your length of stay might be three weeks. If you're looking after someone who has neurobiological deficits from serial abuse and has 15 residential placements and is about to go to gaol, nine months is an appropriate time to change that individual. I'm extremely concerned that this unit will be never recreated. You know, it's obviously expensive. I will accept that it probably needs some reform. It should be under the Queensland Children's Hospital. It's sitting out by itself under an adult mental health unit which doesn't understand it, but to bring it under, as an interim, Dr Stathis or myself, into the child fold – but to lose this service would be lose the place of last therapeutic help for some of our most traumatised Queensland adolescents.

Dr Stathis's evidence yesterday, particularly in view of those who into contact with youth justice, that this group of adolescents you're talking about is probably the most socially disadvantaged in the community already?---Yes. Yes, I mean, they have – it's interesting, the more abused you are the more likely you are to have impairments across multiple domains, educational, occupational, peer, mental health, drug and alcohol, physical health.

Yes, I have nothing further for the doctor, thank you.

COMMISSIONER: Thank you. The Queensland Child Death Case Review Committee Annual Report 2011-2012 will be exhibit 123.

ADMITTED AND MARKED: "EXHIBIT 123"

COMMISSIONER: Mr Hanger?

MR HANGER: I have no questions.

COMMISSIONER: Ms Stewart?

MS STEWART: Doctor, I'm just interested in your opinion in relation to one matter. Just in the submission that you've provided in relation to the multi-generational impact, we've heard evidence from Dr Hoehn that she's of the opinion that it can take many generations to reverse those effects. Is that an opinion that you share?---It's a very difficult question, because I think it relates to the type of experience the person subsequently has. So, for

instance, if you are removed from a highly prejudicial family and then you have a series of placements, then arguably little has changed. So some of the children that I see have had, you know, by age 14, 11 placements. So removal was just the start of a process that, you know, arguably hasn't improved much. The alternative is - and I would expect that genetic restitution not to actually happen in that case, but if you're removed and you have one stable parenting experience, with low numbers of other children, so not removed to a person that's already got six foster children, which happens, removal to a small, you know, nurturing place, then I think that change can happen much, much quicker, probably in one generation.

I got the visual from your evidence of the brain and the ravelling - you know, according - if a child has experienced abused, as opposed to the unravelling. Is there any evidence that goes to how the adult brain responds to, like, that changing position of the brain? ---Yes. Again, this is - the problem with revolutions is they're kind of unfolding, and we are very keenly awaiting, for instance, MRI findings in 40 and 50-year-olds. There is one very interesting bit of research that the methylation pattern of child abuse is still obvious in the 1958 British birth cohort who by my calculations are now 55-ish. So that's a very longstanding, stable situation, and that birth cohort was able to tease out a whole range of interesting factors, abuse and poverty or just abuse alone or poverty alone. So it's likely that after early adulthood these things don't change much at all.

I have nothing further, commissioner.

COMMISSIONER: Thanks, Ms Stewart. Mr Capper?

MR CAPPER: We have no questions, thank you.

MS McMILLAN: I have no re-examination. Might the doctor be excused?

COMMISSIONER: Yes. Doctor, thanks very much for your evidence. Very helpful. We appreciate your time in coming and sharing it with me?---Thank you.

WITNESS WITHDREW

COMMISSIONER: We'll adjourn until when?

MS McMILLAN: Chambers.

COMMISSIONER: Right, okay.

THE COMMISSION ADJOURNED ACCORDINGLY AT 1.54 PM