Royal Australian & New Zealand College of Psychiatrists

Faculty of Child and Adolescent Psychiatry, Queensland Branch

Submission to the

Queensland Child Protection Commission of Inquiry

September 2012

PO Box 261, RBH Post Office QLD 4029 Australia
T +61 7 3852 2977 F +61 7 3852 2199
ranzcp.qld@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Table of Contents

Introduction 1

The Costs of Child Abuse and Neglect 2

Early brain development and the Impact of Abuse and Neglect [1] 3

Attachment and resilience 10

Mental Health Outcomes of Child Abuse and Neglect [2] 11

Child Protection: Universal and Primary Interventions 12

Improving parenting literacy in the general population 12

Addressing parental issues 13

Identifying Children at risk 13

Perinatal and early childhood interventions 14

Child Protection: Social Services and Statutory Intervention 15

The decision to intervene and particularly remove children 17

Children in State Care 17

Placement selection and Transition planning 18

Kinship care 20

Family-based foster care 20

Residential care 21

Secure residential care. 22

Adoption 24

Continued access to support beyond the age of 18 years. 24

Childcare and Education 25

Physical and Mental Health Interventions 26

Screening and identification of health needs 26

Health care and the role of the General Practitioner 27

Triage and referral for Mental Health Care 27

Non-Government Organisations and Private Practitioners 28

Child and Youth Mental Health Services (CYMHS) 29

Evolve Therapeutic Services 31

Forensic assessments 32

The role of family and carers. 33

Child Protection Services in Queensland 34
Effective Organisations 35
Accessible Services 36
Collaborative Practice 37
Working with families 37
Inter-agency collaboration 38
Evolve Interagency Services 39
Specific populations: 39
Aboriginal and Torres Strait Islander populations 39
Culturally and Linguistically Diverse backgrounds. 40
Intellectual Impairment 41
Monitoring and Evaluation, Research 42
Funding Issues 43
Conclusions 45
References & Resources: 46

Author:

Dr. Michelle Fryer
MB ChB FRANZCP Cert. Child Adol. Psych
Chair, Queensland Branch of the Faculty of Child and Adolescent Psychiatry.

With acknowledgement and thanks to the colleagues both locally and federally who have contributed directly and indirectly to the development of this submission.

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand and has responsibility for training, examining and awarding the qualification of the Fellowship of RANZCP to medical practitioners. The vision of the RANZCP is: "a fellowship of psychiatrists working with and for the general community to achieve the best attainable quality of psychiatric care and mental health". The Faculty of Child and Adolescent Psychiatry (FCAP) is specifically concerned with the training of psychiatrists in the mental health care of infants, children and adolescents, and in working with communities to maximise the mental health of young people both during their childhood and forward across the lifespan.

Child and Adolescent Psychiatrists have expertise in the understanding of normal and abnormal child development, the impact of genetic, biological, psychological, family, and social factors on development and in the assessment, diagnosis and management of mental illness throughout childhood and adolescence. The speciality of child and adolescent psychiatry encompasses a range of conditions and impairments of varying aetiology, however, all Child and Adolescent Psychiatrists see the impact of childhood abuse and neglect in their work and some have particularly specialised in the field of childhood abuse and neglect. Child and Adolescent Psychiatrists have expertise in the understanding and assessment of family functioning, inter-generational transmission of family function and dysfunction and understand mental illness in adults including the adult outcomes of abuse and neglect.

The Queensland branch of the Faculty of Child and Adolescent Psychiatry (Qld FCAP) welcomes this needed review of the Queensland child protection system and is pleased to have the opportunity to provide this submission. In doing so, Qld FCAP acknowledges the hard work and dedication of those working across child safety services and other services to further the welfare of children in Queensland. This submission has drawn on RANZCP FCAP expert working committee report "The mental health care needs of children in out-of-home care" [1] and other FCAP submissions regarding child protection issues. [2]

The Costs of Child Abuse and Neglect

The impact of childhood abuse and neglect affects the entire community and the effects persist across generations. Childhood abuse and neglect places the victim at increased risk of short and long-term mental and physical health problems, substance abuse, social adversity and poor social outcomes. It impacts on families, communities, schools and the wider community in many ways; such as through the distress caused by witnessing the impact of abuse, the difficulty of teaching a child with emotional or behavioural problems secondary to abuse, to increased drug and alcohol abuse, adolescent risk taking behaviour and criminality in the community and the victims of this. Children who have suffered abuse are at risk of becoming perpetrators when they have their own children and so the cycle can be perpetuated.

Western societies, including Australia, incur substantial financial costs secondary to the effects of childhood abuse and neglect. In Queensland, the direct costs of expenditure on child protection services, out of home care and intensive family support services have been increasing steadily and constituted $694,804,000 of the State budget in the 2010-11 year.[3] Whilst these direct costs are significant, the indirect personal, social and financial costs are substantial. These costs relate to the increased risk of mental illness, physical illness and drug and alcohol abuse, education failure and subsequent un/or under-employment, homelessness, juvenile offending, criminality and incarceration that is associated with the long-term impact of childhood abuse and neglect. For Australia, it has been estimated that the annual cost of child abuse and neglect for all people ever abused was $4 billion for 2007 and the estimated lifetime costs for the population of children reportedly abused for the first time in 2007 would be $6 billion, with the burden of disease representing a further $7.7 billion.[4]

Prevention of childhood abuse and neglect is a priority not only because of the devastating impact such experiences have on the individual, but also because of the significant social and financial costs that result.

Early brain development and the Impact of Abuse and Neglect [1]

In considering the needs of children, it is important to be aware of the significant influence that early environment and particularly our first relationships, have in shaping the development of the brain and the people that our children will become.

Genetics, the information in DNA, sometimes referred to as the "basic building blocks of life", predisposes children to develop in certain ways with certain vulnerabilities and strengths. DNA provides the basic template but only the template, for the child's brain. It is the subsequent growth and adaptation that occurs in relation to experiences and environment, starting before birth, that determines the person that the child will become. The majority of our development occurring in response to social and environmental influences has been part of what has made our species particularly adaptable and, therefore, successful, in many different environments across the world. However, it creates a vulnerability to the effects of adverse experiences, especially occurring in the first few years of life. As an example of this, children who experience severe environmental deprivation affecting more than one developmental domain, i.e. language, touch and social interaction, are at risk of permanent intellectual disadvantage. The majority of brain development associated with language, values, cultural practices and complex cognitive and emotional functioning that has taken place by adolescence has been determined primarily by experience, not genetics.

The human brain is a complex organ composed of systems that develop sequentially and in an hierarchical manner, from the primitive (brainstem) to the more complex (limbic and cortical systems). Optimal development of the complex systems is dependent on healthy development of the primitive systems. At birth the basic structure of the brain is in place with functioning systems that support the bodily functions necessary for life, including social engagement (e.g. at birth babies are drawn to faces and can recognise their mother's voice). From this start, the more complex brain systems develop, adapt and change and become functionally mature at different times during childhood, adolescence and even into early adulthood. The cortex (involved in abstract thought and complex language) is the last system to fully develop reaching maturity in early adult life (generally by age 25 years).

At birth the brain contains more than 100 billion nerve cells (neurons). Connected systems and pathways develop during childhood through a process of creating, strengthening and discarding of connections (synapses) between the neurons. During the first years of life, there is a rapid proliferation of synapses, reaching approximately 1,000 trillion by the age of 3 years. Some of these synapses remain intact and are strengthened while others are discarded, about half having been discarded by adolescence. This development of neuronal pathways occurs in response to incoming signals from the environment (via the senses), the body and other parts of the brain. It builds the functional organisation of the brain, which controls motor, cognitive and emotional functions and enables the systems to store information and develop 'memories'. Different types of memories enable the developing child to adapt to and navigate their world, prompting learned actions in response to certain signals – for example, smiling in response to kindness or fear in the face of hostility. Information is stored in the brain in a use-dependent fashion. The more a neuronal pathway is activated by the same signal or experience the stronger it becomes, effectively developing 'memories' that invoke interactions with the world that promote survival and growth. When a pathway receives little activation, the pathway becomes weak, is eventually discarded and its related functions will not occur. Put simply, the developing brain is organised on a "use it or lose it" basis.

The first few years of life, when synapse proliferation is highest, is when many of the neuronal pathways that are associated with developing trusting interpersonal relationships are strengthened. It is also a time of prime learning given the appropriate stimulation.

By 3 years of age, the brain has reached 80% of its adult size and a vast amount of development and organisation has occurred. Once a system in the brain is laid down (or 'organised'), it is less sensitive to experience and less amenable to change. This applies most to the more primitive areas of the brain whereas more capacity for change (plasticity) is retained in the more complex systems such as the cortex.

Whilst the basics of food and shelter are, of course, essential to survival; the most important factor in successful growth and development for the human infant is the interaction with stable, attuned caregiving adults (usually parents). Infants who suffer

extremes of absent caregiving are at risk of failure to thrive, reduced brain size, impaired development, and even death; despite basic physical requirements being met. The experiences during infancy and early childhood determine the functional organisation of the brain. The current biological 'revolution' (genetics, molecular biology and brain imaging) has provided clear evidence that childhood abuse damages developing brains, with changes still evident during adulthood. Disturbing findings include: 18% loss of volume in the occipital lobe (primarily responsible for vision) in sexually abused girls [5]; prefrontal cortex (brain executive centre) damage following exposure to harsh corporal punishment [6]; and white matter (connection fibres between brain areas) changes in adults exposed to severe verbal abuse as a child [7]. Imaging evidence strongly supports the notion that early damage may be permanent. The studies of severely deprived children adopted from Romanian orphanages in the 1980s emphasises the influence of neglect and other factors such as chronic malnutrition.

The term "Attachment" describes the relationship between a child (from infancy) and their primary caregiver(s). All infants have an innate need and predisposition to form an attachment to a protective caregiver who will provide:

- Consistent, sensitive nurturing in response to the child's need for comfort and security.
- A 'secure base', from which the child can safely explore the world, learn and develop and return to when they are in need of comfort and nurture.

Whilst attachment is usually described in relation to parents, it can include any adult figure that has a consistent role in providing care for an infant or child over a period of time.

Attachment relationships promote and facilitate neurological and thus cognitive, emotional and psychological development, and this development will be influenced by the quality, character, duration and intensity of the relationships that the child has. Attachment relationships influence not only behaviour and health in childhood but continue to influence thoughts, feelings, motives and relationships throughout life.

Children may be genetically predisposed to aggressive, submissive and frustration behaviours, however, through a positive, secure infant-caregiver relationship, the child learns to regulate these emotions and behaviours and develop more adaptive, pro-social responses. In the absence of such a relationship, the primitive brain responses become dominant and the cognitive ability to control these behaviours and emotions may not develop. The work of Meaney and colleagues, demonstrating that poor parenting leads to changes in the human genome (the new science of 'epigenetics') with changes in gene activity (transcription speed of genes) provides the biological foundation of the attachment – subsequent behaviour relationship. [8] Work with the children of holocaust survivors and mothers distressed following the World Trade Centre attacks has shown how problem biological reactivity secondary to previous abuse can be pasted across generations [9]. In part, helping to explain why multiple generations of families are often engaged in the child protection system.

Children who receive safe, consistent, attuned nurturing develop a secure attachment relationship with the caregiver. Secure attachment in early life is associated with better developmental outcomes in areas that include self-reliance, self-efficacy, empathy, and social competence. Children can have different attachment relationships with different adults in their life and secure relationships with significant others can be protective when the primary attachment relationship is problematic.

When the caregiver is repeatedly physically, psychologically or emotionally unavailable or tends to be insensitive or unpredictable in their responses to the child, an insecure attachment can develop. Insecure attachment is associated with later problems that include conduct disorder, aggression, depression and antisocial behaviour. It is hypothesised that if, during the development of the neuronal pathways associated with building trusting interpersonal relationships, the child's interaction with their environment frequently brings a hostile response, their brain will be sensitised to respond accordingly. Also, their ability to react positively to nurturing and kindness may be impaired. In addition, the more a neuronal pathway is activated the stronger it becomes creating a template through which all future inputs are filtered. Such hypotheses now have a confirmatory evidence base from brain imaging studies, see above.

A ‘disorganised attachment’ can develop when the primary caregiver displays unusual and ultimately frightening behaviours in the presence of the child, (often described as a caregiver who is either frightened themselves or frightening to the child). This frightened or frightening attachment figure invokes simultaneously the need to approach for comfort and withdraw for safety. It is hypothesised that this places the child in an intra-psychic dilemma and the ‘disorganised’ behaviour observed is a result of this unresolvable dilemma. As these infants grow to primary school age patterns of interaction are often seen where they become controlling through aggression or almost perfect compliance as a way of keeping themselves safe. They may attempt to ‘parent’ their parents to keep themselves safe, and may appear mature for their age but underlying this are developmental immaturities. They do not perceive adults as a source of safety and security, or as someone to be respected and listened too. They are focused on having to maintain their safety so have a reduced capacity for learning and development. Children with disorganised attachment have been found to be more vulnerable to stress, have problems with regulation and control of negative emotions, display oppositional, hostile/aggressive behaviours and unusual or bizarre behaviours. Disorganised attachment style is relatively rare in the general population but high rates are seen in populations of children in care.

Neglect, in terms of failing to provide appropriate stimulation to meet a child’s cognitive, emotional and social needs also has lifelong developmental consequences. Without the appropriate stimulation in the first three years of life, the rudimentary neuronal pathways that have developed in expectation of the experiences associated with building cognitive, emotional and social functioning may atrophy resulting in these children not achieving the usual developmental milestones.

Secure attachment relationships provide the basis for learning and development. To learn effectively, a child needs to be in a calm state, through feeling safe and protected. When the attachment process is disrupted through abuse and neglect, the child’s brain focuses on developing the neuronal pathways associated with survival rather than building the pathways that are fundamental to future learning and growth.
Social cognition entails an awareness of oneself in relation to others and an appreciation of other’s emotions. Impaired social cognition is also a potential result of poor early attachments. The child with poor social cognition abilities may experience

many types of social interactions as stressful and respond with aggression or withdrawal. Abused children often show a lack of empathy and understanding of the effects that their hurtful actions may have on others' feelings.

Human survival depends on the ability to initiate a protective response to any threats to physical or psychological well-being. Such a response, known as the stress response, is a physiological mechanism, which prepares the body for survival through strategies commonly referred to as "fight, flight or freeze" ('giving up' or surrendering in the face of danger). Brief periods of stress are not problematic and are necessary for the child to develop appropriate strategies to cope with their environment. Frequent or prolonged periods of stress, however, can result in over-development of the neuronal pathways involved in the fear-stress response and under-development of other systems. These changes to an infant's stress response system can begin in-utero as the hormones associated with the stress response cross the placenta so, for example, domestic violence, through causing a mother to be repeatedly highly stressed or fearful, will impact the developing stress response system and neurological and biological functions of the foetus. These altered developments may lead to functional changes in emotional, behavioural, and cognitive performance. When a child is in a state of persistent fear, the chronic activation of the neuronal pathways involved in the fear-stress response leads to permanent "memories" being stored that influence the child's perception of and reaction to the environment. This state of persistent fear becomes a trait and the response almost automatic.

There are two primary adaptive response patterns that individuals use when faced with a perceived threat. They are the hyper-arousal continuum (fight/flight) and the dissociative continuum (freeze and surrender). Individuals may respond to the same threat differently; however most use a combination of these two patterns. The dissociative continuum tends to be the more predominant pattern in younger children and females and the hyper-arousal continuum the more predominant pattern in older children and males. Infants in traumatic situations may be described as 'good babies', perceived as being unaware of the violence because they sleep a lot. This is concerning as it is likely the infant has 'switched off', frozen or dissociated from the environment in self-protection, not having the options of being able to run or fight.

This has significant impact for neurological, psychological and social development. In the hyper-arousal continuum, the pathways involved in this response pattern are always switched ‘on’ creating a hyper-vigilant state. The brain is hypersensitive to environmental signals and is in a persistent stress-response state, ready to deal with any threats. It is thought that this hyper-arousal state can continue to have an impact long after the threats, which prompted its development, have passed. The parts of the brain involved in the hyper-arousal state can become re-activated when the child is exposed to certain cues in their environment that are reminders of the previous threats or trauma, such as a particular noise, the smell of alcohol or the presence of a perpetrator. The child thinking or dreaming about the traumatic experience can prompt this re-activation. Over time the nature of the memory-prompting cue may become more generalised, for example, a particular noise may become any loud noise or a specific perpetrator any strange male.

Other critical physiological, cognitive, emotional and behavioural functions are dependent on the same parts of the brain that are involved in the fear-stress response so can become de-regulated as the brain systems are sensitised to the repetitive re-experience of the traumatic events. Over time this can lead to the child exhibiting hyperactivity, anxiety, impulsive behaviours, sleep problems, tachycardia, hypertension and a variety of neuro-endocrine abnormalities. In normal circumstances young children, who are not capable of fleeing or fighting when under threat, will cry out for a protective caregiver to take the necessary action - an appropriate response if the caregiver offers protection. When (repeatedly) protection is not forthcoming, the child will adapt to the environment by abandoning the cry for help and surrendering to the perceived threat (dissociating). The neurobiology of the hyper-arousal and dissociative responses are different. Both originate in the brainstem and involve increases in circulating stress related hormones. In hyper-arousal there is an increase in heart rate and blood pressure; in dissociation the opposite happens, blood pressure drops and heart rate decreases and opiate-like brain chemicals are secreted. These have the effect of altering the perception of pain and sense of time, place and reality.

Traumatised children with sensitised hyper-arousal or sensitised dissociative patterns of response will often use ‘freezing’ when they are anxious and the anxiety has been provoked by a suggestive stimulus to which their neuronal pathway is reacting. The

anxiety they experience is intense even though they may not be aware of the evocative nature of the stimulus. This freezing cognitively (and frequently physically) is often misinterpreted by adults as ignoring or refusing to comply with instructions. This initiates another set of directives which may involve an element of threat, increasing the anxiety experienced by the child, moving them along the continuum of hyper-arousal or dissociation and further reinforcing the neurological pathways of abuse.

Attachment and resilience

Childhood resilience refers to the capacity to overcome, adapt to or minimize the effects of adversity. Three major features have been found to influence resilience and the likelihood of children overcoming adversity:

- At the individual level, resilient children tend to have easy-going temperaments (thus can be more appealing and easier to parent and care for)
- At the family level, resilient children tended to have close nurturing relationships with at least one family member, not necessarily the birth parent, who was committed to their welfare, thus resulting in feelings of self-worth.
- At the social level, they tended to have a social environment that provided opportunities to develop supportive relationships with people outside the family, for example: friends, teachers or adult mentors, who could provide support and advice. In addition, developing interests or hobbies or being a member of a school or community-based group provides opportunities to build competencies, which in turn enhances self-esteem and self-efficacy.

Of these 3 factors, temperament is considered static due to its genetic basis, whereas relationships and social engagement is amenable to intervention and the protective effects can be maintained or lost. **Maintenance and enhancement of positive relationships, i.e. maximising the child's access to attuned, safe, stable, consistent relationships, from early life, should be the first goal of child development and child protection. Maintaining stability of protective relationships should be a fundamental consideration of child protection.**

Mental Health Outcomes of Child Abuse and Neglect [2]

The aetiology of children's mental health problems is related to diverse factors, often acting in combination and including:

- Developmental factors such as genetic vulnerabilities, in utero exposure to toxic substances such as drugs and alcohol, malnutrition, chronic illness or disability.
- Social factors such as bullying, physical or psychological trauma (from injury, abuse, bereavement), community and cultural disadvantage, discrimination or marginalisation.
- Parenting and family factors including neglect, insecure attachments, harsh discipline, inadequate supervision, marital conflict/breakdown and domestic violence, maternal depression and parental stress.

Australian and International studies have repeatedly found that children who have experienced abuse and neglect experience have high rates of complex developmental and mental health problems. These problems encompass a range of outcomes including attachment difficulties (difficulty forming and maintaining adaptive relationships), peer problems, externalising difficulties (such as aggression, inattention, hyperactivity, stealing, oppositional and conduct disorder behaviours) and internalising problems (such as anxiety, depression and social withdrawal).

In their 2010 commentary, Scott et al [10], concluded that the epidemiological evidence for the adverse adult outcomes of childhood adversity has been conclusively demonstrated. Childhood adversities have been grouped into those reflecting maladaptive family functioning (e.g. parental mental illness, parental substance abuse, criminal behaviour, domestic violence, physical abuse, sexual abuse and neglect) and other (e.g. parental death, divorce, physical illness and family economic adversity). In reviewing the literature they found that 'Childhood adversity arising from problems in family functioning was significantly associated with all types of mental illness.' And that mental illness arising from difficulties in family functioning was more pervasive than that arising from other adversity making it likely that 'the burden of disease attributable to maladaptive family functioning would be sizable.' Childhood adversity is a risk factor for adult (and therefore parental) mental illness, which is then a risk

factor for childhood adversity in the next generation. Therefore, effective intervention in reducing childhood adversity will not only save children from the damaging effects of abuse and reduce the burden on society for this generation but will potentially reduce the social burden for future generations.

Child Protection: Universal and Primary Interventions

The environmental, social and economic determinants of childhood abuse and neglect necessitate a 'whole of government', multi-disciplinary approach to addressing the contributing factors. The current child protection system is unsustainable socially and economically, making it imperative that there be a focus on reducing the number of children suffering abuse and neglect in the community overall; reducing the numbers experiencing removal into State care by improving family functioning wherever possible; and reducing the harm from repeated removal and reunification and re-exposure to a childhood maltreatment by early identification of parents who will be unable to sustain the necessary improvements to their parenting capacity and early permanency planning for their children.

This first step to reducing rates of childhood abuse and neglect occurs by increasing the parenting capacity of the entire population and this can be done in innovative and cost-effective ways. From conception to school entry, the priorities for children are their social, emotional and physical development, for which the relationship with primary caregivers is of fundamental importance.

Improving parenting literacy in the general population

Improving the capacity of all parents will potentially help lift the capacity of parents who are at risk of ineffective and abusive parenting when under stress or when faced with children with a difficult temperament that are more challenging to parent. This can be achieved by:

- Providing the general population with accurate, evidence based information on child mental and social development; e.g. it has been established that an "authoritative" parenting style - one that combines warmth and affection with effective limit setting, is associated with good outcomes for children.
- Providing and enhancing access to established, evidence-based universal parenting programs such as the Queensland developed Triple P program [11] and

the Incredible Years program [12] and considering innovative measures of delivery to the general population e.g. through television [13], internet and on-line media (e.g. YouTube).

It is important to note that change takes time and perseverance with strategies across arenas of community engagement, delivered in a manner that is acceptable and not blaming or stigmatising.

Addressing parental issues

In Australia and internationally, the leading reasons for children entering care have been found to be parental drug and alcohol abuse, domestic violence and physical abuse with parental mental illness also a significant factor. These risk factors are rarely found in isolation, childhood abuse and neglect being associated with co-occurring risk factors. Therefore, development, implementation and evaluation of policies aimed at addressing social, economic and environmental determinants of childhood abuse and neglect is indicated. These include interventions addressing alcohol and substance abuse, domestic violence and parental mental illness.

Parents, generally, are doing the best that they can for their children. When this parenting is inadequate, it often stems at least in part, from parental psychological problems, which have origins in the parents' upbringing. These same factors may generate fear, shame, ignorance and denial that interferes with the parents willingness or ability to engage with those offering help and change their parenting practices. A respectful, collaborative approach with parents can help make accessing service more acceptable.

Identifying Children at risk

Early identification of any child at risk due to parental mental illness, substance abuse, domestic violence or other factors facilitates entry into intervention programs early, before difficulties have become entrenched and less amenable to change. **It is recommended that all services working with adults have in place policies and procedures in place to identify dependent children and refer for parenting and social supports.**

Any professional or agency working with children, parents or families in any context is likely to encounter at-risk families and children who have experienced abuse and neglect. Therefore, strategies should be implemented to raise awareness of the identification of and impact of abuse and neglect, the aetiology and manifestation of mental disorders associated with child maltreatment and disrupted attachment and how to interact in a safe, therapeutic way with potentially abused children. This would include government agencies such as housing, Centrelink and police as well as health, education etc.

Mandatory reporting requirements are in place in Queensland for doctors and nurses who suspect child abuse and neglect and should be supported by referral pathways and access to training resources.

Child protection systems tend to target the more easily recognised forms of maltreatment such as physical and sexual abuse. However, the most common and overall damaging abuse occurs from emotional abuse and neglect. There is a lack of identification, evaluation and intervention for emotional abuse and neglect in child protection systems.

Perinatal and early childhood interventions

A key strategy to helping families is working with them from the early stages of parenthood, even pre-conception, such as the key public health messages around the avoidance of smoking and alcohol consumption during pregnancy. **Antenatal education could include a focus on parenting skills that promote the development of positive parent-child relationships. Maternal antenatal assessments could include a review of the mother's psychological, emotional and physical capacity to establish a quality child-parent relationship with interventions offered for those mothers identified as being at high risk of having difficulties.**

The move towards early discharge from hospital following birth has left some mothers vulnerable to difficulties due to the limited support to establish breastfeeding and infant care in the community. Intensive nurse home-visiting programs for high-risk mothers that support new parents and guide their parenting skills have been shown to be cost-effective in improving childhood outcomes. The Government

advocacy and support for breastfeeding should continue as the many short and long-term health benefits include protective effects for maternal and child mental health and reduced rates of child abuse, especially maternal neglect. In addition, enhancement and access to child health programs such as the programs that provide peer support and education for new mothers through Child health services could be considered with improved acceptability and accessibility for young mothers, disadvantaged mother and other at risk groups. This can also be an avenue for early identification of difficulties in the mother-infant relationship through up-skilling of staff as necessary and development of referral pathways and roll out of appropriate interventions. Improved access is needed to secondary and tertiary interventions that improve the capacity for attuned care giving and relationships of the maternal-child unit in the first few years of life, such as Infant Mental Health Services, specialist mother-child groups and other programs.

Implementation of adequately resourced, evidence based parent education and home visiting programs aimed at providing family support, enhancing parenting skills and preventing child maltreatment for those families identified as high-risk or demonstrating high risk behaviours and provision of Infant Mental Health services that provide tertiary level care is recommended.

Specific intervention programs have been developed for Aboriginal children and families such as the Strong Women, Strong Babies, Strong Culture Initiative in the Northern Territories and such interventions should be considered for Queensland.

Child Protection: Social Services and Statutory Intervention

Children need:

- Safe, stable, consistent attuned relationships.
- Adults and services working cooperatively and collaboratively to support and nurture the child, their family and each other.

We recommend that the first priority of child welfare be the maintenance of important relationships in the child's life, to the extent that the adult can safely participate in the raising of the child.

This means offering intervention and support as early as possible in the child's life, to maximise the opportunity for improvement in the parents' capacity and the development of a safe, functional family unit.

This should not mean exposing the child to ongoing abuse and neglect or repeated disruption to relationship. Child and Adolescent Psychiatrists have experienced cases of young people where, due to emphasis on the principle that a child should be with their family, reunification was attempted multiple times. Each time risk to the child necessitated removal from their biological family they went to a different foster placement. Over time, the repeated trauma and fractured relationships resulted in such challenging behaviours that the young person was very difficult to parent and to maintain in family or residential placements. The risk of poor short and long-term outcomes was now high. We have seen, developing understanding of the impact of multiple moves on children and such initiatives as the 'one chance at childhood', a move towards earlier decision making on permanency but there is still much work to be done.

It does mean:

- Maintaining relationships with parents through contact, as much as the parent can safely provide, and continuing to support the parent to address the issues that disrupt their capacity to be a safe parent to their child.
- Maintaining relationships with extended family including consideration of kinship care and supporting extended family to provide care.
- Maintenance of relationships with childcare workers, teachers and other community supports, through stability in community, school and extra-curricular activities. Importantly, children should be placed such that they can continue in their current school, which may need support or resourcing to maintain that stability, and so they can continue any extra-curricular activities that they are involved with.

It also means early determination of parental capacity to provide adequate safe, nurturing care with permanency planning if it is deemed likely that the parents are unable to make sustained changes such that they can parent appropriately. Early determination and permanency planning provides the opportunity for establishing stable, consistent, relationships. This gives the child the best chance of resolving early trauma and neglect and returning to a healthy trajectory into adulthood. Healthy adults become healthy parents thus potentially breaking the cycle of abuse. For example, studies of the Romanian orphans who suffered extreme neglect found better outcomes for those adopted before 6 months of age compared to those children who had been adopted as toddlers.

The decision to intervene and particularly remove children

One of the difficulties for child protection agencies and social systems is balancing the rights and civil liberties of parents, including their right to make choices about their parenting style and practice, with the rights of the child to have safety and security and have their needs met. The decision to step in and take over because parents lack the ability or will to change harmful behaviours is complex and does not have a simple answer. Highly trained, competent teams should make evaluations and decisions in this regard with input from specialist professionals available.

Accurate identification of such children and predicting which biological parents will not be capable of making sustainable improvements in their parenting capacity is a challenge and unnecessary removal is to be avoided. However, the mental health and development of the child, particularly those aged under 2 years, should take precedence in situations where the balance of probability is that the parents will not be able to make sustainable changes; given the evidence that younger age of entering care is associated with better mental health, educational and social outcomes.

Children in State Care

Children removed into care follow paths through interim, short and long-term orders, reunification and sometimes re-removal and crisis, short and long-term placements. Children removed into care are highly vulnerable to further psychological damage. It is essential to their mental health that the principle of consistency in relationships be

paramount in their journey through the care system. The risk of problems for future placements and for poor outcomes rises with each change of placement.

Placement selection and Transition planning

Children's needs will vary depend on the extent and type of abuse they have experienced and their experience of any protective or resilience factors. Children coming into care need a comprehensive assessment of their needs and patterns of interaction with adults and significant others and consideration should be given to the 'fit' or match between the child and the placement.

Our experience is that, whilst the Queensland Child Safety Practice Manual [14] gives advice on placement matching and obtaining the child's input into decision-making, scarcity of placements and lack of choice means children go simply to the next available placement. On removal, children will probably go to an 'emergency placement' first, then there may be temporary placements, while the parents' capacity is assessed and intervention is attempted. If a longer-term order is sought, due to the scarcity of placements, they are usually transferred to the first placement available with only minimal attention able to be paid to the 'fit'. Similarly, when a child is deemed able to move from a transitional placement to a foster-placement, financial pressure (to move the child to a less expensive model of care) and scarcity of placements mean that there is little choice. If the placement is a poor 'fit' between the child's personality, difficulties and needs and the foster-parents parenting style, experience, expertise and capacity to meet those needs, the risk of placement breakdown is increased and the child may be started on a trajectory of repeated placement breakdown and change and a poor outcome. Minimising the number of placement changes through time spent evaluating the child and ensuring the best fit is a worthwhile investment in reducing the risk of placement breakdown and increasing the probability of a positive prognosis.

Of course, placement change cannot be completely avoided and there can be appropriate and positive reasons for placement change. In these instances, thoughtful, planned management of the change is recommended. In the past a philosophy of the 'clean break' was seen, which resulted in children being up-rooted abruptly from one placement to the next with no contact with their previous carers, often accompanied

by a change in school and loss of other social connections. It is our experience, that there is now much greater appreciation of the damaging impact of these fractured relationships and unresolved losses for the child and an openness to transition planning and maintenance of relationships with previous carers where that is appropriate. Where possible, time is spent introducing new carers and allowing the child to get to know them and facilitating a process of farewelling and grieving for the previous carers. In one case, for example, carers that were unable to continue to have custody of a young person due to their increasing age and infirmity were encouraged to consider moving to a grandparent role where some connection was maintained. The old and new carers were able to form a friendly relationship, which facilitated continuing contact with the young person. Flexibility in placement transition is recommended, with attention to the maintenance of significant relationships in some form where possible and supporting the young person to farewell, grieve and value their memories of their previous carers when it is not.

We recognise that in some instances the urgent safety of the child may necessitate an abrupt change, usually from biological parents. Clearly, safety is paramount, but the impact of loss on the child should still be recognised, attention paid to the child's cognitions around the placement change, as they may believe it was 'their fault', and therapeutic support provided as needed. In addition, it is important to note that the child may be distant from new carers and reluctant to trust initially and will need time to establish new trusting relationships. This may need to be facilitated by therapeutic support, depending on the past experiences, behaviours and internal working models of the child.

Family based care tends to be more successful for younger children rather than adolescents with conduct and mental health problems, also children with severe behavioural or emotional disorders may have better outcomes from placement in group home settings staffed by trained carers.

Children in care can lose their history, the personal narrative each individual develops as part of a coherent sense of self. Maintaining the child's history through practices such as keeping diaries, photographs and stories from home and placements and interventions such as Life Story Work can help prevent this identity loss.

Kinship care

In current practice, if a child cannot live safely with their parents, first preference is for kinship care (provided by child's relatives or other parents who have a kinship bond e.g. step-parent, godparent, close family friend). Kinship care appears to be associated with better outcomes for younger people than non-related foster-care although the research on this has not shown a strong effect and the children continue to have difficulties compared with the general population.

Kinship carers tend to receive lowest remuneration, they are often grandparents, and raising grandchildren comes with significant financial, social and legal burdens. It is important to ensure assessment of family occurs, as they are likely to have many of the same risk factors for inadequate and abusive parenting as the biological parents. Assessment of extended family should be cognisant of both the inter-generational continuance of risk factors for abuse and neglect and the capacity for change with the development of maturity. Evaluation should include the level of support required for extended family to parent safely.

Family-based foster care

The current system of child protection is resulting in increasing numbers of children coming into care, whilst numbers of foster-carers are decreasing; a situation, which is unsustainable. The increasing gap between the number of children requiring care and the number of carers available, has been attributed to the increasing number of women returning to the workforce, inadequacy of remuneration for carers, increasing expectations on carers and the ageing of current carers. [15]

The neurobiological development, stress responses and psychology of children who have been subject to abuse and neglect includes patterns of internal beliefs and relationships (referred to as internal working models) that make them hard to parent. They can interact in ways that place them at risk of further abuse and their needs go beyond 'normal' parenting and loving care. They generally have difficulty regulating their emotions and behaviours because of the trauma or neglect they have experienced.

A spectrum of expertise and capacity for therapeutic parenting is required that is child focused and attends to developmental and attachment needs, to help these children overcome the traumatic effects of abuse and neglect. This starts with careful selection of adults who have secure attachment histories themselves or who have resolved any personal history of childhood trauma or other difficulties and have the capacity to nurture children followed by training to assist them in meeting the needs of these children.

In Australia, foster-care receives little social recognition, remuneration is low, attracting new carers is difficult and retention problematic. Costs associated with raising a foster-child are estimated to be more than 50% higher than for children not in care, due to the higher maintenance costs associated with children with complex needs.

Overseas, foster-care has received recognition through the development of courses in child development, impact of trauma and therapeutic parenting, through appropriate reimbursement and social recognition. For example, SACCS, a UK provider of residential services for children who have been traumatised by abuse and neglect has developed courses leading to Foundation and Bachelors Degree in Therapeutic Child Care, in partnership with Glyndŵr University. [16] Such development is recommended for foster-care in Qld.

Residential care

There are a group of children in care, predominantly but not exclusively over the age of 12 years, who are unable to be managed in family based care so are housed and cared for in youth worker supported residential units. They vary from placements for one to several young people and in the number and skill of support workers. The placements generally occur because the emotional, behavioural and psychological problems of the young person cannot be managed in a family-based environment but may also be a temporary measure while a foster family placement is identified. The placements are usually deemed ‘transitional’, having a view to stabilising the young person so they can be moved to a lower level of support (e.g. co-located with peers), a family based placement or sometimes to independent living. Ideally, such placements provide ‘therapeutic care’ but this is highly dependent on the quality, expertise and

experience of the carers working with the young people, which is highly variable. They are generally staffed by highly motivated individuals who have, however, limited training and who receive low levels of remuneration. When positive relationships are formed with carers who can respond with caring, consistency and appropriate boundaries the benefits can be invaluable. However, there is the risk of these homes becoming mainly ‘holding facilities’ for young people with nowhere else to go who receive little therapeutic benefit.

There is a need for recognition of the importance and potential therapeutic effects of the relationships that are formed by these carers working day to day with young people. As for foster-carers, review of the skills and expertise present and needed in such placements is recommended, along with the development of training and professional development, career pathways, and social and financial recognition.

Secure residential care.

There is a further small group of young people in Queensland who are on Child protection orders but have disengaged from placements and services. We estimate the majority are adolescents but a few are younger. They come to the attention of mental health, child protection and other social services through intermittent contact, usually in crisis via emergency department presentations or encounters with police. They rarely contact through business hours services and are difficult to access to form relationship with. When placed they tend to exhibit destructive behaviours that lead to placement breakdown such as physical aggression to carers, destruction of property and self-harm and they have a history of absconding and ‘living rough’. They are often engaging in substance misuse, have an antisocial peer group, and are at high risk of homelessness, promiscuity, antisocial and criminal behaviours, are at risk from others from exploitation and assault (including sexual assault). They are at increased risk of premature death from misadventure (e.g. from the effects of substance abuse), suicide or even at the hands of others. They are resistant to engaging with services and may not see themselves as having a problem. Even services with capacity for active engagement and intensive follow-up, such as Evolve Therapeutic Services, find them very difficult to locate and engage with. Occasionally they are admitted to acute

adolescent mental health in-patient units in crisis and in an attempt to engage them in service or appropriate placement. This approach is rarely successful; as such in-patient units are designed for acute (short-term, 2 to 3 week admissions) of young people with an acute, treatable mental illness not long-term therapeutic work. For these adolescents, their difficulties are long-standing and not amenable to acute treatment. Also these adolescents generally do not meet criteria for detention under the Mental Health Act, they cause disruption to the units and to the care of young people with acute mental illness and they often abscond.

Therapeutic management of such young people requires long-term placements (12 to 24 months or more) in a therapeutic facility where their emotional, psychological and educational/learning needs can be met through the establishment of relationships with highly skilled and supported care staff and their externalising behaviours (such as aggression) can be safely contained and managed. Due to their lack of insight and absconding behaviour, these facilities must be secure. Currently, the only framework in Queensland for secure detention is the criminal justice system and incarceration in Youth Detention Centres. Young people can only access this when they have a significant criminal history, so are far down the criminal trajectory and change is difficult to achieve.

We recommend that the inquiry consider alternative models for these young people for example the "secure children's home" model that is used in the United Kingdom [17]. Such models provide secure therapeutic facilities for such young people where they can receive the therapeutic help that they need before they are on a trajectory towards long-term incarceration in the adult prison system. The criteria for secure children's home placements are in relation to the child's risk and welfare, not their offending; and the aim is explicitly therapeutic.

Important in the process of establishing such facilities would be:

- Development of a new legislative framework which allows for restrictive care of children at extreme risk
- A needs analysis regarding the number of young people requiring secure placement

- The development of appropriate facilities
- Staff that are highly skilled in trauma-based therapeutic care of young people
- Ongoing support, supervision and professional development of those staff so they are able to maintain provision of therapeutic care in the face of often highly challenging behaviours
- Collaborative relationships with specialist services such as Child Protection, Paediatrics, Mental Health, Education and vocational training;
- Step-down services and supports and processes to manage transition out from the secure placement to a community placement, supported accommodation or semi-independent living in the community.

Adoption

Adoption is a rarity under current Queensland legislation, policy and practice. We recommend that this be revisited and reviewed. Adoption provides for permanency and can provide the child with an increased sense of belonging that facilitates the development of security and identity.

Adoption is used more commonly interstate and overseas e.g. in the UK, to facilitate permanency planning and improved outcomes.

Continued access to support beyond the age of 18 years.

In the general population, parents support to their children continues throughout young adulthood and sometimes beyond. The State offers little support to young people after the age of 18 years and transition from care planning and support is variable. A move to permanency planning, provision for adoption and a focus on sustainable relationships can help to improve the long-term social support for young people in the care system. Outcomes can be further improved by continuing social welfare support from the State to the age of 21 years or beyond and studies from the USA have demonstrated this.

Childcare and Education

Education settings have a role in promoting the welfare of children across the spectrum of universal, primary and secondary interventions; working in collaboration with specialist services for those children with significant problems.

Early childhood centres could be used as a hub to provide a variety of services such as parenting programmes and health checks.

Access to quality childcare for at-risk and high-risk families may be protective in providing infants and pre-school children with a safe secure consistent environment, attachment informed childcare is preferred for such children where consistency of caregiver and relationship and high staff retention is prioritised within the centre. It also gives parents the time-out they may need to de-stress and attend to their own health and welfare needs. Accessibility and affordability should be targeted at high-risk families.

Schools can also provide a safe environment and, if children are engaged in school with positive relationships with teachers and peers, can promote resilience. In schools, school health nurses and guidance counsellors are well-placed to provide additional services to young people and can be accessible to children and adolescents who would not otherwise be able to access counselling e.g. if the parents will not facilitate attendance at appointments. Local and international resources have been developed to assist schools in managing the behaviours and psychological and emotional needs of children who have experienced abuse and neglect such as Calmer Classrooms [18]. It is recommended that such resources be made available to all schools and awareness of the behaviours and needs of children who have experienced childhood adversity, abuse and neglect be raised.

Alternative education schools have been developed that take on those children and young people whose behaviours have excluded them or are at risk of excluding them from mainstream schooling. It is highly likely that a majority of children in such schools will have backgrounds of adversity, abuse and neglect so such schools will also benefit from trauma-informed education and resourcing. Alternative education

schools should be appropriately resourced with highly skilled teachers and access to mental health professionals and social workers to interrupt the trajectory of these children who are at high risk of mental health and conduct disorder problems and of entering the justice system.

Physical and Mental Health Interventions

Screening and identification of health needs

Children entering care have suffered abuse and neglect and are therefore at increased risk of physical and mental difficulties and disorders. In Queensland, children entering care receive a physical health check and progress has been made on ensuring a child's medical information follows them if e.g. they change placement (through the Health Passport). However, there is no routine mental health check, despite these children being at increased risk for mental disorders. Assessment and intervention is sought when carers, child safety officers, teachers or other professionals identify concerns about an individual child. A mental health check is recommended as routine because as well as identifying individual needs, it raises the awareness of the psychological and psychiatric effects of childhood adversity. These impacts of childhood adversity can be subtle or misinterpreted or missed so mental health checks also help identify difficulties earlier when intervention carries a better prognosis and facilitating entry into appropriate treatment as needed.

It is recommended that there be health checks for all children entering care, repeated at intervals while they remain in care, which include:

- Physical health check
- Developmental appraisal
- Mental health check
- Hearing and Vision assessments
- Dental health check

Health checks should be available for infants and children where there are concerns about their care or development, or family functioning and regular checks considered for children who return or remain at home; especially when child protection concerns were significant.

Health care and the role of the General Practitioner

Ideally, all families would have a consistent General Practitioner (GP) who is able to monitor their health and coordinate the care provided by specialist services. However, many GPs have neither the expertise nor resourcing to take on this role. Our experience is that high-risk families often do not have a regular GP and more often attend emergency GP clinics and hospital emergency departments. Also, that children in care rarely have consistent GP care, especially if they are without stability of placement. However, this is a clinical impression that would need to be confirmed by data collection. We recommend that high-risk families be encouraged and supported to engage with a GP that they see consistently, with whom they can develop a trusting relationship and who is aware of the family background and difficulties. The GP is then well placed to follow the family over time, provide regular health checks and coordinate further medical and mental health care as required.

Triage and referral for Mental Health Care

Mental health screening should identify the needs and severity of impact of the abuse and neglect and the most appropriate support. Where it has identified issues of significant concern, the child should receive a comprehensive mental health assessment, undertaken by clinicians with specialist knowledge and the ability to interpret clinical information in the context of the child's developmental and bio-social history. Effective assessment and management of children who have experienced childhood abuse and neglect can require inter-disciplinary assessment and coordinated collaborative intervention across home and school settings.

The workforce for children includes those who work in education, child safety, health and mental health. Access to service should be tiered so that the most vulnerable families are seen by those with the most expertise.

It is our observation that Child Safety Officers lack expertise on identifying mental health difficulties and deciding on appropriate referral pathways for assessment and further treatment. A recent project on the Gold Coast, Konnect 4 Kids, dedicated an experienced child and youth mental health nurse employed within Queensland Health Child and Youth Mental Health Services (CYMHS) to working with Child Safety

Services. The nurse attended service centres weekly for consultation and case discussion and provided training such as Mental Health First Aid Training. The position sat within the CYMHS Access (intake and assessment) team and was fully aware of referral pathways available across the region for all levels of care. This enabled advice to be provided on the child's presentation and needs and the most appropriate referral for assessment and intervention. Surveys before and after the project, identified that Child Safety staff believed the position had increased their knowledge around the mental health problems of the children and families they work with, improved relationships with CYMHS and improved referral pathways and access to care for children. There was disappointment that resourcing was not available to extend the project when it finished. The position was not resourced to provide direct clinical assessment but this is an option that could be considered for this model. Further information about this project and the evaluation data collected can be obtained on request.

Non-Government Organisations and Private Practitioners

Across the State, children and young people with difficulties arising from abuse and neglect may receive counselling from a number of NGOs who have established expertise in the area e.g. ACT for Kids, Benevolent Society, Boystown, etc.

These agencies provide trauma informed care for young people and families including early intervention, parenting and family-based interventions and more specialists counselling for individual children. They are an important resource for children at-risk and children in care and their contribution should be recognised, valued and resourced appropriately.

There are private practitioners that work with such young people including private child and adolescent psychiatrists, psychologists, social workers. This group also offer significant expertise in the area and often the benefit of long-term continuity of care. Long-term, low to moderate intensity of therapeutic intervention can be valuable for some children and young people, through the security of the therapeutic relationship that is established and the sense of feeling known, understood and valued. It can also provide continuity of care for foster-parents and carers where they can problem-solve issues as they arise.

Children in care have high rates of mental illness for which treatment may include psychotropic medication. The need for medication, prescription and ongoing monitoring should be undertaken by a Child and Adolescent Psychiatrist whenever possible. Where a young person is on medication, long-term follow-up with a child and adolescent psychiatrist should be in place and private practitioners are well placed to offer this long-term care.

Child Safety Services should have an awareness of the resources available in their community and have in place referral pathways. We suggest that there are network relationships between child safety services and therapeutic agencies within districts.

Child and Youth Mental Health Services (CYMHS)

Children in care with mental health problems are recognised as a group that warrants special attention and priority access to mental health services. Child and Youth MHS require adequate resourcing to enable provision of assessments and interventions at tertiary level and education, training and support to those government and non-government agencies working with children.

CYMHS offer tertiary level mental health care across the spectrum of mental illness in young people; services strive to balance the needs of all young people and their families with mental health problems, in the communities they serve. Children in state care form one section of this population at need. The major barrier to effective service provision for all children including children at-risk and children in care is the significant gap between the current resourcing of CYMHS and the rates of mental illness in children and adolescents and population need. CYMHS have triage processes that liaise with referrers to identify most appropriate pathways for assessment and intervention. Strong relationships between CYMHS and Child Safety Services should be facilitated and developed and there is considerable willingness to this end e.g. with the development of the Memorandum of Understanding between the Department of Communities (Child Safety, Youth and Families) and Queensland Health, Child and Youth Mental Health Services 2010-2013.

A multi-disciplinary team approach, such as provided by Child and Youth Mental Health Services and Infant Mental Health Services, is recommended for

comprehensive assessment of infants and very young children and those presenting with more severe or complex symptomatology. This provides specialist consultation and supervision from a child and adolescent psychiatrist in combination with the expertise of psychologists, nurses, social workers and other disciplines working as a collaborative team to achieve the best outcomes.

Comprehensive mental health assessment identifies optimal treatment for the child, and provides carers and other professionals (e.g. schools, child welfare workers, judges) with valuable information to assist them in understanding the child's difficulties and meeting their needs. Treatment plans are developed that organise and prioritise interventions in the major areas of the child's life i.e. home, peers, school. CYMHS provides or facilitates access to interventions as indicated from the assessment. This may include education, training and support for carers, teachers and other professionals involved with the child, learning assessment and support, individual psychological interventions, family and social interventions (with family-of –origin, foster-families or carers) and psycho-pharmacology (to reduce symptoms and facilitate functioning) which should be prescribed and monitored by a child psychiatrist as above. As noted, CYMHS are not resourced to provide long-term care so, as problems reduce and resolve, discharge planning includes assessing the child and family's needs for ongoing care and support and referring appropriately. Where a child is on medication this is likely to include recommendations for referral to private child and adolescent psychiatrists for monitoring of progress overall and medication management in particular.

It is important to note that it is accepted by experts in the field, that current diagnostic systems do not capture impact of childhood abuse and neglect. A diagnosis of Developmental Trauma Disorder has been proposed but is not yet accepted. Under current systems, children who have been affected by abuse and neglect can meet criteria for several different disorders, often a combination of learning difficulties, behavioural disorders and anxiety/mood disorders. Specialist child and adolescent psychiatrists have the expertise to assess, discriminate between disorders and avoid inappropriate and unhelpful labelling or medication use.

Evolve Therapeutic Services

The Evolve Inter-agency Services (EIS) program commenced in 2005 as an outcome of the Forde inquiry recommendation that there be specialist services for children in care and has been progressively rolled out across the State.

Queensland Health, via district CYMHS, provided the mental health arm of this program, Evolve Therapeutic Services (ETS). ETS, which targets the 17% of children in care with the most severe and complex difficulties, has resulted in improved outcomes for these children with improvements in mental health and psychological wellbeing, placement and educational stability and engagement and decreased externalising behaviours.

It is our recommendation that ETS and the EIS program be continued, and that consideration be given to expansion of ETS to allow further service provision for at-risk children and children in care through areas such as:

- Step-down care for young people who require continued consistency of therapeutic contact but less intensity in intervention and are at high-risk of relapse.
- Assessment and intervention of all infants taken into care, where the subtle but potential long-term impact of childhood abuse and neglect can be easily missed and early intervention can have significant benefit.
- Early intervention with highly complex families before they reach the point of removal of their children or when children have been recently removed and the capacity for the parents to change is being evaluated. Comprehensive assessment and intervention with such families from a specialist service would be able to facilitate best practice in intervention with the family and, if reunification or change is unsuccessful, permanency planning with a clear understanding of the child's needs.
- Capacity to provide a transition service to facilitate mental health input into decisions relating to an individual's post-care independent living. This may include assisting transfer to adult mental health services and/or multi-disciplinary assistance with mental health resilience enhancement or specific skills acquisition around independent living skills.

- Return to the former capacity of the ETS to provide child psychiatry registrar training positions given work in this area is core to child and youth mental health practice and ETS training will enhance the continuation of specialist expertise in this area.
- Enhance the amount of specialist child and adolescent psychiatrist input into ETS to expand the accessibility of the role and facilitate training of registrars and other professionals.

Forensic assessments

CYMHS are well placed in terms of expertise, to work with families and provide advice to child protection services about family and child functioning and engagement with and response to treatment.

There is a well-recognised and accepted differentiation of the role of treating, therapeutic practice and services and the role of independent assessment for the purpose of assisting courts to make decisions. This differentiation extends to the field of child protection.

CYMHS and ETS are therapeutic treating services, not forensic or legal services. Through their assessment and knowledge of a young person, practitioners and services can provide advice that assists in some areas of the child's needs, including:

- Assisting with identifying appropriate placement and 'fit' and working with carers to stabilise placements.
- Advice on the outcome of the therapeutically based assessment of child and family.
- Information on the parent's engagement with service and degree of change observed in the clinical setting.

CYMHS framework is to work collaboratively with families and young people, drawing CYMHS into the adversarial framework of current child protection services would negatively impact on engagement with families and young people and, therefore, on the outcomes that can be achieved.

In the course of our work, Child and adolescent psychiatrists have had access to reports prepared to assist Child Safety Services and the Court in decision-making. Our experience is that the quality of reports is highly variable. Some practitioners who complete forensic parenting assessments and similar describe doing repeats of reports that were inadequate in content or standard; this is not only expensive and inefficient; it results in delayed intervention planning and permanency planning for children and families.

Appropriate intervention and planning for child and family requires good quality, independent forensic reports that provide the best possible assessment of parent's pathology, parenting capacity and likely prognosis for change. Our recommendation is that Child Safety Services personnel receive education as to what compromises an appropriate report and how to get the right report the first time. Also that Child Safety Services build a database of appropriately skilled report writers so timely referrals can be made to the best available practitioner.

The role of family and carers.

Effective management of any child's health problems depends on the involvement of their primary caregiver, be that biological family or other caregivers, as an active partner who provides vital information to the treating doctor or team and ensures that treatment regimes are followed and appointments attended. In normal circumstances, parents are advocates and participants in their children's healthcare; for children in care guardianship may sit with the State or the biological parent with some delegation to foster-carers regarding matters of day-to-day care. In addition, the 'competent minor' can give consent for health care, including mental health care, and has a say in determining who has access to their health information. For complex mental health problems, it is essential that primary caregivers are fully informed of their disorders and provided with appropriate education, support and training to enhance their capacity to provide optimal care. Involving the biological parents is necessary when they retain guardianship rights and generally appropriate and preferred, especially when reunification is likely. This may include assessing their capacity to provide suitable care and building their capacity to do so through education, training and support. Issues can arise when biological parents retain guardianship rights and are either able to be contacted or unreasonably refuse consent to mental health treatment

(including but not limited to psychopharmacology), when specialists and those with day-to-day care of the child or young person see a clear need for treatment. Protocols for facilitating prompt access to necessary treatment in this situation are needed.

Child Protection Services in Queensland

Currently, Child Safety Services in Queensland struggles to complete its function i.e. the protection of children from abuse and neglect, despite valiant efforts and highly motivated staff. Our experience is of a service that suffers from deficits in the number, experience and training of staff, exacerbated by rapid burnout and high staff turnover. Our impression is of a service struggling to maintain a minimum level of investigation of cases, with efforts weighted to the more severe end, so that cases of low to moderate risk that might be more amenable to intervention and support do not get the attention they require. Lack of early intervention with moderate cases makes it highly likely many children will represent at a later date having experienced more severe abuse.

Children and their carers express their frustration at the changes in staffing and lack of continuity of the Child Safety Officer (CSO) they are dealing with. We, as psychiatrists, and the clinicians we work with in CYMHS and ETS, find ourselves spending valuable time repeatedly explaining the child's background, difficulties and strengths to the new CSO and helping them come to know the young person they are now responsible for so as to facilitate better decision making that occurs in the child's best interests. This is important work, but frustrating to have to repeat at regular intervals for the same child. We also see the benefits that occur when a child has a consistent CSO for a long period of time and develops a trusting relationship with their CSO through experiencing and believing that they are known and heard.

We feel it is imperative a root cause analysis (RCA) is undertaken to more clearly understand factors leading to poor CSO retention and rapid staff turnover. Such an undertaking could be expanded to include a thorough review of the knowledge and skills required to address the needs of children and families and development of training and professional development to address these needs. A more expert

workforce is likely to have better morale and stability, returning that investment to the workplace, and is better placed to function efficiently. Attainment of increasing skills, knowledge and experience should be recognised in career pathways; it is better to pay for more highly trained staff who are more effective and efficient than to have staff that stay in jobs for short periods. Any other issues, including problem work practices identified in a RCA must be addressed if the professionalism of CSOs, and ultimately their ability to care for children is to be improved, see section below.

Effective Organisations

Effective organisations consist of people who feel calm, safe and secure and have good networks and working relationships. The functioning of people and groups is influenced by internal and external factors, with all functioning being state dependent i.e. a group or employee in a state of safety and predictability will function differently (more effectively) than a group or person who is under threat (either actual or perceived). Child protection and welfare services have been found to function better when there is a climate of safety, security and calmness for the employees. These organisations achieve better outcomes for the young people and families with whom they are working. [19] This has led to the development of models of organisational functioning that promote a strong, resilient, tolerant, caring, knowledge-seeking, cohesive and nonviolent community where staff are thriving, people trust each other to do the right thing, and clients are making progress in their own recovery within the context of a truly safe and connected community e.g. the sanctuary model [20] for working with traumatised people and families.

It is our experience that Child Safety Services staff operate in a climate of pressure and anxiety, related to high workloads, limited experience, limited professional development, support and supervision, high community expectations and fears of adverse attention from the media and political spheres. [In this context, 'supervision' is the process by which individuals and groups spend time with an experienced and senior person and reflective peers, where they can reflect on their practice, learn from experience and develop skills. It is not critical or judgmental.] It is difficult for staff to function effectively in such an environment, which then adversely impacts on outcomes for the young people and families, despite the best intentions and efforts of the staff involved. The decisions around protection of children, especially related to

removal and placement change, involve making a decision between 2 options both of which carry a risk of harm. Removing a child from the family, breaking the relationships that they have, however maladaptive they may be, has a negative impact. Child protection workers should receive support in managing the conundrums in which they frequently find themselves.

Accessible Services

Families can have difficulty getting to the various services that they need to access, especially when they have multiple appointments (e.g. relating to parent, child and family counselling, healthy checks and child safety appointments). Barriers to accessing services can come through practical issues such as location, transport and lack of childcare for the parent's appointment or for siblings; and psychological barriers such as shame, fear and stigmatisation. Creating services in easy to access areas such as near shopping centres and transport hubs can increase use, as can creating environments that are appropriate to location and community and welcoming. One option is providing services in a 'natural environment', one in which children spend time such as schools and shopping centres. At least some Council jurisdictions provide family services including coffee groups, play groups, childcare, exercise classes based at community centres. Consideration could be given to e.g. outreach clinics from health and child welfare at these venues and developmental of co-located service and community centres where facilities are lacking.

Another is combining services into a 'one stop shop', which can decrease the burden on vulnerable families of multiple appointments with multiple agencies in different locations and facilitate better coordination of services. Provision of a childcare facility could be considered where parents are accessing service for their own issues or for siblings; a one-stop-shop set-up would assist in making this be cost-effective. Again activities could be provided that benefit parents and families, such as parenting groups and play groups, health checks and immunisation clinics. In infants and young children, diagnosis may be uncertain and co-morbidity is common, therefore, access to service should be related to the presence and severity of difficulties and concerns rather than being diagnosis based, requiring a specific diagnosis for entry. This improves accessibility, reduces stigma and prevents premature labelling in order to access services.

The Children's Mental Health Coalition recommends the establishment of "Kids Life Centres – Growing Healthy Minds". Early intervention centres for 0 to 12 year olds that co-locate family supports, parenting interventions, paediatrics, developmental specialists and mental health services. [21]

Home visits also help with accessibility issues and can result in effective intervention but are costly in staff time and resources.

Collaborative Practice

Working with families

Parents who have suffered childhood adversity often have high levels of shame and guilt leading to difficulty accessing services. In addition, the current system is highly adversarial, our 'black and white'; legal based system, which looks for 'proof' to answer the dichotomous question "is this a good parent?" does not facilitate families accessing help and support. The current system is based on investigation, a process families often perceive as being negative, intrusive and blaming and which sets up an adversarial relationship between parents and the services attempting to assist them and their children.

Whilst it will take long-term extensive systemic and social changes across legal, welfare and health systems, we recommend moving to practices that are collaborative as much as possible whilst always placing the health and welfare of the child at the fore.

Two main types of child welfare systems have been described in Western countries that are otherwise similar in being reasonably prosperous and having established welfare systems, the UK-North American-Australian and the Continental West European approaches. [22] Whilst this by necessity is over-simplified description, the difference in approaches is worth consideration. The UK-North American-Australian model is investigative, eligibility is determined by families reaching severity and risk criteria and compulsory, there is a tendency to residual and selective provision for those families who have 'failed' and permanent removal of a child is more common.

The child protection system is legal, bureaucratic, investigative and adversarial. The primary focus is on individual children and professionals are primarily responsible for the child's welfare. Investigating risk is the basis of service provision and planning and resources are concentrated on families where the risks of abuse and re-abuse are immediate and high. These symptoms may be more consistent in their identification of abused and neglected children. In contrast Continental West European approaches tend to comprehensive and universal provision of service that is accessible to all, embedded within and normalised by broad child welfare or public health services. The child protection systems are voluntary, flexible, solution-focused and collaborative and there is an emphasis on family unity. Professionals usually work with the family as a whole. Service(s) are focused on therapeutic responses to meeting needs or resolving problems and resources are available to more families at an earlier state. Child protection in these countries seems better at matching services to the needs of both children and their families.

Inter-agency collaboration

Effective care, including mental health care, for children requires a coordinated approach with liaison between medical specialities and other health professionals, education, child protection, carers and their support agencies and other agencies the young person is involved with as needed, e.g. youth justice. Coordination of care is not only important in providing optimal care; it also helps ensure access to and efficient use of services. Psychiatrists working in private practice and CYMHS have experienced a young person under their care being referred by a well-meaning CSO to another practitioner or service without any consultation, often precipitated by a crisis. This results in fragmented, inefficient care, and confusion for young people and their carers. Child Safety Officers seem best placed to undertake the coordination of care but often lack the time and understanding to undertake this task.

We recommend consideration be given to resourcing and training CSOs to coordinate care, with an emphasis on collaborative practice, and discussion with all current treating professionals before involving any new agencies or specialists.

A significant proportion of children and adolescents seen by CYMHS have histories of abuse and neglect and current contact with the child protection system. Referral

may occur in both directions between the services. Collaboration has improved but it is important to consider that functions and frameworks are significantly different. One concern is when child protection services believe that a referral to CYMHS means the child's safety is being monitored when CYMHS not able to take on this role. CYMHS have expertise in the assessment and management of traumatised and neglected young people, family assessment and care planning and intervention.

Subsequent to the development of the EIS, has been the development of a Memorandum of Understanding between Child Safety Service and Child and Youth Mental Health Services. Implementation of this MOU is in the early stages, but there is considerable willingness to improve collaboration, identification of children in need of service and appropriate service provision between CSS and CYMHS.

Evolve Interagency Services

A major goal of EIS was improved collaboration between services and this was facilitated by legislative change allowing information sharing by 'prescribed entities'.

Sharing of information has been a crucial factor in the success of EIS and facilitation information sharing in the best interests of the child across involved agencies is recommended. Information to ensure the safety of the child should be shared by all professionals involved in the care of the child and the primary caregivers. In particular, information sharing on at-risk children with early identification of indicators such as school absence and enrolment change could help services respond early to problems in the child's care or home life.

Specific populations:

Aboriginal and Torres Strait Islander populations

The Australian Indigenous population is a diverse group with different kinship groups and languages that has adapted to diverse living conditions over many years. Their social and cultural integrity is challenged by the cumulative effects of colonisation, damaging policies e.g. 'the stolen generation', exploitation, separation from the land, poor health, alcohol, drug abuse, gambling, unemployment, poor education and

housing and general disempowerment leading to the breakdown of traditional values and customary law. Traditional child rearing practices are significantly from those of Western society so care must be taking in ensuring parent and child assessments are culturally appropriate and any assessment tools are relevant and valid with the indigenous population. Understanding and expression of mental illness and health also differs and care must therefore be taken to avoid misdiagnosis.

28% of the Australian population of ATSI peoples live in Queensland (2011 census data) [23]

In 2008–09:

- The rate of Indigenous children on care and protection orders was more than 8 times the rate of non-Indigenous children.
- The rate of Aboriginal and Torres Strait Islander children in out-of-home care was just over 9 times the rate of non-Indigenous children.
- Indigenous children were 7.5 times as likely to be the subject of substantiations as non-Indigenous children. [24]

Aboriginal and Torres Strait Islander (ATSI) children are over-represented in the population of children at risk and in out of home care.

Culturally and Linguistically Diverse backgrounds.

Australia is a culturally diverse country; this is well represented in Queensland with over 26% of Queenslanders having been born overseas (2011 census data [25]) and approximately 20% of households speaking a language other than English at home. A significant proportion of new settlers come from countries affected by war or political unrest. Currently there are no published data on the proportion of children in the care system that are from CALD backgrounds although it has been estimated as being about 2 to 4%, a small percentage of these would be refugee children who have arrived in Australia unaccompanied and may have spent time in detention.

Child-rearing practices are strongly influenced by culture and cultural values impact on the mother-child relationship, e.g. western cultures value independence, whereas other cultures uphold familial inter-dependence. Cultural values impact on the parent-child relationship and prompt responses to child behaviours that ensure consistency

with culturally valued behaviours. Maternal responses that do not match those considered appropriate by the prevailing Western culture may be wrongly interpreted as being harmful or dysfunctional if parent-child relationships are assessed without culturally sensitivity and culturally appropriate measures. Similarly child behaviour can be wrongly judged as symptomatic when judged against behaviour considered normal in the Anglo-western culture. Migrant children acculturate more rapidly than their parents and this can be a source of tension within families and a source of stress for the child, who is attempting to be socially competent in 2 cultures.

Child protection, health and other services involved with families of ATSI and CALD background should:

- **Ensure they are culturally informed and sensitive, especially around culturally norms of child-rearing and family functioning.**
- **Have access to professional interpreters and should have a low threshold for using interpreters even when a parent's spoken English appears reasonable, especially when health, legal or other complex information needs to be communicated.**
- **Should avoid using family or community members for interpretation as there is a risk of issues of confidentiality, misunderstanding of 'jargon', and shame in the community that will impact on the information given and interpretation.**

Intellectual Impairment

Children with intellectual disabilities are at increased risk of mental disorders when they experience childhood abuse and neglect, and the development of disorder may be missed due to their intellectual impairment. Therefore, it is recommended that all children with an intellectual disability should have a comprehensive mental health assessment when entering care.

Evolve Behaviour Services is the Disability Queensland arm of EIS. It is resourced to provide specialist intervention for children who have a disability, severe behaviour problems and are in out-of-home care. ETS and EBS collaborate in the functions of the EIS Panel (for triage, case allocation and discharge) and may work together to assist a young person where this is indicated. Our impressions of EBS are that it has

motivated, well-intentioned allied health staff but has been slow to adopt a trauma-based model of care, lacks specialist input e.g. from paediatrician or child psychiatrist, can lack coordination of care, is isolated as DSQ does not otherwise provide services to school-aged children, lacks step-down and alternative referral pathways if EBS is at capacity or children need a lower level service and staff retention has been problematic in some districts. A review of the model of care, particularly in regard to implementing specialist input and a trauma-based model of care in additional to the behavioural focus is recommended.

Monitoring and Evaluation, Research

Data collection, evaluation, feedback and research are the foundations of evidence-based practice and quality care and enable determination of the relevance, effectiveness, efficiency, and impact of activities in achieving their goals. Together they inform the planning and delivery of services and measure the impact on the burden of disease.

There should be processes in place for the routine collection and review of epidemiological data on children in care and the general population, processes should allow for the comparison of sub-populations such as ATSI and CALD with appropriate comparison groups and methodologically sound evaluation should be utilised. Information gathered is used to ensure that the provision of care and protection to children at risk and children in care is accessible, relevant, culturally appropriate and cost-effective.

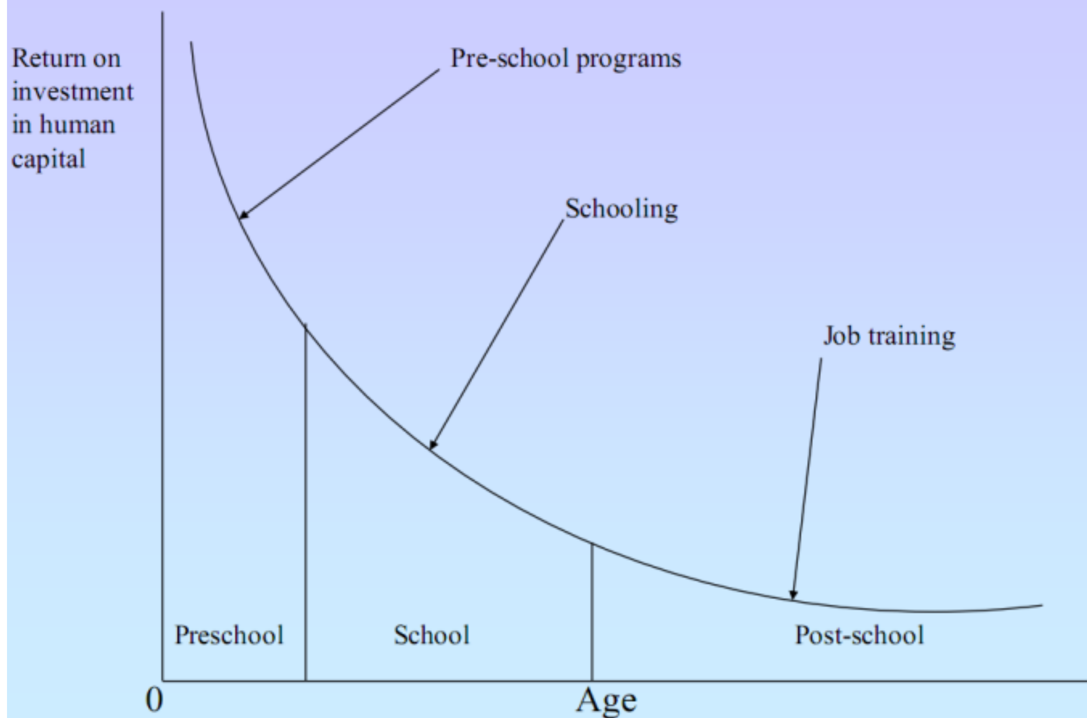
Information should be used to enhance the knowledge base regarding children in care, their needs, and the effectiveness of interventions. Little research has been conducted regarding children in care in Australia and international research may not be generalizable, particularly in regard to interventions.

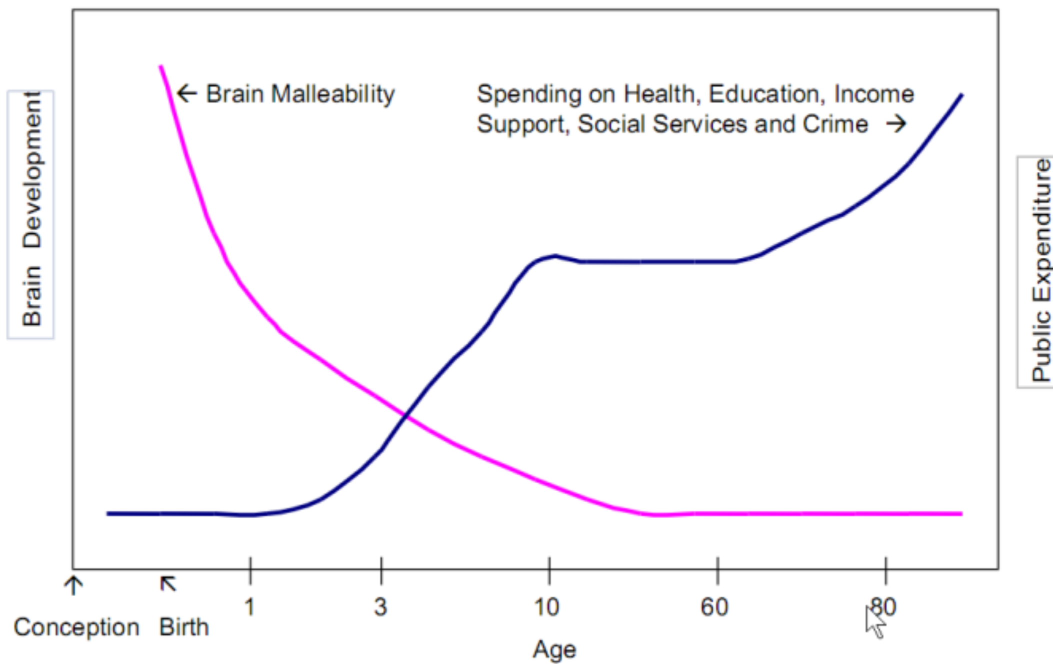
Funding Issues

The sustainability and economic future of our State depends on a healthy, socially competent and skilled population that actively participates in the workforce. School achievements and adult economic productivity are dependent on the cognitive, social and emotional capabilities developed in childhood i.e. on healthy development and sound mental health. Early childhood development programs for disadvantaged children have been shown to have positive socio-economic benefits extending into middle adulthood. Investment into early childhood interventions for children at risk, disadvantaged children and children in care including access to quality childcare, parenting and early developmental interventions, health care and mental health services will prevent result in significant social and economic savings across generations.

The economic, social and personal costs of mental, emotional and behavioural disorders in young people are high. Mental disorders cause the highest burden of disease in the 0 to 18 years age group, almost a quarter of the overall disease burden. Half of mental illness starts before the age of 14 years and many disorders continue into youth and adulthood if not treated. [26] Whilst mental disorder results from diverse genetic, developmental and environmental factors; as discussed above, child maltreatment is a significant and potentially preventable predisposing factor.

Social strategies and early intervention that improve the safety and development of children early in life improve outcomes and reduce the burden of disease. Strategies and investment targeted at families and young people have the potential to generate greater personal health, social and economic benefits. The economy of early investment is highlighted in these graphs by Nobel Prize winning economist and psychologist James Heckman:


Rates of return to human capital investment (Heckman 2000)
Return on investment in human capital
Pre-school programs
Schooling
Job training
Preschool
School
Post-school
0
Age


Brain Development
– Opportunity and Investment
Brain Development
← Brain Malleability
Spending on Health, Education, Income Support, Social Services and Crime →
Public Expenditure
Conception
Birth
1
3
10
60
80
Age

Heckman notes the cost savings to be made by investing in the development of children's early social skills, leading to enhancement of their later working capacity and economic contribution to their community. [27]

Balancing budgets across a diverse population with diverse needs is an ongoing challenge for governments but currently children are not getting their fair share and investment in children is missing the crucial early years where spending has the potential to have the most effective outcomes. Budgetary spending on child and youth mental health services makes up a much smaller proportion of the health budget than children do in the population. Investment in children, through spending more on their needs, will reap benefits in the long-term for the whole of society.

Conclusions

The World Health Organisation defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease and infirmity". Children with sound mental and physical health are an asset to their societies. Children at risk and those placed in care to protect their safety will need support and intervention to enhance their chances of developing to their full potential despite the adversity they have experienced. To reach their potential, they will need to be provided with appropriate, therapeutic physical, psychosocial, educational, and economic environments. Provision of such services is sound social and economic investment for society and should be a priority for governments.

Child and Adolescent Psychiatrists have considerable expertise and experience in child development, the impact of abuse and neglect and the current interventions and treatments that are indicated for this population of children and families. There is considerable motivation and impetus among the Faculty to further the understanding of this field across the community, especially directed to those working with this group, and improve outcomes for children, families and society.

References & Resources:

Due to the time frame for preparation of this document, this is only a limited list of the references and resources underlying this submission; further references can be provided on request.

---

[1] The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry. RANZCP June 2008
http://www.ranzcp.org/Files/ranzcp-attachments/Resources/FCAP_paper_on_Out_of_Home_Care_June_2008-pdf.aspx

[2] RANZCP FCAP Submissions:
Special Commission of Inquiry into Child Protection services in NSW (March 2008)
http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/sub3-pdf.aspx
Feedback from the RANZCP FCAP (NZ) on the Green Paper for Vulnerable Children.
http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/sub93-pdf.aspx

[3] The Economic Costs of Child Abuse and Neglect
Australian Institute of Family Studies, June 2012
http://www.aifs.gov.au/cfca/pubs/factsheets/a142118/index.html

[4] Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). *The cost of child abuse in Australia*. Melbourne: Australian Childhood Foundation and Child Abuse Prevention Research Australia.

[5] Tomoda A., Navalta CP, Polcari A, Sadato N, Teicher MH . Childhood sexual abuse is associated with reduced grey matter in the visual cortex. Biological Psychiatry

[6] Tomoda A., Suzuki H., Rabi K., Sheu YS., Polcari A, Teicher MH . Reduced prefrontal cortical grey matter volume in young adults exposed to harsh corporal punishment. Neuroimage 2009, suppl 2, ppT66-71.

[7] Choi J., Jeong B., Rohan ML., Polcari, AM., Teicher MH. Preliminary evidence for white matter tract abnormalities in young adults exposed to parental verbal abuse. Biological Psychiatry 2009, 65(3), 227-234.

[8] Meaney MJ., Szyf M. Maternal care as a model for chromatin plasticity? Trends in Neuroscience, 2005, 28:456463

[9] Yehudas R., Engel SM., Brand SR., et al. Transgenerational effects of Posttraumatic Stress Disorder in Babies of mothers exposed to the world trade centre attacks during pregnancy. Journal of Clinical Endocrinology and Metabolism, 2005, 90(7):4115.

[10] As the twig is bent, the tree inclines. Adult Mental Health Consequences of Childhood Adversity. Scott, J. Varghese, D. McGrath, J. Arch Gen Psychiatry 2010: 67 (2)

[11] University of Queensland, Parenting and Family Support Centre, Triple P evidence-base
http://www.pfsc.uq.edu.au/research/evidence/

[12] The Incredible Years program – evidence of effectiveness
http://www.incredibleyears.com/ResearchEval/effective.asp

[13] The Mass Media and the Prevention of Child Behavior Problems: The Evaluation of a Television Series to Promote Positive Outcomes for Parents and Their Children. Sanders, M R. Montgomery, DT, Brechman-Toussaint ML Journal of Child Psychology and Psychiatry 2000; 41 (7); 939–948

[14] Department of Communities, Child Safety and Disability Services. Child Safety Services. http://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/introduction

[15] Bromfield L and Osborn A. 'Getting the big picture': A synopsis and critique of Australian Out-of-home care research. Child Abuse Prevention Issues No 26. Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies. 2007.

[16] SACCS, UK. http://saccs.co.uk/about-us/professional-development/

[17] UK, Department of Education. Secure Children's Homes. http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065676/secure-childrens-homes

[18] Calmer Classrooms: a guide to working with traumatised children. Child Safety Commissioner, State Government of Victoria. 2007 http://www.kids.vic.gov.au/downloads/calmer_classrooms.pdf

[19] Dr. Bruce Perry, MD, PhD, Senior Fellow, Child Trauma Academy, Houston, USA. http://www.childtrauma.org Speaking tour, Melbourne, August 2012.

[20] The Sanctuary Model http://www.sanctuaryweb.com/index.php

[21] Our Children, Our Future. The Children's Mental Health Coalition. http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Our_children_our_future_final_updated_010910-pdf.aspx

[22] International Perspectives on Child Protection. Report of Seminar held 20/3/2002 as part of the Scottish Executive Child Protection Review – Protecting Children Today and Tomorrow. http://www.scotland.gov.uk/Resource/Doc/1181/0009926.pdf

[23] Australian Bureau of Statistics, 2011 Census Data http://www.abs.gov.au/census

[24] Child Protection 2008-9. Australian Institute of Health and Welfare http://www.aihw.gov.au/media-release-detail/?id=6442464861

[25] Australian Bureau of Statistics http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/3?opendocument&navpos=220

[26] Lifetime prevalence and age of onset distributions of DSM-IV disorders in the national comorbidity survey replication. Kessler RC et al. Arch Gen Psychiatry 2005: 62: 593-602

[27] Working paper – Investment in the very young. Heckman JJ. Chicago: Harris Graduate School of Public Policy Studies 2000.