QCPCI Tendered in Chambers

Date: 17. 12. 2012

Exhibit number: 131

AFFIDAVIT OF DR ANJA MELANIE KRIEGESKOTTEN

I, Anja Melanie KRIEGESKOTTEN, of the Royal Children's Hospital in the State of Queensland, Medical Practitioner, solemnly and sincerely affirm and declare:

Qualifications and Experience:

1. I make this statement pursuant to a request to provide information to the Queensland Child Protection Commission of Inquiry (QCPCOI) in my role as the Psychiatrist for Evolve Therapeutic Services Brisbane North, and in my role as community Child and Adolescent Psychiatrist at North West Child and Youth Mental Health Service (NW CYMHS), Royal Children's Hospital, Brisbane.

2. I have a Medical Degree awarded by the University of Saarland, Homburg/ Saar Medical School, Germany. I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists and hold the Advanced Certificate in Child and Adolescent Psychiatry. I am a member of the Faculty of Child and Adolescent Psychiatry.

3. I practice as a Child and Adolescent Psychiatrist and have held the position of Consultant Psychiatrist with the Royal Children's Hospital, Brisbane, since 2005. I was appointed to the role of Evolve Psychiatrist in September 2010, while continuing to also work at NW CYMHS.

4. I have an interest in early childhood trauma and its effects on the developing brain and have presented on this topic at the annual congress of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 2011.

5. From 1999 to 2003, I was employed by the Royal Darwin Hospital, Top End Mental Health Services, Northern Territory, including visits to remote Indigenous communities, mostly in Arnhem Land, which gave me some insight into their culture and the complexity of the problems such communities face. In 2008 Professor Graham Martin and I visited Mornington Island in the Gulf of Carpentaria, Queensland, in an attempt to explore their needs and available services in view of opening access to Child and Youth Psychiatry Services for Gulf communities. Unfortunately this did not progress as funding was not forthcoming in the wake of the 2008 financial crisis.

6. I am registered with the Australian Health Practitioner Regulatory Agency as a Medical Practitioner to practice in the specialist field of Psychiatry.

The Implementation of recommendations of the Forde Inquiry and the Crime and Misconduct Commission reports into child abuse

The **Crime and Misconduct Commission Inquiry** recommended under **7.5** "That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated". This led to the establishment of Evolve Therapeutic Services.

The Evolve program provides intensive therapeutic and behaviour support services to children and young people in the care of the Department of Communities (Child Safety Services) with severe and complex psychological and behavioural support needs. The target population has been identified as approximately 17% of children in care. The program caters to children referred by Child Safety Services who are aged from birth to 18 years with severe and complex psychological and/or behavioural problems. The program provides assessment and intensive intervention over approximately 18 months via the ten Evolve Therapeutic Services teams across Queensland.

The Evolve Interagency Services (EIS) are a partnership between the

- Department of Communities (Child Safety Services)
- Department of Communities (Disability and Community Care Services)
- Queensland Health (QH) and
- Department of Education and Training (DET).

Specialist therapeutic interventions are provided by Queensland Health through Evolve Therapeutic Services and specialist disability assessments and positive behaviour support interventions are provided by the Department of Communities (Disability and Community Care Services) through Evolve Behaviour Support Services.

Child protection, placement and case management support is provided through the Department of Communities (Child Safety Services), with the Department of Education and Training providing educational support.

The Evolve model of service is based on two fundamental principles of operating under a child centred focus within an interagency collaborative framework. The Evolve Performance report highlights enhanced access to quality therapeutic and behaviour support services for children and young people in out-of-home care.

Data and information for 2009 and 2010 from across the partner agencies confirms:

- reductions in clinical symptoms across a range of behavioural and emotional indicators of function and overall well being: reflecting improvements in aggressive, noncompliant, and anti-social behaviours, self-injuring behaviour, destruction of property, unusual or repetitive behaviours, problems with attention and concentration, non-organic somatic complaints, self-care and independence, and emotional difficulties
- increases in the child or young person's involvement in other activities
- improvements in the child or young person's family relationships

- improvements in carers knowledge and their understanding of the child or young person's difficulties and relationships with carers
- improvements in problems with scholastic and language skills
- increased placement stability
- a more functional engagement in peer relationships and with their wider environment
- improvement in attendance at and participation in educational/vocational activities.

A cost-benefit analysis in the 2009/10 Performance Report indicated short and medium term savings in costs of care for 181 children and young people receiving Evolve services in 2009 who were identified as being on Transitional Placement Packages. This is evidenced across this group in the average cost per child or young person reducing by $48,000.

From January to December 2009, 406 children and young people accessed an Evolve service. A review of data from the *Evolve Performance Report 2008* shows an overall increase of clients accessing Evolve services of 19.4 percent from December 2008 to December 2009. From January to December 2010, 585 children and young people accessed an Evolve service.

Overall the proportion of Indigenous children and young people supported by Evolve closely reflects the proportionate representation of Aboriginal and/or Torres Strait Islander children and young people in care and reflects variations in demographics and need across service delivery locations.

Evolve staff provided training across government, non-government and private sectors to support professional development within the sector, develop knowledge and skill across children and young people's support networks, and provide direct support to carers to enhance outcomes for children and young people. Evolve Therapeutic Services records showed that across 2009 and 2010, training was provided for 11,852 attendees.

The Evolve Performance Report identified appropriate outcomes and performance measures taking into account the small size and specific nature of the target population. Outcomes sought are linked to client benefits. They demonstrate that positive outcomes have been achieved for children and young people with severe and complex psychological and behavioural problems. This includes benefits through moulding the child's environment by guiding stakeholders in providing support to these children and young people.

Service delivery to those children and young people experiencing mental health, alcohol and drug and or behavioural issues and who are in or at risk of entering the child protection system.

CYMHS (Child & Youth Mental Health Services) treat children and young people with moderate to severe mental health problems with or without behavioural components, independent of their status with child safety. CYMHS tend to deal with the aspect of co-morbid drug and alcohol problems too, at times in liaison with specialist services such as Hot House (local youth drug and alcohol service).

Mild mental health and behavioural problems tend to be referred to NGO's or the private

sector.

In some cases the cause of mental health and or behavioural issues can be found in child abuse and or neglect. CYMHS can work across the spectrum of child protection involvement, from first notifying suspected abuse or neglect to working with children and young people well known to the child protection system and placed in out-of-home care.

Evolve Therapeutic Services (ETS) is a sub-speciality of CYMHS and provides intensive evidence-informed therapeutic interventions to children and young people with Mental Health problems who are under protection orders with the Department of Child Safety and who have complex and extreme needs, with severe psychological, emotional or behavioural concerns. ETS is a specifically targeted program for this client group.

Key examples of service delivery or specifically targeted programs for responding to this cohort of children and young people and any other key persons able to speak to the initiatives. Evolve Therapeutic Services (ETS)

The **Crime and Misconduct Commission Inquiry** recommendation **7.5** led to the establishment of Evolve. I have described the service at the beginning of this document under "The Implementation of recommendations of the Forde Inquiry and the Crime and Misconduct Commission reports into child abuse"

Queensland Health and Disability Services Queensland formed two services specific to children in care:

(1) Evolve Behaviour Support Service (EBSS). EBSS focuses on children with disabilities who are in or at risk of entering foster care and is governed by Disability Services Queensland.

(2) Evolve Therapeutic Services (ETS). Collaboration between the two arms occurs in some cases requiring mental health and disability input.

In this document I will focus on Evolve Therapeutic Services (ETS), as this is the area I work in and am most familiar with. ETS is governed by Queensland Health. Referrals to ETS are only made by the Department of Child Safety.

The target population for ETS are children and young people who are under protection orders with the Department of Child Safety and who have complex and extreme needs, with severe psychological, emotional or behavioural concerns. ETS provides multi-modal treatment with intensive evidence-informed therapeutic interventions, in a wrap around style, not just focusing on individual therapy with the child, but on moulding the environment to facilitate and optimize healing for the child. Hence ETS is supporting not only the identified patient, but also all relevant significant adults involved in the child's life, such as the school, foster parents, child safety officer, biological parents and any other significant adult in the child's life. We may support well over a dozen people per child. This has a ripple effect flowing on to benefit other students at that school, other foster children in the care of that foster parent or residential facility – the indirect benefits can be exponential over time.

The caseload per ETS clinician has to be capped to enable this intensive wrap around service.

This is a logical consequence, considering that usually the most problematic children and young people in care are being referred to Evolve, who may frequently present in crisis or their high risk behaviour may elevate the anxiety level of the whole system around them.

Staffing of ETS Brisbane North:

I work at ETS Brisbane North in the 0.5 FTE (full time equivalent) psychiatrist position. We also have a team leader, several clinicians (psychologists, social workers, a nurse, an occupational therapist), a Professional Development Coordinator, an Indigenous Program Coordinator, a Service Evaluation and Research coordinator and an administration officer. There is potential for expanding the role of the Psychiatrist in ETS to incorporate more focus on statewide strategic leadership and service development. The RANZCP submission talks about the benefits of establishing a position for a psychiatrist in a state wide director position.

Interventions used at Evolve TS Brisbane North:

The Evolve TS Brisbane North team provides multi-modal treatment, including intensive evidence informed trauma and attachment based therapy, which focuses on the relationship and attachment between the child and a significant adult, usually the carer. ETS is utilising evidence informed practices for treatment for trauma and attachment disorders having accessed high quality training and supervision from world renowned specialists in the field. Our Professional Development Coordinator co-ordinates training and supervision, but is also involved in running parenting programs specifically tailored to this population, providing trauma and attachment focused training to carers and to residential staff, educating school staff etc.

Therapeutic life stories assist our clientele to establish their identity and are an important step in the healing process. Our Indigenous Program Coordinator is invaluable in collecting the family history and cultural background for our Indigenous children and young people.

Systemic interventions can involve all the players in the child's life. An ETS clinician may be involved with well over a dozen stakeholders in each individual child's case. Thus school teachers and other educators, residential staff or carers, child safety officers, at times biological parents and any other significant adults in this child's life meet for frequent, usually monthly, stakeholder meetings to discuss how this child is travelling in different settings. A representative from Child Safety, usually the CSO, needs to be present at stakeholder meetings. One of ETS' strengths lies in their collaboration with multiple stakeholders on a regular basis. The Team Leader and Psychiatrist meet regularly with the manager and other relevant senior staff of each child safety service centre in their region. We are also working on closer links with the Placement Unit. By being part of CYMHS we have close connections throughout Queensland Health (expanded upon below) unlike NGOs and the private sector.

Our interventions are in accordance with international literature regarding this population.

To be able to provide this specialized care to this very challenging and vulnerable client group, ETS clinicians receive extensive professional development in areas of trauma and attachment, systemic therapies and other evidence based treatment modalities. Thus ETS is a sub-specialized aspect of CYMHS work. A reduction in professional development resources would potentially have a negative impact on future service delivery.

Factors influencing treatment success:

Above all children need to feel safe to thrive, without feeling safe they're unable to engage in therapy. (See Pyramid below by Kim Golding).

Other factors influencing the success of treatment include: (1) individual factors, such as individual resilience, level of trauma experienced, presence of a supportive adult, age at removal; and (2) external factors such as the number of previous placements and placement stability, the foster parent's capacity for psychological mindedness and their ability to have empathy, show commitment and provide unconditional love to the child.

In my clinical experience, the younger the child is and the more committed and consistently affectionate the foster carer is, the more effective is the treatment. This can also be explained scientifically, especially for treatment based on strengthening the attachment relationship between carer and child, as there is a developmental window in early childhood to form attachments to significant care givers. Those attachments enable the child to gain a secure sense of self. Additionally, the plasticity (ability to change) of the brain is greater the younger the person is.

The earlier the child is exposed to trauma, the more profound is the effect on his/her brain. Studies of significantly neglected children (Romanian orphans), who were removed and placed in a nurturing permanent home before the age of two, showed that these children can develop normally with adequate therapeutic interventions. However if the child is up to 6 years old by the time of removal, their IQ tends to only reach the borderline low range, if they were 16 years old, their IQ showed moderate intellectual impairment.

At times when ETS reaches capacity, children who would benefit from this intensive wrap around service are referred to alternative services negotiated at the local EIS panel. These include CYMHS, NGOs, and private mental health practitioners. Unfortunately those services aren't in a position to provide the same intensive interventions as ETS.

Evolve Therapeutic Services is in my opinion well suited to treat children and young people involved with the child protection system, especially in out-of-home care, such as foster care or residential facilities, who have experienced complex trauma and many losses due to substantiated abuse and or neglect. As ETS also works with biological parents, including preparing them and their children for re-unification, I believe ETS would be well suited to expand its portfolio to children or young people whose parents are being investigated by the child protection system.

Is the current use of available resources across the child protection system adequate and can resources be used more efficiently?

Adequacy of resources:

The adequacy of resources across the child protection system depends on what one wants to achieve.

We all know the extensive costs associated with children who have suffered abuse and or neglect due to their trajectory to drop out of school, be unemployed, access the welfare system, their increased likelihood to become involved with the forensic system, drug and alcohol misuse, increased physical illnesses leading to increased health costs, psychiatric treatment costs, domestic violence, unplanned pregnancy and all this human suffering and

extensive cost is passed on to the next generation via intergenerational trauma. The cost (and the human suffering) of such a traumatized child throughout their lifespan and the transmission to future generations is significant.

There is growing international scientific research indicating economic benefits of increasing resources to (if possible) prevent early childhood trauma, or minimize it and intervene early with high quality intensive treatment together with good quality stable foster care or adoption. This can later save costs in health care (physical and psychological), forensic services and many other aspects of government costs dealing with the sequelae of early childhood trauma. The investment into the child protection system (the care environment and intensive specialised therapy) can be yielding great returns. The reason for this is due to changes in the developing brain that occur due to child abuse and or neglect.

Changes to the brain due to early childhood trauma and its long term sequelae:

International research suggests early childhood trauma can cause the brain to be smaller, the hormones to be in disarray and even changes the genes (epigenetics), which can be inherited to the next generation.

Clinically we see children who have 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.

I would like to point out the following scientific evidence in this context:

1) The retrospective ACE study performed by a Californian Health fund with middle class Americans (Felitti, 2002) showed the more Adverse Childhood Events (ACE) one had endured, the more mental health problems, but also significantly more physical health problems (such as diabetes, heart disease, liver and lung problems etc) occurred later in life. For example, a person who endured 4 x Adverse Childhood Events, as an adult has a 260% increased risk of developing obstructive lung disease, a 240% increased risk for hepatitis and a 460% increased risk of depression. 80% of all suicide attempts were attributable to Adverse Childhood Events.

2) The prospective NZ study (Danese, 2009) also found a strong graded dose-response relationship of adverse childhood events and later higher risk for age related disease, hence confirming what the ACE study had found.

3) The discovery that telomeres on the tips of chromosomes are shortened with trauma and chronic stress, leading to premature ageing and even earlier death, confirmed those study results and raised a hypothetical explanation for it.

4) The Hypothalamic-Pituitary-Adrenal (HPA) axis, which is the key hormonal axis in the body, is chronically over-active in survivors of developmental trauma. This leads to a very easily triggered hormonal and physiological stress response involving a dysregulation of Adrenalin and Cortisol.

5) Trauma, especially neglect can cause atrophy to neurons, which affects the size and strength of neural networks within the brain. Reduced in size are for example:

   a) the limbic system including the Amygdala, needed for emotional regulation,

b) Hippocampus for forming and retrieving verbal and emotional memories,

c) Pre-frontal Cortex which is the executive decision making centre,

d) Corpus Callosum (connects L and R hemisphere, disruption associated with ADHD),

e) diminished growth of left hemisphere increases the risk of Depression.

6) The growing field of epigenetics has shown that trauma causes epigenetic changes that can be inherited to the next generation: a study on descendents of Holocaust survivors showed those traumatic epigenetic changes in the next generation. In animal studies trans-generational inheritance of traumatic epigenetic changes were followed to the 3rd and 4th generation.

Hence there is a plethora of evidence that early trauma increases not only life long suffering, but also health costs, both mental and physical. The wider social costs in terms of unemployment, inter-generational transmission of domestic violence and abuse, social welfare costs and forensic costs are considerable.

Most of the above deleterious changes can be reversed with intensive wrap around therapy in conjunction with safe permanent nurturing placements. Therefore providing intensive trauma and attachment focused interventions as early as possible in conjunction with stable nurturing environments will be well worth the investment. Cost savings are exponential as they encompass mental health, physical health and social cost savings for decades to come.

The highly complex nature of working with traumatized children and young people requires a specialised service like Evolve TS. As a multidisciplinary government service we can provide excellent continuity of care and expertise due to our close links with other government sectors. By being part of CYMHS we have close connections to inpatient facilities, the Child and Youth Forensic Outreach Team (CYFOS) and Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS), which is placed in the Brisbane Youth Detention Centre, which makes transitions smoother and collaboration easier. All of Queensland Health Mental Health Services use the same integrated electronic record system, Client Integrated Mental Health Application (CIMHA). This highlights the advantage of ETS being a highly networked government agency as opposed to specialist services being provided by NGO's and/ or the private sector.

Can resources be used more efficiently?

Referrals to Evolve for infants and toddlers could be increased, as research shows better outcomes with earlier interventions. Evidence informed interventions for infants and toddlers and their foster parents are available. As trauma led changes to the brain are easier to reverse the younger the child is, one could logically conclude that work on this age group would yield the greatest returns, not only financially.

In Evolve Therapeutic Services an obstacle to efficiency in my opinion is the amount of paperwork required by clinical staff. ETS has to fulfil the paperwork requirements developed by the EIS, including Qld Health, Child Safety, Education Qld and Disability Services. This creates significant inefficiencies as there is duplication of process. Time spent on

administrative duties negatively impacts on the time clinicians can spend in direct contact with the child, their carer's and support systems.

Another inefficiency affecting ETS appears to come from Child Safety's side: the Child Safety Officer's (CSO) tend to carry a heavy and emotionally draining workload and are often quite inexperienced. This can lead to burnout and high staff turnover. In our experience the CSO workload can preclude them from being available to attend all stakeholder meetings and respond in a timely manner to requests for carer support or stakeholder liaison. The recent public sector staff reduction appears to have impacted within Child Safety and has exacerbated the workload issue.

For further suggestions I would like to refer to the submission by the Australian Association of Social Workers, Qld Branch by Prof Karen Healy, and the RANZCP submission by Dr Rebecca Wild and Dr Michelle Fryer and the Infant Mental Health submission by Dr Michael Daubney.

The current Qld government response to children and families in the child protection system

Parent support and assessment:

There is a need for greater investment in the early phase of child protection involvement by providing parents with more intensive support (including in home) and education to help them safely care for their child, if possible, and improve family functioning. This should also include a thorough assessment by a qualified and experienced mental health practitioner of the parent's capacity to parent this child with all his/ her needs. This assessment can inform the decision whether to remove the child. This assessment should also be repeated before considering re-unification. Decisions based on such an assessment, together with child safety's investigation, could lead to better evaluation of the situation and better outcomes. Liaison between Child Safety and ETS can be helpful in assessing this possibility.

Some parents may improve to the degree that they can safely parent a new child that hasn't been traumatized. This doesn't mean they are also able to parent their older child(ren), who have been exposed to abuse and or neglect and are more difficult to parent as they require reparative care. The assessment of the parent's capacity to parent needs to include whether they are able to parent THIS child with all his/ her needs at this time.

Professional foster care could be considered for children with particularly high needs requiring high level reparative care. I think sometimes the carer is at risk of burnout due to being constantly exposed to the challenging behaviour of the foster child. This can lead to placement breakdown, when the carer might have just need a break to recuperate. In my experience respite placements can be difficult to access, especially for the high needs child.

Residential facilities with youth workers trained in attachment and trauma informed parenting would form another tier of care.

Early Permanency Planning:

The child psychiatrists of Queensland have recently been discussing child protection issues in the light of this inquiry. From the child psychiatrists' view there was a sense that child safety may be over-emphasising re-unification with biological parents at the potential cost of the

emotional wellbeing of the child. To collect sufficient evidence for the court to get a long term order children may be left in the care of their poorly coping parents, risking being re-traumatized. In the UK and USA priority is being given to early permanency planning in the best interest of the child, above re-unification and the parent's rights.

Early permanency planning involves finding a permanent placement for a child, including adoption. It is important to reduce the harm from repeated removal and reunification and re-exposure to childhood maltreatment. This can be done by early identification of parents who will be unable to sustain the necessary improvements to their parenting capacity and find a permanent nurturing home for those children early, ideally with the possibility of adoption.

It appears to me that at times the removal of a child occurs late, only once significant trauma has already been suffered. A thorough assessment of the parental capacity to parent this child (with all his/ her special needs) by a trained professional should be done as soon as possible.

The transition of children through and exiting the child protection system

Children in care, especially the more challenging ones, may have frequent placement changes. In the public health system case managers can change too. This makes forming trusting relationships even more difficult for those children, who already struggle with relationships. Placement changes may occur due to a lack of appropriate foster placements being available. Hence children are put into temporary placements. Due to this the child cannot develop a reasonable attachment to a significant adult, which affects their development of a secure sense of self and their ability to form healthy relationships later in life. There are some highly traumatized children who require a reparative care placement as well as intensive therapeutic intervention. ETS is well suited to provide the therapy required, but the reparative care can be difficult to access.

Foster carers and referrals of pre-school/ infants

EIS would support the screening process for foster carers and would recommend this be continued and potentially expanded to ensure they are best suited to provided a warm, nurturing, loving, committed and consistent environment

The low rate of referrals to Evolve for infants and toddlers is concerning. As mentioned above, there are evidenced informed interventions for infants and toddlers and their foster parents. Research suggests better outcomes with earlier interventions.

Exiting the child protection system

In the general population, parents support their children throughout young adulthood and sometimes beyond. The State offers little support to young people after the age of 18 years. In some cases it can be problematic when all support is withdrawn at once when the young person is 18 years old. Contact with trusted Youth Workers in residential care facilities, the therapist from Evolve or CYMHS, and their CSO - it all stops at the age of 18 years. Many young people who have suffered early childhood trauma have developmental delays. A possible solution may be to allow services to remain involved to a later age at least in some cases. Note that some youth services define youth to 25 years of age (e.g. Headspace).

The effectiveness of monitoring, investigation, oversight and complaint mechanism and ways to improve the oversight of and public confidence in the child protection system

Public confidence may increase by providing extra in-home support and parent training to help the family improve their functioning and prevent children from entering out of home care. The safety of the child needs to be ensured though.

Robust assessment of the suitability of foster parents and residential staff is needed, as well as providing them with consistently high quality attachment and trauma focused training. The government sector may be best suited to provide this training. Training provided by various NGO's can vary greatly in quality and applicability to carers or residential staff.

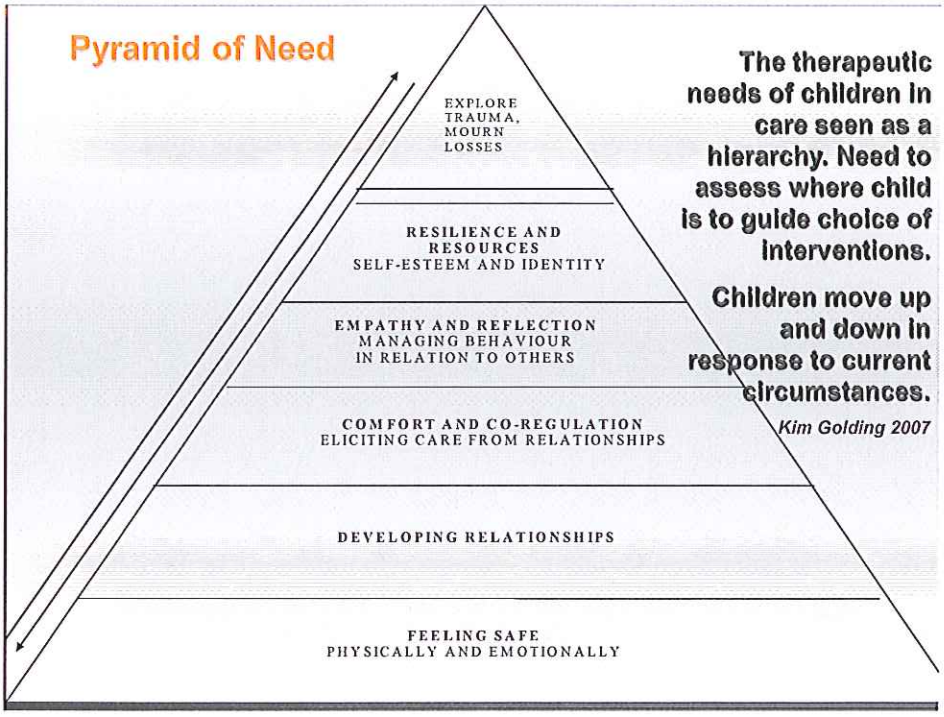
Affirmed by ANJA KRIEGESKOTTEN on 17/10/2012 at Brisbane in the presence of

N Packer C.dec 24869 (Dianne Lenore Packer)
at Highvale 4520

Deponent

References:

Kim Golding: Pyramid of Need (2007)



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- http://www.jaspermountain.org/brochures_reports.html
- Zeanah et al recently wrote an editorial re the need for permanency planning early
- 3 websites showing financial costs of childhood trauma:
  - http://www.childhood.org.au/Assets/Files/976067aa-98e0-47fc-a608-cbc3d3c11f06.pdf
  - http://www.aifs.gov.au/cfca/pubs/factsheets/a142118/index.html
  - http://www.asca.org.au/displaycommon.cfm?an=1&subarticlenbr=111