Childhood Maltreatment

Contemporary understandings and implications for children's neurodevelopmental health services in Queensland

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Childhood Maltreatment: Contemporary understandings and implications for children's neurodevelopmental health services in Queensland
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Summary

- Child maltreatment, including exposure to family violence, impacts on children, families and communities throughout Australia
- Many children who experience childhood maltreatment will have been exposed to multiple sub-types of abuse and other adverse social conditions
- The life-long impacts of exposure to adverse domestic environments and trauma in the early years will cross domains such as:
    - Mental health
    - Physical health
    - Social-emotional health
    - Education participation and outcomes
- Prevention is the most effective strategy. Failing this, early detection, intervention and family support strategies are key
- Support and intervention strategies must cross the health care continuum, and involve cross sectorial working that is inclusive of other government departments and non-government organisations
- The human impacts and financial costs of failing to address this issue are significant for both individuals and the community more broadly
- Child development services across the care continuum have an important role to play in advocacy, identification and intervention for children who have experienced maltreatment, including those living in out-of-home care.

Introduction

The purpose of this document is to provide preliminary contemporary understanding of the implication of childhood maltreatment for health practitioners in Child Development Services throughout Qld Health. Children who have experienced family violence, abuse and neglect live in all communities throughout Australia. While we increasingly understand the impact of childhood maltreatment on both the individual and on our society more broadly, understanding what to do to better support children and young people who have experienced abuse and neglect is an ongoing challenge for contemporary health and other social systems.

The purpose of this paper is to:

- Build a common understanding of issues pertaining to childhood maltreatment that are important to Child Development Services and other paediatric teams in Queensland Health
- Explore current legislation and whole of government responses to supporting children who have experienced child maltreatment, particularly those who are living in out-of-home care (OOHC)
- Make recommendations for Child Development and other paediatric health services in terms of providing interventions and supports to this particularly vulnerable group of children.

What do we mean by 'childhood maltreatment'?

'Childhood maltreatment' refers to harm, experienced by a child under18 yrs through abuse and neglect that is perpetrated by a parent, caregiver or other significant adult. The terms 'child abuse and neglect' and 'childhood maltreatment' are often used interchangeably. Childhood maltreatment is generally defined as one or a combination of five subtypes:

1. Physical abuse,
2. Emotional abuse,
3. Neglect,
4. Sexual abuse, and
5. Exposure to family violence.

While there is general agreement that these five subtypes describe child abuse and neglect, there is significant variation between jurisdictions regarding definitions, thresholds, and mandated reporting processes. Defining what constitutes abuse and/or neglect is complicated by considerations related to culture, age, and the severity, frequency and duration of exposure to harm.

Childhood maltreatment can occur regardless of the perpetrator's intent, and rarely occurs in isolation. Contemporary understanding is that the majority of children who experience maltreatment are exposed to two or more subtypes (known as multi-type maltreatment), and that children who experience more than one form of maltreatment demonstrate poorer wellbeing outcomes than those who experience a single form of abuse or no abuse at all.

In fact, understanding the frequency and severity of exposure to a range of abusive behaviours is more important than understanding the sub-type of maltreatment experienced when looking to understand the developmental and behavioural impacts and subsequent support needs of children in OOHC.

Childhood Maltreatment statistics

What are we measuring?

Determining the prevalence and incidence of childhood maltreatment is difficult. Not all children who experience abuse and neglect will be reported to authorities; not all reports of abuse and neglect are substantiated; and not all children who are the subject of a substantiated report are in OOHC. In addition, legislation, policies and procedures around definitions of childhood maltreatment and thresholds of significant harm differ from state to state. Subsequently, while recent moves to a Child Protection National Minimum Data Set are a major step towards improving the consistency and comparability of child protection data across jurisdictions, available statistics do not accurately reflect the number of children in our communities who have been abused and neglected.

When interpreting data, consideration needs to be given to what is being reported. Generally, data is collected in regard to the number of:

1. reports/notifications, investigations and substantiations
2. child protection orders
3. children placed in OOHC

'Notification' refers to an allegation of child maltreatment; 'investigation' refers to the process of gathering information in regard to the notification; and 'substantiation' occurs when the investigation determines that there is sufficient evidence to confirm the allegation of harm.

An application for a Child Protection Order can be made when it is determined that a child has been harmed, or is at unacceptable risk of harm, and is a child in need of protection. Orders may be short term (up to two years) or long term in nature, and may or may not alter the custody or guardianship of a child or young person. There are several types of child protection orders in Queensland including directive, supervision, custody and guardianship orders.

Children are placed in out-of-home care when it is determined that a child cannot remain at home due to experiencing harm or risk of harm. This may take the form of home based care (usually foster care or kinship care), residential care, family group homes or independent living. Youth detention and disability respite are also considered types of out-of-home care, even though young people are not always placed there due to child protection incidents. The number of children living in OOHC is increasing, with children coming into care earlier and staying in care for longer, with higher rates of emotional and behavioural problems reported.

Table 1 – Total number of notifications, investigations, substantiations, children on orders, and children in out-of-home-care in Australia 2013-2014

Year	Total Notifications	Completed Investigations	Total Substantiations	Children on Orders	Children in OOHC
2013-14	304 097	137 585	54 438	45 746	43 009

AIFS (2015a)

What does this mean in Queensland?

Neglect and emotional abuse are the most commonly substantiated harm types across Australia. In Queensland in 2013-14, there were 7 406 substantiated reports of child maltreatment, with neglect and emotional abuse making up nearly 80% of these reports. There is some speculation that the rising incidence of emotional abuse substantiations is related to the increasing awareness of the life-long impacts of a child's exposure to family violence.

While abuse and neglect occurs in all communities, some children are at increased risk due to co-vulnerabilities. Aboriginal and Torres Strait Islander children are over represented in child protection and OOHC compared to non-Indigenous children. The reasons for this are varied, have a foundation in historical contexts and practices, and are extremely complex. In Queensland, Aboriginal and Torres Strait Islander children are 6.2 times more likely than a non-Indigenous child to be the subject of a substantiated report, and 8.3 times more likely to live in OOHC. The Aboriginal and Torres Strait Islander Placement Principle has been endorsed by all states and territories. This principle identifies a preferred order of placement for an Aboriginal or Torres Strait Islander child who has been removed from their parent/s and has been embedded in legislation such as Section 83 of the Child Protection Act 1999. In Queensland, 55% of Aboriginal or Torres Strait Islander children in OOHC are placed in care with a relative or other Indigenous carer. This is a lower rate than the national average (67%).

What is the impact of maltreatment on the developing child?

All aspects of brain function are the result of the interaction between an individual's genetics and their life experiences. Mental health, social competence, cognitive development, emotional development, language and physical health and development are interrelated functions that are shaped by the interplay between a child's genetic building blocks, the experiences they have, and the relationships that support them to engage with their environment. The highly plastic brains of infants and young children are particularly responsive to both protective and adverse experiences and environments which in turn influence how well or poorly the brain matures (see Appendix 1 for Harvard's story of child development).

While the immediate impact of physical harm or injury can often be explained and understood, vulnerabilities of health and development related to sustained exposure to abuse and neglect are pervasive and complex. Not all children who experience abuse and neglect will respond to their experiences in the same way. A range of factors inclusive of genetic predispositions, life experiences, family circumstances and support systems will impact on a child's vulnerability or resilience in the face of their maltreatment.

However, we do know that exposure to sustained maltreatments can lead to permanent changes to brain development, including structural differences to the:

- Hippocampus which is critical for memory and learning and for regulating emotions and stress hormones
- Corpus Callosum which is responsible for communication between the two hemispheres of the brain
- Prefrontal Cortex which is required for higher order thinking skills, decision making, planning and for the formation of personality
- Cerebellum which aids motor coordination

Developmental impairment can be a key sign of cumulative harm and complex trauma. The Royal Australasian College of Physicians (RACP) report that up to 60% of children who have experienced abuse and neglect demonstrate developmental impairments. Health and education professionals, along with others who work

with this population of children, need to understand the multifactorial nature of sub-optimal outcomes if they are to contribute meaningful solutions to complex problems.

Adverse social conditions

In addition to the trend to multi-type maltreatment, children who have experienced abuse and neglect are more likely to experience other types of victimisation such as bullying and peer assault (known as polyvictimisation). Similarly, maltreatment is often experienced by children who live with multiple adverse social conditions. Children living in OOHC have often had exposure to domestic violence, parental substance abuse, socio-economic disadvantage, homelessness and parental imprisonment.

Each of these adverse social conditions is prejudicial to optimal life outcomes. The cumulative effect of adverse experiences and social conditions adds to the complexity of the presentation of many children who have been maltreated, particularly if the maltreatment is prolonged and/or severe, and when it occurs during the early years of life when brain growth and development is most active.

Out-of-home care placement does not always reduce a child's exposure to adverse social conditions. Research indicates that up to 20% of children in OOHC experience placement instability which further contributes to psychosocial harm. This may involve changes in foster or kinship care arrangements, or changes in staff in residential facilities. There is a correlation between OOHC placement instability, and children who have experienced extremely traumatic and highly unstable family backgrounds prior to being placed in care.

Toxic stress

Learning to deal with stress is an important childhood experience that builds resilience and that enables children to learn to self-regulate their emotions and overcome challenging situations. 'Toxic stress' is the term commonly used to describe the outcome of a prolonged and/or excessive activation of the physiologic stress response in the absence of the protection afforded by stable, positive and nurturing adult caregivers. Toxic experiences create an unstable foundation across neurological, emotional, and developmental domains. This is not merely a behavioural response to an unpleasant situation. Medical imaging demonstrates compromised neural connections in the learning and reasoning areas of the brains of children who have experienced toxic stress.

Exposure to significant adversity leads to the production of 'biological memories' that compromise health and wellbeing throughout life. This may include a persistent fear response (even when a child has been removed from harm), hyper-arousal, internalising emotions, and diminished executive function.
There is increasing evidence that childhood toxic stress is related to juvenile offending, unhealthy lifestyles into adulthood, persistent socioeconomic inequality, compromised adult productivity and poor physical health (including high rates of diabetes and cardiovascular disease). Understanding these associations has significant implications for early childhood policy.

Interpersonal attachment

Contemporary health and development professionals understand the ecological model of development. Children require a relationship with an adult who is nurturing, protective, and who fosters the trust and security required to enable engagement with and exploration of one's environment/s. Secure attachment is based on a child's assumption that their primary carer will provide day-to-day attention to his or her needs, including comfort and affection. Attachment is a dynamic process that changes according to a child's needs, context and age.

Insecure attachment can result in emotional and behavioural disturbances, and an inability to develop the trust required for healthy relationships throughout life.

Placement disruption and unplanned placement changes (including school changes) can have adverse impacts on the developing brain and on a child's ability to make and maintain strong and secure attachments. This has been associated with long term mental health problems and delinquency.

Physical health

In addition to the psycho-social implications of exposure to abuse and neglect, children who experience maltreatment have high rates of acute and chronic illness. This group of children are less likely to have consistently engaged with primary health care services in the early childhood period. Subsequently, they are less likely to be fully immunised, more likely to experience high rates of poor growth, and are significantly more at-risk of pervasive developmental delays (reportedly as high as 60%). They have higher rates of hearing and vision deficits, often have poor oral health, and have much higher rates of clinically significant eating problems.

The RACP have long advocated for systems change that enables the identification and management of the previously unmet health needs of children in OOHC. This is increasingly becoming a feature of policy in this area. Challenges in the realisation of this includes the availability and transfer /sharing of medical history knowledge, particularly if there is a recent or frequent change in caregiver, poor communication between health and child protection organisations, and the capacity of local health services to provide integrated assessment and interventions in a timely way.

Educational needs

Education is important for all children and for the prosperity of the society they live in. Lost educational opportunities have a cumulative effect on children and may compromise their development and whole of life wellbeing. Children who live in OOHC are known to be educationally disadvantaged and are:

- Over represented in special education;
- At increased risk of truancy, repeating year levels, suspensions and exclusion;
- Less likely to continue with mainstream education beyond the compulsory period;
- More likely to be older than other children in their grade;
- More likely to attend a greater number of primary and high schools than other children;
- More likely to miss substantial period of school, including at times of changes in placement; and are
- Less likely to progress to tertiary or other post-secondary education.

Analysis of basic literacy and numeracy standards as assessed by the National Assessment Program – Literacy and Numeracy (NAPLAN) indicate that children who live in OOHC consistently demonstrate significant gaps across domains (see Table 2). On analysis, children living in OOHC performed significantly more poorly

Table 2 - % children in OOHC who meet NAPLAN minimum standards compared with all children.

Grade	Domain	% children in OOHC meeting min. standard	% children meeting min. standard nationally
3	spelling	74	94
5	numeracy	71	93
7	reading	71	94
9	writing	44	83

than their peers on all domains and in all year levels. The gap widened each year from Grade 3 through to Grade 9.

A child's success in and satisfaction with school may be related to factors associated with the child (such as those related to the neurological impacts of trauma and the child's biological predispositions) and/or related to factors associated with OOHC (such as placement stability, court appearances, and contact visits). Some research suggests that carers and teachers may have lower expectations of children who live in OOHC, and there may not be anyone in their life who is actively considering and discussing education and career aspirations with them.

Of course, school provides children with a lot more than just academic instruction. School can be a regular, predictable and safe environment for children to grow and explore, and is a place of positive and robust social experience.

Benefits of OOHC

Despite the history of adversity experienced by many children in OOHC, and the increased likelihood of a range of challenges throughout life, there is evidence that most children who are in long-term stable OOHC adjust to their placement and derive benefits from this change. Legislation in this area has long recognised the importance of safe and stable living environments for children. Reunification with family is prioritised across jurisdictions, although long term care arrangements and even adoption are options for children for whom reunification is not possible.

Challenges when providing services to this population of children:

While this population of children is well known to be developmentally vulnerable and often poorly understood, they are significantly underrepresented as a clinical cohort in Queensland Health developmental services. CDS teams across Queensland report a number of challenges when working with this population of children including:

- Knowledge or awareness at the time of referral that the child is in OOHC
- Access to information:
  - availability of health and other records,
  - foster carer knowledge of the child's medical and health history,
- Understanding and navigating the guardianship, consent and communication requirements involving biological parents, the Department of Communities, Child Safety and Disability Services, foster or kinship carers and other invested stakeholders
- Integrating the implications of multi-type maltreatment, polyvictimisation and adverse social conditions on the emerging understanding of a child neuro-developmental support requirements
- Understanding the need for flexibility in terms of access to services, particularly during transitional periods
- Supporting carers to understand the current and future needs of the child and build capacity to support improved functional outcomes
- Being able to be responsive to the needs of the individual in a timely and integrated way

Key Documents

The statutory child protection system in Australia is constantly evolving. This is due in part to changing community attitudes regarding the rights of children, changing expectations of government in terms of the support for vulnerable families, as well as increasing awareness of the impacts of an ever widening range of maltreatment subtypes on the developing individual and our society more broadly. With a spotlight on the needs of children who have experienced maltreatment, this is an important time for paediatric health services in general, and Child Development Services in particular, to better understand how they can support the needs of this vulnerable group of children with a view along the continuum of care.

While there is persistent variation in legislation across jurisdictions, there is increasing alignment in child protection policy from state to state throughout Australia. To demonstrate this, five key documents will be profiled in this paper:

1. The Royal Australasian College of Physicians (RACP) document 'The Health of Children in 'Out-of Home' Care paediatric policy (2006)
2. The Council of Australian Government's (COAG) Protecting Children is Everyone's Business National Framework for Protecting Australia's Children 2009-2020 (2009)
3. The Australian Government's National Clinical Assessment Framework for Children and Young People in out-of-Home Care (2011)
4. The Queensland Government's 'Taking Responsibility: a Roadmap for Queensland Child Protection (2013)
5. The Queensland Department of Health's Statement of Intent: The prioritisation of health services for children and young people in the child protection system (2015)

RACP - The Health of Children in 'Out-of-Home' Care

In 2006, the RACP released their policy document pertaining to children who live in OOHC. The document clearly states the vulnerability of this group of children across physical, mental and social health and wellbeing domains, and identifies the limited access to necessary resources to understand their needs and support their health and development. As well as outlining the impact of abuse and neglect on the developing child, this document makes a series of recommendations:

- Routine health screening and assessment of all children entering alternative care, inclusive of a general health assessment, developmental assessment, and mental health screen.
- Formulation of a health plan that identifies a health coordinator for each child and that promotes an annual follow up review.
- Enhanced care, management and treatment services facilitated by local systems, fast-tracked therapeutic services, and inclusive of health and wellbeing domains and of private and public sectors.
- Data collection that is accessible and transferable
- Improved access to health records of birth parents, consistent with privacy legislation.
- Enhanced communication by improved linkages between key stakeholders, community based interagency forums for complex cases, consultation with the child, and, where possible, engaging birth parents in their child's health planning.
- Improved support and training for foster carers to ensure they have the skills needed to support the children in their care.

COAG - Protecting Children is Everyone's Business National Framework for Protecting Australia's Children

This document champions a shift in child protection policy from merely responding to abuse and neglect, toward a whole of community approach to promoting children's safety and wellbeing. Core to this is the notion that protecting children is everyone's business, from parents and families to communities, non-government organisations, the private sector and all levels of government. The framework that is set out in this document consists of six supporting outcomes that are seen as indicators of change. Under each of these supporting outcomes sit a series of strategies. The supporting outcomes are

- That **children live in safe and supportive families and communities** that protect children from abuse and neglect
- That **children and families access adequate support to promote safety and intervene early**,providing the right supports and services to vulnerable families at the right time to prevent abuse and neglect where possible
- That **risk factors for child abuse and neglect are addressed in both individuals and in communities**, with a focus on parental mental health, domestic violence and drug and alcohol abuse
- That **children who have been abused or neglected receive the support and care they needs for their safety and wellbeing** that is child focused, evidence based, attentive to their developmental needs and helping them to overcome the effects of trauma, abuse and neglect
- That **Indigenous children are supported and safe in their families and communities** with a view to reducing the over-representation of Indigenous children in the child protection system
- That **child sexual abuse and exploitation is prevented and survivors receive adequate support** through specific therapeutic and legal responses

This document profiles the agency functions and past, recent and planned reforms of each state and territory of Australia

Australian Government – The National Clinical Assessment Framework for Children and Young People in OOHC

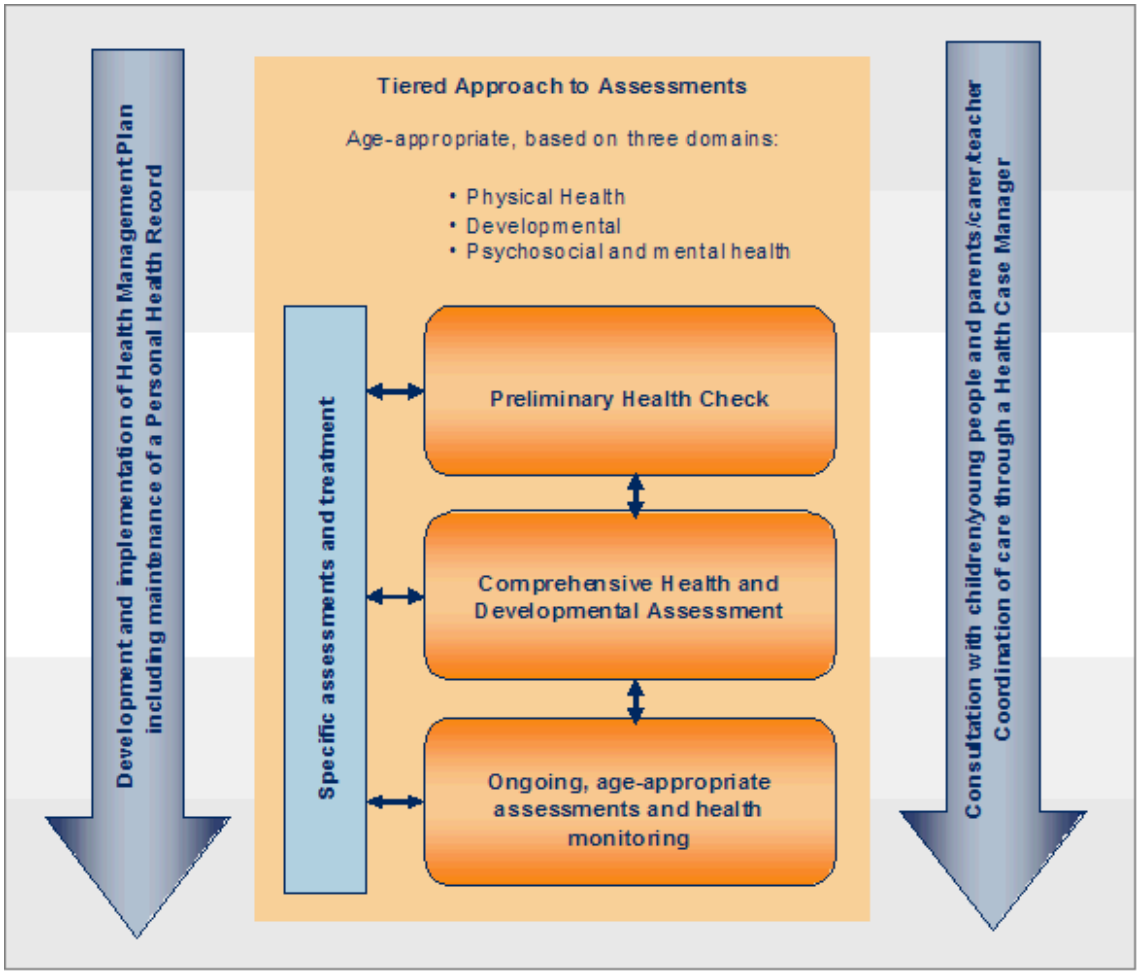
This Framework was one of a number of initiatives that is aligned under the COAG National Framework outlined above, with a focus on supporting outcome four (that children who have been abused or neglected receive the support and care they need for their safety and wellbeing). The Assessment Framework aims to provide better consistency of healthcare assessments and services for children and young people in OOHC so that concerns can be detected and supported in a timely way which reflects best-practice.

The National Clinical Assessment Framework is of particular importance to specialist Child Development Services and other paediatric services who are involved in the support of children in OOHC. This framework clearly illustrates the need for a tiered and integrated approach to understanding vulnerable children. This Framework needs to be understood as being inclusive of the continuum of care and needs to be applied in an individualised way with consideration to the personal history and cultural context relevant to the child and their family. The elements of the Framework are:

- A preliminary health check no later than 30days after entry into care to determine areas of immediate concern

- A comprehensive health and developmental assessment to be completed within three months of placement
- The development of a Health Management Plan including a personal health record that is integrated with other management plans.

Figure 1 – Core elements of the National Clinical Assessment Framework



Australian Government (2011)

Queensland Child Protection Commission of Inquiry - Taking Responsibility: A Roadmap for Queensland Child Protection

In July 2012, the Queensland Government established the Queensland Child Protection Commission of Inquiry (QCPCI). This became known colloquially as the Carmody Inquiry and was tasked with reviewing all elements of the existing child protection system and delivering a roadmap for an improved future state. The QCPCI final report focused on:

- Reducing the number of children in the child protection system
- Revitalising frontline services and family support with a view to breaking the intergenerational cycle of abuse and neglect
- Refocussing oversight on learning, improving and taking responsibility.

The QCPCI found that the child protection system in Queensland was stressed and a wide range of recommendations for improvement were made. The 121 recommendations made in the final report were organised under 15 categories. The Queensland Government accepted 115 of the recommendations in full with the remaining six accepted in-principle.

A number of the recommendations were specific to proposed amendments to the *Child Protection Act 1999*. About 31 of the 121 recommendations (26%) are likely to have significant practice and resource implications for Hospital and Health Services statewide. Recommendations 7.7 and 7.8 made specific reference to Queensland Health's responsibility to be involved in developmental assessment and early intervention:

7.7
In accordance with the elements of the National Clinical Assessment Framework for Children and Young People in out-of-home care the Department of Communities, Child Safety and Disability Services, in conjunction with Queensland Health, ensure that every child in out-of-home care is given a Comprehensive health and Developmental Assessment, completed within three months of placement

7.8
The Department of Communities, Child Safety and Disability Services negotiate with Queensland Health and other partner agencies to develop a service model for early intervention specialist services for children in the statutory child protection system, including those still at home.

The first stage in implementing the QCPCI Recommendations was the passing of three Acts upon which a new child protection system would be built:

1. Family and Child Commission Act 2014
2. Public Guardian Act 2014
3. Child Protection Reform Amendment Act 2014

Throughout the end of 2015, the Queensland Government was engaged in broad community consultation as part of the process of building a new, future focused legislative framework that both supports families and protects children in Queensland.

Queensland Department of Health – Statement of Intent: the prioritisation of health services for children and young people in the child protection system

In November 2015, the Queensland Department of Health released a statement of intent pertaining to vulnerable children and young people who are in OOHC or at risk of entering the child protection system. This document recognises the specific and unique health care needs of this population of children and signals Queensland Health's commitment to the National Framework for Protecting Australia's Children and the Taking Responsibility recommendations. It states that "Queensland Health's commitment to these vulnerable children and young people is demonstrated by prioritising access to health services wherever possible".

Future Directions

The needs of children who have been exposed to maltreatment are under the spotlight and future directions will be shaped by a range of factors and initiatives. This includes:

- Outcomes from consultation regarding the new legislative framework for child protection in Queensland
- Application of Queensland Health's Statement of Intent re: the prioritisation of health services for children and young people in the child protection system
- Adaptation of the National Clinical Assessment Framework (figure1) to the Queensland context.

Implications for Child Development Services in Queensland Health

Queensland Health has a responsibility to ensure timely access to appropriate services for children who have experienced maltreatment. Specialist Child Development Services within Queensland Health are an important point of reference along the care continuum, particularly for children who require a coordinated and integrated multidisciplinary approach to neurodevelopmental diagnosis, support and understanding.

The Act Now for a Better Tomorrow resource document has established Principles of Practice to guide Child Development within Queensland Health. Children who have experienced maltreatment (including those in OOHC) must have their needs considered in the context of the principles that guide CDS service delivery.

However, with a view to applying the Department of Health's Statement of Intent, Queensland Health Child Development Services must also:

1. Understand the prejudicial nature of abuse and neglect on development on both the long and short term
2. Actively clarify this as a risk in presenting children
3. Work with health partners across the care continuum to facilitate early identification and intervention
4. Understand that intervention requires an integrated approach across contexts particular to the individual child
5. Actively engage with cross sectorial service partners to develop local solutions to barriers pertaining to information sharing (eg court orders, consent, changes of carer or case workers) and the challenges of communication between multiple agencies

Appendix 1

The Core Story of Child Development

Centre on the Developing Child, Harvard University

1. Early Experiences in life build “brain architecture” with simple circuits forming first and more complex circuits building upon them.
2. Children develop in an environment of relationships that begins in the familybut also involves other adult caregivers. The developmental process is fuelled by a reciprocal “service and return” process, in which young children naturally reach out for interaction and adults respond.
3. Genes and environments interact to shape the architecture of the brain. Genes provide the basic instructions, but experiences leave a chemical “signature” authorising how and even whether the instructions are carried out.
4. Cognitive, emotional and social capacities are inextricably intertwined, and learning, behaviour and both physical and mental health are highly interrelated over the life course. We can’t have one without the others.
5. “Toxic stress” derails healthy child development and can have long-term negative effects on learning, behaviour and physical and mental health.
6. Brain plasticity and the ability to change behaviour decrease over time, so getting things right the first time produces better outcomes and is less costly to society and individuals than trying to fix them later.

National Scientific Council on the Developing Child (2014)

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