Children in Care:
what we know versus what we do: Is there a gap?

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acknowledgements

• Charles Zeanah
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2 AM consult: Kanita aged 11

- Rung by registrar PMH ED due to presentation of 11 yo girl with carer due to DSH –cutting- “behavioral” as angry she didn’t get her way

- Poor background developmental history, or clear account of current stressors

- Girl presented as flippant and denied ongoing urge to harm self

- History of multiple similar presentations over past 3 months
History provided by case worker following day

- Increasing marked emotional and behavioural disturbance over past 6 months in context of rejection from long term foster carer and breakdown of multiple subsequent placements
- First experience of therapy 5 months ago (psychologist) with recent change of therapist
- Increasing concern with request for specialist MH assessment and intervention
Current symptoms

- Profound emotional disturbance - lack of empathy, dissociation, lability, disinhibition, sexualised behaviour to carers
- Behavioural disturbance with aggression, rivalry, running away, fire setting, deliberate self harm in context of anger and frustration
- Desire to die, yet expressed fear of dying and fears for safety
Background story

- Born to adolescent mum in volatile on off relationship with defacto
- Admitted PMH aged 8/12- FTT- Mum using skim milk
- Placed with Paternal GPs until 18/12
- Reunited with Mum- who had had 2\textsuperscript{nd} baby girl
- Aged 27 months 3\textsuperscript{rd} baby born- died aged 2/12 ?cause of suffocation
- Aged 3 yrs removed 2*substantiated physical and emotional abuse
- Placed briefly with paternal GPs who could not cope with sibling rivalry and emotional problems
Placement history

- 0-8/12 mum
- 8/12 - 18/12 paternal grandparents
- 18/12 - 3 yrs of age mum with new sib
- Aged 3-11 yrs, 2 sisters placed with departmental carer
- Significant emotional and behavioural problems leading to placement breakdown
- Returned to paternal GPs - unsuccessful
- 11+ String of emergency placements then group home
Mental health intervention

• Age 11 following placement breakdown
• Childhood adversities associated with mal-adaptive family functioning (parental mental illness, child abuse, neglect) strongest predictors of disorders (Kessler et al, 2010)

• **Child abuse:** increased risk of depression (OR 2.9), PTSD (OR 4.0), psychosis (OR 2.7), alcohol dependence (OR 1.8) and drug problems (OR 2.1) (Jonas et al, 2011)

• **Sexual abuse:** increased rates of adult depressive disorder (OR 6.2), PTSD (OR 6.8), probable psychosis (OR 15.3), alcohol dependence (OR 5.2), eating disorder (OR 11.7) (Jonas et al, 2011) and attempted suicide (OR 9.4) (Bebbington et al. 2009)
Cumulative stressors and psychiatric disorders

Egger, 2004
Odds Ratios of Later Disorders Following Early Childhood Maltreatment

- Physical
- Neglect
- Sexual

Categories:
- Depression
- DBDs
- SUDs
- Cluster A
- Cluster B

Graph shows the odds ratios for different disorders across various types of maltreatment.
Adverse Childhood Events and Adult Substance Abuse

Self-Report: Alcoholism
Dube et al, 2002

Self-Report: Illicit Drug Use
Dube et al, 2005
Adverse Childhood Events and Adult Ischemic Heart Disease

Dong et al, 2004
Predictors of severity of symptomatology

- Child’s age at first traumatization
- Frequency of traumatic experiences
- Extent to which caregivers implicated in trauma
- Parent’s psychological status and quality of relatedness to child
Why do Kids in care have such poor mental health outcomes?

- Impact of early childhood abuse/trauma most profound

- We know relational abuse and trauma derails normal acquisition of developmental capacities: How and why does this happen?

- Long term consequences for emotional, social, cognitive and physical competence
The paradox

- Children less than 1 yoa account for >40% fatalities, and less than 3 yrs of age >70%

- Children younger than 5 disproportionately represented in homes with domestic violence, which is associated with neglect

- Cumulative effect of multiple individual, family, community and cultural risk factors

- Profound gap between prevalence and known impact of early childhood relational trauma with assessment and treatment by specialist infant mental health programs for infants entering care
Economics of child abuse

- For Australia estimated annual cost of child abuse and neglect was $4 billion for 2007
- Estimated lifetime costs for the population of
• Why don’t we read...
We are all relational beings, and our brain develops optimally only within the context of a good enough relationship.

In particular, the Right orbitofrontal cortex is dependent on positive experiences in relationship for its growth.

Its development is shaped, positively or negatively by attachment experiences.
Evolutionary function

- The essential task of the first year of life is the creation of a secure attachment bond of emotional communication between the infant and caregiver.

- We are hardwired (deeply genetically ingrained) to attach and this happens even in situations of deprivation and maltreatment.
Attachment: the basics

- Parents provide a **secure base** from which infants can explore the world
- Parents provide a **haven of safety** that protects, comforts and organises feelings and behaviors when it is all too much for the infant
- Infant uses the caregiver as a secure base for exploration.
- Infants return to caregiver when wary or distressed:

> “*Flight to attachment figure as a haven of safety in times of alarm*”
Building the blocks of Attachment

- How the parent is.. how they respond to the baby **shapes** the developing attachment relationship over the first year of life.

- At about 7 months children develop primary attachment patterns

- Over the 1st year a process of regulation is developing between caregiver and infant:
  - This vital regulation builds positive feeling states and dampens negative feeling states
  - The heart of developing a secure attachment is the sense that your caregiver is available to “be with” you at times of need.
Attachment disruptions

• Even brief separations can be upsetting and reunions are special, even when infant is not upset

• Prolonged separations are profoundly disturbing, with characteristic sequence of protest, despair and detachment.

• On reunion, infants often ignore caregiver, followed by angry ambivalence and then rapprochement

• Research into the effect of prolonged separation has profoundly altered hospital practice (Robertson films)
Lifelong significance of Attachment

• As the attachment system is woven into a relationship an affectional bond is created.

• This persistent bond sets up what we think of ourselves and what we expect in relationships for life, an “internal working model” of self and other.

• Variation in the quality of attachment depends on how responsive caregiver is and how much reciprococity there is in relationship.
Circle Of Security
Parent attending to the child’s needs – Top half of the Circle

I need you to
- Watch over me
- Help me
- Enjoy with me
- Delight in me

Support My Exploration
Circle Of Security

Parent attending to the child’s needs – Bottom half of the Circle

- Protect me
- Comfort me
- Delight in me
- Organize my feelings

Welcome My Coming To You

I need you to

I need you to

SAFE HAVEN
Almost everything I need to know about being a parent:
25 words or less

Always: be BIGGER, STRONGER, WISER, and KIND.

Whenever possible: follow my child’s need.

Whenever necessary: take charge.

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The Attachment Cycle

**Child Distressed**
- Increased heartrate, breathing
- Feels enraged, helpless, hopeless

**Carer Soothes Child**
- Physical contact, food, dry pants, comfort.

**Child Learns**
- Caregiver = Comfort
- The world is a good place
- I can trust people to meet my needs
- My needs make sense

**Child Content/Asleep**
Disrupted Attachment

Child Distressed
- Increased heart rate, breathing
- Feels enraged, helpless, hopeless

Child Learns
- Caregivers are untrustworthy
- The world is a hard place
- No-one can meet my needs
- My needs don’t make sense

No Comfort
Caregiver doesn’t come, or doesn’t acknowledge or attend to child’s need

Child Distressed
- Increased heart rate, breathing
- Enraged, helpless, hopeless
INFANT BRAIN DEVELOPMENT

- Experience-dependent, increase of 100% volume in first year, 15% in 2nd
- 41 Billion neural pathways per hour
- 11 Million per second
- Establishing Patterns that appear to last throughout our lives, unless altered
- New neural pathways can be formed
Brain: early tasks

- Our brain is genetically programmed to need certain experiences at certain times early in life to develop: The mind emerges as the brain responds to experience.

- Quality of interpersonal relationships are of crucial significance to HOW structure and function develop.

- Explains WHY trauma and stress in early years (when rapid development and reorganisation occurring) has greatest impact on growth of mind.
What is role of prefrontal cortex?

- Integrates social, emotional, bodily and autobiographical aspects
- Central emotion regulation system
- Enables us to understand the emotional states of others (empathy)
- Fear coded by amygdala, can be overridden by prefrontal cortex
- Senior executive of socioemotional brain
Neurobiological consequences of early relational trauma

- implicit memory encoding of trauma, with structural limitations of early developing right brain and prefrontal system:

  - functional outcome is abnormal development of social and moral behaviour and:

    - Inability to regulate emotional states under stress: fear/terror, aggression

    - Childhood chronic traumatic maltreatment can result in enduring brain deficits and is risk factor for developing personality disorder
Neurological experience for traumatised infant

- Abusive or neglectful carer induces traumatic states of enduring negative feeling in infant with extreme levels of stimulation and arousal
- Lack of interactive repair prolongs duration and intensity of toxic negative states and leads to low stress tolerance
- Sympathetic hyperarousal marked by increased levels of CTRF, leading to increased catecholamines in brain, cortisol, and vasopressin
- Later reaction of dissociation: passive disengagement and withdrawal, dramatic increase in vagal tone “riding gas and brake” leading to freeze response
“Disturbed and abusive parents obliterate their children’s experience with their own rage, hatred, fear and malevolence. The child (and his mental states) is not seen for who he is, but in the light of the parent’s projections and distortions. The infant then takes on the parent’s hatred and aggression, a primitive form of identification with the aggressor.”
Link between mentalization and attachment

• Early experience is vital to development of individual to process social relationships

• Child discovers their primary feeling states, intentions and sense of themselves through their 1st relationship, via their caregiver’s capacity to reflect their experience in action and language

• Research demonstrates strong links between maternal reflective function, attachment status and child attachment status
Mentalization / Reflective function

- Self reflective and interpersonal capacity
- Complex dimension comprehension of desires, beliefs, feelings and intentions - and their internal and interpersonal nature and function
- Explicit and implicit
- Inherently regulating
- Especially important in trauma
Consequences of failed mentalization

- Child loses capacity to recognise subjectivity of self and of other
- Triggers fear, fight or freezing
- Threat to survival
- Linked to later psychopathology
Children’s experiences of multiple traumatic events that occur within the caregiving system – the social environment that is supposed to be the source of safety and stability in a child’s life.

refers to the simultaneous or sequential occurrences of child maltreatment—including emotional abuse and neglect, sexual abuse, physical abuse, and witnessing domestic violence—that are chronic and begin in early childhood.

Initial traumatic experiences leads to emotional dysregulation, loss of a safe base, and inability to detect or respond to danger cues, can lead to subsequent trauma exposure (e.g., physical and sexual abuse, or community violence).
Domains of Impairment

- (I) Attachment
- (II) Biology
- (III) Affect regulation
- (IV) Dissociation
- (V) Behavioral regulation
- (VI) Cognition
- (VII) Self-concept.
Limitations of Diagnostic systems

- Current diagnostic systems do not capture the impact of childhood abuse and neglect.

- A diagnosis of Developmental Trauma Disorder has been proposed but is not yet accepted.

- 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 mental health assessment is required to assess, discriminate between disorders and avoid inappropriate and unhelpful labelling or medication use.
“ordinary sensitivity is usually insufficient to give emotionally deprived children a feeling of predictability and continuity...for children who have not known love learning that they are wanted does not come automatically; it calls for conscious and deliberate teaching on parent’s part. Good enough parenting is often not good enough for emotionally disturbed child”

Lieberman 2003
Challenges in care

- Especially difficult for adoptive parents and carers to reflect on and accurately interpret their child’s mental states and behaviour.
- Carers can be poorly equipped to understand and respond to child’s emotional distance, refusal to be comforted, apparent lack of appreciation and preference for them, sudden mood shifts, defiance, non-compliance and aggression.
- Hard to tolerate own emotional responses, and can lead to hopelessness.
Tulane infant team

- Providing comprehensive program for infants and toddlers with substantiated abuse/neglect
- Charles Zeanah Infant Psychiatrist leads multidisciplinary team
- Purpose: Evaluate and treat ALL children < 60 months who are adjudicated in “need of care”
- Focus on young children due to higher incidence of maltreatment and highest vulnerabilities to complex trauma consequences
Goals of program

- Reduce length of time in care (reunify or adopt)
- Reduce maltreatment recidivism rates
- Improve psychological care to infants/ toddlers
- Improve quality of information provided to courts regarding children, biological parents, relatives and foster carers
- Assist foster parents (as much as biological or kin) in management of maltreated children
Funding

- Core funding from state child protective services
- Supplemental funding from charitable foundations
- Housed with government human services entity:
  - Mental Health,
  - Substance abuse,
  - Developmental disabilities
Child Protective services context

• Substantiated allegation leads to removal to foster parent or relative

• Heard in Juvenile Court within 72 hours leading to return or formal Hearing:

• If Hearing occurs informed by assessments

• Outcome:
  • returned to parents
  • Transfer of custody
  • Freed for adoption
Clinical Principles underpinning Evaluation

- Relationship with caregivers in early childhood powerfully effects development
- Young children can have vastly different relationships with different caregivers
- Assessments of behaviour need to be elicited in both structured (WMCI) and naturalistic observation
Case Evaluation Process

- Home visits
- Clinic Visits
- Ancillary measures
- Case conference
- Parent conference
- Court report
Predictors of treatment success

• Acceptance of responsibility for child’s maltreatment and need to change behaviour

• Capacity to place child’s needs first

• Acknowledgement of psychiatric/ substance use / relationship difficulties

• Capacity for change and willingness to try something different

• Capacity to work constructively with involved professionals

• Willingness to engage with available community resources
Treatment

- Individual Psychotherapy
- Couples Psychotherapy
- Family Psychotherapy and therapeutic visitation
- Dyadic psychotherapy:
  - Infant-Parent Psychotherapy
  - Interaction Guidance
- Psychopharmacology
Other treatments

• Crisis Intervention
• Substance Abuse interventions
  • Counselling
  • Residential placements
Percentage of Children Diagnosed with PTSD

Lieberman, Van Horn & Ippen, 2005
Interventions Aim to change SYSTEM

- Infants, families and service providers embedded in a complex system of care
  - Child Welfare
  - Legal
  - Mental Health, Substance Abuse, Developmental Disabilities
  - Healthcare
  - Education
  - Other community resources
Goals of System Change

• To inform system to facilitate change in how it deals with young children holding in mind
  • Developmental impetus
  • Time frame importance
  • Importance of caregiving relationship

• Enhance access to services

• To improve integration and coherence of services
Legal System Impacting Infants

Judge

Protective Services
Attorney
Supervisor
Caseworker

Biological Parents
Mother
Father

Parents’ Attorney(s)

Infant

CASA
Child’s Attorney

Foster Parents
Mother
Father
Levels of System Intervention

- Immediate Clinical Context
  - Infant parent relationship
  - Childcare setting
  - Child protective services

- Legal system
  - Juvenile court judge
  - Lawyers for CPS, children and parents

- Other larger systems
Features of Program

- Comprehensive Multimodal expert services
- Integrated treatment plans
- Relational Infant Mental Health perspective
- Naturalistic and clinical settings- structured and unstructured assessments
- High intensity low volume case load
- Recognition of Countertransference and importance of reflective supervision
- Systems focus
Outcome Questions

Was there change to permanent plan implemented?

Was length of time in foster care reduced?

Where the rates of recurrence of maltreatment reduced?

Consecutive cohort design compared pre and post infant team
Permanent Plan Outcomes

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<thead>
<tr>
<th></th>
<th>Control (91-94)</th>
<th>IT (95-98)</th>
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<tbody>
<tr>
<td>Reunification</td>
<td>49.0%</td>
<td>34.7%</td>
</tr>
<tr>
<td>Relative Placement</td>
<td>18.6%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Termination</td>
<td>20.7%</td>
<td>44.2%</td>
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<tr>
<td>Surrender</td>
<td>11.7%</td>
<td>8.4%</td>
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Percentage Reunifications by Risk Factors

- Education
- Psychiatric History
- Substance Abuse
- Criminal history
- Child abuse history
- Partner Violence
- Depressive Symptomatology
Length of time in care

• Pre permanent decision making: reunification or adoption
  • Control group: 18 months
  • Intervention group 20 months
Risk reduction for reunified children

Of those reunified:

- Intervention group:
  - 68% reduced risk for future substantiated abuse and neglect

- Control group:
  - 50% reduced risk for future substantiated abuse and neglect
Recurrence in caregivers

For those terminated:

Same rates in both intervention and control group:

- 60% risk reduction for subsequent substantiation and adjudication for subsequent child
Child centred outcomes

- Follow up at age 6-7 (only 81 cases)
- Compared with never maltreated children matched on age, gender, ethnicity

Assessment:
- Cognitive: IQ (KBIT) / school adjustment
- Parent, teacher and child report symptomatology CBCL, HBQ
- Interaction with parent
- Home environment
Outcomes of treatment program

- Children treated in program only minor non significant differences in parent, teacher and child self-reports compared with never maltreated children

- Of note home scales, measuring responsivity, acceptance, enrichment, family companionship same between groups

- Breaking down intervention group to bio/kin versus adopted, caregiving environment significantly better in adopted sample

- Caregiving environment mediated effects of maltreatment on several outcomes
Conclusions from Tulane team

Complexity of problems of maltreatment in young children must be matched by *comprehensiveness* of our efforts to

- Minimise suffering
- Reduce developmental deviations
- Enhance development
- Promote competence
Features of Effective Organisations/Systems

- Effective organisations are made up of people who feel calm, safe and secure and have good networks and working relationships leading to collaborative practice.

- Groups or employees in a state of safety and predictability will function 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 and achieve better outcomes when there is a climate of safety, security and calmness.

- Sanctuary has developed model of organisational functioning that promote a strong, resilient, tolerant, caring, knowledge-seeking, cohesive and nonviolent community.
Interagency Collaboration

- Effective care, including mental health care, for children requires a coordinated approach with liaison between health, mental health services, education, child protection, non-government agencies and most of all carers.

- Coordination of care is not only important in providing optimal care; it also helps ensure access to and efficient use of services.

- Unplanned referrals result in fragmented, inefficient care, and confusion for young people and their carers.

- Collaboration requires shared understanding of roles, functions and frameworks
How are we going in WA?

- Do we have an effective comprehensive assessment system for young children and their carers with substantiated abuse and neglect?
- Does this system provide accurate early determination of parenting capacity?
- Does this system facilitate early permanency planning based on needs of child?
- Do we evaluate outcomes of decisions for children?
Do we have right mix of services?

- Do we have an expert intervention system to give young child best chance of resolving early trauma and neglect?

- Does this system focus on caregiving environment and assisting carers via dyadic work?

- Are placement changes avoided, and if necessary carefully planned and thought through?

- Is our workforce adequately supported with training and reflective supervision?
Specialist Clinical intervention versus social support..

- Can these concepts be separated? Challenge of changing perception that specialist mental health care is just about acute inpatient care

- Ideally clinical intervention needs to be integrated with social support rather than model of collaboration

- Integration requires joint understanding, training and development of coherent model of care

- Does current system of tendering for social support create barriers to collaboration?
Does the system in WA function collaboratively?

- Do we have safe services for workers?
- What is service culture?
- Does each part of system function collaboratively?
- How effectively is care coordinated?
Does the system in WA function collaboratively?

- Do we have safe services for workers?
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- How effectively is care coordinated?
Where does our system work best?

- Map what we have versus these questions
- If we could how would we plan differently?
- What are our main priorities?
Minding the Baby

- Dr Linda Mayes Professor of Child Psychiatry, Dr Arieta Slade Child Psychologist, Lois Sadler Professor of Nursing

- Team: Pairs paediatric nurse home practitioner and clinical social worker to home visit weekly for first year, then fortnightly for 2nd year to young vulnerable first time parents.

- Aims to address complex needs of poor, traumatised socially isolated mothers and their families
Key program features

- Enhance attachment relationships by developing parental mentalization and reflective parenting capacity
- Focus on forming a therapeutic relationship with mother and baby
- Provide information and coaching
- Delivers and integrates mental health and case management services: interdisciplinary and mentalisation based
- **Joint training and Reflective supervision**, visitors trained to constantly model reflective awareness in everyday caregiving and nurturing
Reflective parenting approach

- Strategies to give voice to the baby’s experience (both physical and emotional).
- Strategies to give voice to the mother’s experience of herself as a parent.
- Strategies to bring alive mother’s positive feelings for the child.
- Strategies to develop the mother’s capacities to reflect and contemplate. Help mother to learn words and ideas to express ideas about own life...before she can think about how the baby experiences her.
- Strategies to develop mother’s sense of competence
Sample characteristics:
86 intervention & 59 control dyads

- Mean maternal age 19.5- 60% in teens
- Ethnicity: 66% Latina, 24% African-American, 10% white
- 12% married, 60% cohabiting, 28% single no FOB
- Multigenerational violence patterns
- High levels of emotional trauma
Initial Findings:

- High acceptability and low attrition
- No intervention group mothers have 2\textsuperscript{nd} child within first 24 months cf 17% control group
- No referrals to child protective services in intervention group, 5% open cases control
- Immunisation schedule complete in intervention
outcomes

• Intervention: 64% classified as secure versus 46% control

• Intervention 32% disorganised versus 44% disorganised in control group with higher mean disorganised scores

• Greater improvement in reflective functioning in intervention group, with strongest effects seen in behaviour