Australian Association for Infant Mental Health

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Submission to the National Early Years Strategy 2023

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About AAIMH

The Australian Association for Infant Mental Health (AAIMH) is a national organisation of professionals from many fields who work with infants, young children, and their families. Our mission is to work towards improving professional and community recognition that infancy and early childhood is a critical time for the development of emotional, physical and mental health.

A not-for-profit Australian charity with 439 professional members and branches in all states and territories, AAIMH is affiliated with the World Association for Infant Mental Health (WAIMH) through which, along with 63 Infant Mental Health Affiliate organizations from around the world, AAIMH contributes to international developments and initiatives.

Infant mental health refers to how well an infant develops socially and emotionally from conception to three years and is defined by the World Association for Infant Mental Health (WAIMH) as "the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system" (WAIMH.org, 2023).

AAIMH organises regular national conferences as well as workshops and seminars to enhance knowledge about social and emotional development in 0 to 3-year-olds and develop skills to assist families and communities to build nurturing and strong relationships with their infants and young children.

AAIMH works with other agencies on advocacy and educational initiatives, responds to Government inquiries and reports relating to infancy and provides information to members through its website and newsletter.

AAIMH also develops position statements and guidelines to support Infant Mental Health professionals and parents.

AAIMH welcome the opportunity to collaborate with the Commonwealth Government and early years stakeholders in the development of the National Early Years Strategy and the creation of an enduring vision and national roadmap for promoting the health and wellbeing of Australia's infants, children and their families in the early years.

AAIMH Vision

The needs of every infant and young child from before birth to age three are prioritised and addressed in a timely and responsive way to enhance their relationships and their mental health and wellbeing.

AAIMH Mission

Our Mission is to work for all infants and young children from pre birth to age three to ensure their social, emotional and developmental needs are met through stable and nurturing relationships within their family, culture and communities.

To achieve our Mission, AAIMH has set the following 2021-2024 strategic priorities:

- Advocate and collaborate for infants and young children in the interests of infant mental health wellbeing through improving professional and public recognition within Australian health, welfare, education and community networks.
- Increase the capacity of those directly involved in developing or advocating for policy or services that provide support to infants and young children through provision of education, professional development, and the dissemination of scientific knowledge. *
- Educate, inform, and support professionals through the promotion and dissemination of infant mental health research and the science behind evidence-based infant mental health practice.
- Implement evidence informed professional competencies and standards in infant mental health.
- Reviewing and enhancing good governance.

Further details of our activities can be found on the Australian Association for Infant Mental Health website: AAIMHI - Our Vision And Mission

Proposed structure of Early Years Strategy

1. Do you have any comments on the proposed structure of the Strategy?

The structure of the National Early Years Strategy is linear and hierarchical.

AAIMH propose a holistic approach to the design and delivery of the National Early Years Strategy with future Commonwealth strategies, initiatives and reforms able to be translated in to meaningful and coordinated front-line early years systems and services across all Australian States and Territories.

AAIMH welcome new ways of systems thinking, new models of care and an infant mental health informed multi-disciplinary service for Australian infants, young children, and families throughout the early years.

Flexibility afforded in the National Early Years Strategy by measuring progress and outcomes through continuous feedback cycles, collaboration and quality improvement will ensure

responsive and evidence-based and evidence informed[1] infant and early childhood centred practice.

Vision

2. What vision should our nation have for our youngest children?

The needs of every infant and young child from before birth to age three are prioritised and addressed in a timely and responsive way to enhance their relationships and their mental health and wellbeing.

AAIMH have a vision for an early years Australian health, welfare and education system and services that is infant/young child-centred and focused upon 'getting it right' for infants from the beginning – holistically supporting Australian families and communities through a strengths-based approach to provide for an infant's health and wellbeing needs.

Proactive and coordinated Australian health, welfare, education and community systems and services are needed that are guided by early years infant mental health research and evidence-based and evidence-informed practice.

Outcomes

3. What mix of outcomes are the most important to include in the Strategy?

AAIMH calls for consideration of the following outcomes to be included in the National Early Years Strategy:

- Infants and young children and their families have equal opportunity to thrive, connected to community and culture.
- Infants and young children and their families have access to high quality health, mental health, welfare, educational, and community services regardless of postcode or cost.
- There is no negative gap on any measure between Aboriginal and Torres Strait Islander infants and young children and their families and other groups in the Australian population.
- Vulnerability is identified early and addressed in a proactive strengths-based manner.
- Infants and young children have equal opportunity to be cared for by each of their parents or caregivers (mothers, fathers or carers).
- Australian governments, health, welfare, education and communities systems and services recognise and value the perinatal period, infancy and the early childhood of infants and young children as a crucial time of health and wellbeing development that lay the foundations for life-long health, wellbeing and mental health outcomes.
- Kith and kin are supported to provide care and support for infants and young children and their families.

[1] AAIMH notes that there is insufficient research in the efficacy of interventions in the Australian context and reliance is often upon evidence from international contexts that has not been tested on Australian families.

- Infants and young children and their families are supported by an infant mental health literate workforce, ensuring that all who engage with infants and young children and their families understand mental health development in the early years and beyond.
- Commonwealth investment in perinatal and infant mental health workforce education and recruitment of infant mental health clinicians across all levels of universal, secondary, and targeted health, welfare and education service systems is urgently needed.
- Commonwealth investment in infant mental health strategies, initiatives and reforms that interact with the early years and the promotion of an infant mental health workforce is the key to providing quality, over-arching and effective early years health, welfare, education and community services.
- Investment in research and evaluation is included as a standard component of every initiative

Policy priorities

The Policy Landscape:

AAIMH acknowledge and welcome the range of Commonwealth strategies, initiatives and reforms that interact with the early years including the following:

Early Childhood Education and Care (ECEC):

- Cheaper Child Care for Working Families election commitment National Quality Framework (NQF) Review – implementation of changes to the Education and Care Services National Law and National Regulations and guidance for the sector
- Productivity Commission Inquiry into Child Care Sector
- Preschool Reform Agreement 2022-2025
- Early Childhood Care Development Sector Strengthening Plan
- Early Childhood Care and Development Policy Partnership 2022
- Shaping Our Future: National Children's Education and Care Workforce Strategy – development of implementation plan and commitments to boost ECEC workforce – incl. fee- free TAFE places, Y Care Careers program

Disability:

- Australia's Disability Strategy 2021-2031
- National Autism Strategy First Nations:

Health and Wellbeing

- National Aboriginal and Torres Strait Islander Early Childhood Strategy National Agreement on Closing the Gap
- National Action Plan for the Health of Children and Young People 2020-2030
- National Children's Mental Health and Wellbeing Strategy
- National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028
- National Mental Health and Suicide Prevention Agreement
- National Preventive Health Strategy 2021-2030
- Treasury Wellbeing Framework
- National Strategy to Achieve Gender Equality Safety:
- National Plan to End Violence against Women and Children 2022-2032
- Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031

Additionally, AAIMH consider the ***National Framework for Universal Child and Family Health Services (2011)*** a relevant Commonwealth initiative and strategy that underpins the health and wellbeing of infants, children, and families in the early years – a universal health and wellbeing service that promotes perinatal and infant mental health in the early years that has not been listed as a 'relevant' Commonwealth strategy in the Early Years Strategy discussion paper.

4. What specific areas/policy priorities should be included in the Strategy and why?

AAIMH Policy priorities

Policy: AAIMH call for the removal of the 'Baby Blind-spot' from Commonwealth strategies, initiatives and reforms. Infants are often included under the banner of 'children' and/or 'children and young people', which does not reflect their unique developmental needs as being different to those of children or young people. This is referred to as the 'baby blind-spot'.

Why: Infants are the most vulnerable population or cohort in Australian health, welfare and education systems and services.

When infants are not acknowledged in Commonwealth strategies, initiatives and reforms the unique biopsychosocial needs for the health and wellbeing of infants is not recognised.

Furthermore, the invisibility of infants across Commonwealth strategies, initiative and reforms results in Australian infants not being 'seen' by health, welfare, education and community systems or services and subsequently the opportunities to holistically support families and further promote safe, caring, and responsive relationships of infants and young children is systematically missed.

AAIMH call for increased visibility of infants and infant mental health in all relevant Commonwealth and State strategies, initiatives and reforms.

AAIMH also call for infants to be named in all relevant Commonwealth and State government strategies, initiatives and reforms – this will increase the 'visibility' of infants and infant mental health across Australian health, welfare, education and community systems and front-line early years services.

Examples of increasing the visibility of infants across Commonwealth early years strategies, initiatives and reforms include:

- The National Action Plan for the Health of ***Infants***, Children and Young People 2020-2030;
- National Plan to End Violence against Women, ***Infants*** and Children 2022-2032;
- Shaping Our Future: National ***Infant*** *and* Children's Education and Care Workforce Strategy – development of implementation plan and commitments to boost ECEC workforce – incl. fee- free TAFE places, Y Care Careers program;
- Safe and Supported: the National Framework for Protecting Australia's ***Infants*** and Children 2021-2031;
- National Framework for Universal ***Infant,*** Child and Family Health Services (2011)

Policy: Inclusion of infants specifically in the National Children's Mental Health and Wellbeing Strategy – **the "National *Infant* and Children's Mental Health and Wellbeing Strategy**".

Why: The National Children's Mental Health and Wellbeing Strategy is a foundational Australian mental health strategy that draws on the science, policy and evidence-based practice that informs the multi-disciplinary workforce who care for infants and their families across universal, secondary, and tertiary health, welfare, education and community systems and services. The visibility of infants in the strategy needs to be strengthened.

Policy The **National Infant Mental Health and Wellbeing Strategy**

Why: Because of the importance of the years from birth to age 3, infants require a National Mental Health and Wellbeing Strategy in their own right.

The neuroscience of infant mental health highlights that the foundations for sound life-long mental health is built on infant's early experiences and relationships with parents, caregivers, relatives, teachers, and communities – who through early relationships quite literally shape the physical brain architecture of the infant's developing brain.

Disruptions in the development process of an infants' brain architecture as a result of adverse childhood experiences (ACE's) or cumulative exposure to environmental toxic stress can lead to impairment of an infant or young child's capacity to learn and engage with others.

Infant and early childhood exposure to adverse childhood experiences and environmental toxic stress is accompanied by poor care-giving relationships leading to the risk of lifelong adverse health and wellbeing implications for the infant.

For society, poor infant mental health outcomes can lead to costly social problems associated with early learning, social competence, and lifelong physical health – ranging from poor academic achievement at school, adolescent and adult mental health issues, homelessness, drug and alcohol issues, unemployment, incarceration and general poor health and wellbeing of individual Australians and families.

Infant mental health research provides an understanding of stress and resilience at the societal level and highlights that Australian social health and wellbeing concerns can be dramatically reduced through investment in improving the relationships and environments of infants and young children in the early years.

Adopting an 'infant mental health' lens and multi-disciplinary approach across universal, secondary, and tertiary health, welfare, education and community early years systems and services is an opportunity to create a 'common language'.

A 'common language' of infant mental health is a framework that will facilitate the disruption of siloed workforces and create boundary-spanning system pathways that will in turn, facilitate greater understanding, collaboration and communication between current early years systems, services, and the early years multidisciplinary workforce.

Policy: Proactive engagement of fathers

Why: Evidence shows that active engagement of fathers in the early years leads to better health and wellbeing outcomes for infants and their families.

Why include fathers:
A key feature of studies examining parental influences on child development published in the last five years is the separation of father and mother effects. The evidence shows fathers' influence as a separate, important factor in children's successful transition though infancy to adulthood. Even in areas where fathers' impact on infants and children can be harmful, professionals and government are increasingly recognising the need to engage fathers in services for the sake of their children (Maxwell et al., 2012).

Barriers to father-inclusion:
While barriers to father-inclusive practice have remained unsatisfactorily stable over the last two decades, there is now a clearer understanding of specific factors that inhibit or facilitate father's involvement in family-related services and programs. At the Government level, current barriers include social benefits and parental leave. At the service level, practitioner approaches remain maternal-focused, and many practitioners feel they lack the capacity to respond to men's violence in family work.

Facilitators of father-inclusion:
A number of strategies enhance father-inclusion in human services. These include staff skills and competencies, system level policies and practices, and government strategies that support men's involvement in family life.

Programs that successfully engage fathers:
Successful strategies include intervening early in men's transition to fatherhood; targeting co-parenting; using behaviour change programs to address fathers' violence; and linking programs, staff development and community awareness. Including Indigenous fathers requires building relationships between fathers, community and service, and focusing on school-based programs.

Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. (2014). Engaging fathers: Evidence review. Canberra: Australian Research Alliance for Children and Youth (ARACY).

Engaging-Fathers-Evidence-Review-2014-web.pdf (aracy.org.au)

Policy: Equal access to paid parental leave

Why: Bringing a baby into the world incurs additional expenses at a time when many families are reducing their income. Fathers particularly face the choice in many families between providing financial support through long work hours and forming a close relationship with their infants and children.

Infants are acutely sensitive to stress, including stress from poverty, hardship and parental worry and are best protected from chronic stress.

Policy: Paid baby leave - available to kith and kin (caregivers of infants and young children: grandparents, aunts, uncles, neighbours, friends)

Why: For tens of thousands of years infants have been raised in small family groups, with several adults available to provide care and protection for the infant and support for each other, and infants and their families in 2023 have never been more isolated.

Relational health is the most important cornerstone of resilience and the best buffer for the effects of adverse childhood experiences (Hambrick & Perry, 2017), and a policy of providing paid baby leave will strengthen relational health of the infant from the beginning and provide support for families by enabling key stakeholders to invest their time in building a relationship with the baby and supporting the family.

Paid Commonwealth baby leave is an important consideration in supporting infants and families who are at risk of experiencing exposure to parental psychosocial vulnerabilities and will facilitate kinship care of an infant or toddler through alleviating some of the financial burden of raising an infant in the early years.

Policy: Accessible, affordable, flexible, and high-quality childcare

Why: The importance of high quality ECEC cannot be over-stated with virtually all research indicating that high quality care regardless of setting or provider is associated with more positive outcomes for children compared with low quality care (Gialamas, Mittinty, Sawyer, Zubrick, & Lynch, 2014; Productivity Commission, 2015).

It is important to note that the aspect of ECEC quality with the strongest association with improved developmental outcomes is the quality of the caregiving relationship (Gialamas, Mittinty, et al., 2014) (Gialamas, Sawyer, et al., 2014). Studies have also demonstrated that it is not only the quality but rather the frequency of positive caregiving interactions between carer and child that was related to more secure attachment relationships, as well as improved cognitive and social and emotional outcomes (Howes & Spieker, 2018). This finding that children require more frequent positive interactions with their carer is important in the context of staff-child ratios and the amount of time a carer has available to dedicate to each child.

Approaches to ECEC need to ensure that the developmental needs of young children are prioritised, and prevail over parental and social-economic characteristics, the aims of labour force and income support policies, and other political considerations. This includes providing parents with the opportunity and choice to decide if they want their child to access ECEC or remain solely cared for by the family network.

AAIMH considers access to high quality ECEC services designed to meet the individual emotional and developmental needs of every child as a fundamental right of all infants, toddlers, and young children, and crucial to maximizing developmental opportunities in the early childhood years.

Policy: Strong universal infant, child and family health services provided through an infant mental health lens and literate workforce who are focused on health promotion and preventative health initiatives across Australian states and territories.

Why: Universal (infant), child and family health services, together with high quality antenatal services, provide the first stage of the universal service system to support human development in Australia. Along with early childhood education and schooling, universal infant, child and family health services aspire to support optimal health and development to give infants and children the best opportunity to succeed in life and learning.

The population health approach of universal infant, child and family health services facilitates the systematic identification of infants, children and families who require further assessment, intervention, referral and/or support. Universal infant, child and family health services work alongside targeted or specialist and intensive services for vulnerable families or for those infants and young children where a health or development need is identified. In recognition of the importance of the early years of life in influencing the health and development of children, the services outlined in the National Framework for Universal Child and Family Health Services (2011) monitor progress and promote health, development, and wellbeing during critical periods in an infant or child's life throughout the early years.

This includes recognising the importance of optimal health and wellbeing of parents and other primary carers and ensuring optimal maternal physical and mental health as well as a focus on developing father-inclusive services. Universal child and family health services also contribute to the health of the population through health promotion and preventive health initiatives such as immunisation programs, breastfeeding promotion, child safety and parenting support".

National Framework for Universal Child and Family Health Services (2011, p1). NFUCFHS_National Framework for Universal Child and Family Health Services.pdf

Policy: A strong perinatal focus that is father inclusive and culturally literate to identify and support psychosocial and mental health vulnerabilities early that may adversely impact on the development of infant emotional, physical and mental health and the health and wellbeing of the family system.

Why: Commonwealth investment in government and non-government perinatal and infant mental health research, initiatives, and services will improve accessibility for coordinated infant, child and family early years mental health services.

From a perinatal and infant mental health perspective there are unique gendered psychosocial challenges mothers and fathers experience with the arrival of a new baby, and it is important to provide responsive parenting support for both under the umbrella of 'parents' and 'partnerships' so infants and children are raised in loving and supportive families and communities. This in turn promotes infant mental health and subsequently promotes the health and wellbeing children and young people through the middle years, adolescence, and young adulthood (0-24 years).

Fathers are often under-engaged in universal infant, child and family services and greater proactive efforts to remove system and service barriers is needed. This includes expanding universal antenatal and postnatal screening for perinatal depression to include fathers.

Costs to the community for paternal perinatal depression have been estimated at $242 million per year excluding the costs of impaired infant development due to paternal mental illness.

For fathers to be supported in their role as equal caregiver, as well as providing access to paid parental leave, national guidelines framing the provision of mental health screening and care of parents after miscarriage or stillbirth should be reviewed to include fathers.

Homepage | Australian Commission on Safety and Quality in Health Care

Policy: Address infants' experience of family violence in their own right.

Why: Pregnancy and the immediately postnatal period have been identified as a time of increased risk of partner violence (Chhabra, 2007; McFarlane, Campbell, Sharps, & Watson, 2002; Menezes-Cooper, 2013).

Due to their total dependency, infants are more likely than any other age group in childhood to be present during episodes of family violence. This puts them at greater risk of harm, injury and death, than any other childhood age group (AIFS, 2014; AIHW, 2012a; Brandon et al., 2008; Frederico, Jackson, & Jones, 2006; Jordan & Sketchley, 2009; Zeanah & Scheeringa, 1997).
Infants also make up the largest cohort of children entering women's refuges as a result of mothers fleeing family violence (AIHW, 2012a, 2012b; Shinn, 2010).

Relational violence and trauma experienced by infants has far-reaching detrimental consequences for development across their entire lifespan (Lieberman, Van Horn, & Ippen, 2005; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 1996; Schore, 2005; Schwerdtfeger & Goff, 2007; Shonkoff, 2010; Siegel, 2012; Van der Kolk, 2014).

Infants exposed to family violence face more than the risks of physical harm. The infant brain is at a critical, rapid and formative stage of development. Family violence can damage the developing brain of the infant (Cirulli, Berry, & Alleva, 2003, p. 80). These infants are more likely to experience compromised mental health, face poorer social/emotional development, educational/employment outcomes as well as engage in substance use and engage in or re-experience violence in their adult relationships (Bosquet Enlow, Egeland, Blood, Wright, & Wright, 2012; Holt, Buckley, & Whelan, 2008).

Despite the plethora of evidence supporting the critical need to provide effective interventions to address trauma in the early years, infants and young children remain the least likely to receive direct or effective services in addressing the impacts of family violence (Fantuzzo & Fusco, 2007; Jordan & Sketchley, 2009; Lieberman, Chu, Van Horn, & Harris, 2011; Newman 2015; Bunston 2015; Toone 2015).

Policy: Ensure infants and very young children have their important relationships supported and protected, especially when they are involved with care and protection services.

Why: Early relationships matter and child maltreatment (physical and emotional abuse, physical and emotional neglect) of the infant can lead to disorganised attachment, emotional and behavioural difficulties, neurological and stress responses that can cumulate over the life course.

The number of children subject to child protection intervention and entering OoHC in Australia continues to rise (AIHW, 2020). Infants under one year of age are around twice as likely as other age groups to have at least one child protection substantiation, with emotional abuse and neglect being the most common primary and co-occurring types of substantiated maltreatment (AIHW, 2021).

The United Nations (UN) Convention on the Rights of Children describes the civil, political, social, economic, and cultural rights of children. Australia ratified the UN Convention in 1990 (United Nations, 1989). Accordingly, Australia has legal obligations to ensure that all have the right to experience the conditions for optimal health, growth and development and that society has an obligation to ensure that parents have the necessary resources to raise children (Reading et al., 2009).

Further to this, the World Association for Infant Mental Health (WAIMH) Position Paper on the Rights of the Infant highlights the unique considerations of the infant. Infants are completely dependent on the availability of consistent and responsive care from specific adults for the adequate development of their basic human capacities. As a result, infants are in need of special safeguards and care; including legal protection and continuity of attachment relationships being valued and protected, especially in the context of child protection concerns (WAIMH, 2016). Both documents highlight that the needs and rights of children, and especially infants, are often overlooked amid conflicting priorities with the rights of parents and other complexities.

The ideas and values behind these documents are not abstract and can be used to develop specific policy approaches and interventions to best support the needs of infants involved in the child protection system and OoHC.

Viewing abuse and neglect as a violation of an infant's basic human rights allows the infant's perspective to be prioritised, with the subjective experience of the infant being at the centre of decision making for infants in OoHC (Sketchley & Jordan, 2009).

AAIMH welcome the collaboration by the Commonwealth, state and territory governments, together with Aboriginal and Torres Strait Islander representatives and the non-government sector in the delivery of Safe and Supported the National Framework for Protecting Australia's Children 2021-2031.

The AAIMH Position Paper: Continuity of Relationships (2022) aims to serve as a guide for policy makers and staff working in the justice system, child protection services, out of home care (OoHC) service providers, family support services, non-government organisations (NGOs) and all those involved in decisions affecting the continuity of relationships for children involved in the child protection system.

While much of the position paper is relevant to all children, the focus of this paper is on infants (from prebirth to three years of age). AAIMH believes that the best interests and subjective experience of the infant, should be the primary consideration for all decisions involving their care, safety, and welfare.

For the full AAIMH Continuity of Relationships Position Paper refer to Appendix I

Policy: Special recognition of infants as a vulnerable priority group within the Safe and Supported the National Framework for Protecting Australia's Children 2021-2031.

Why: Infants are overrepresented in all child protection priority groups and are disproportionately affected by early adversity and separation from family.

The 4 priority groups identified in the Safe and Supported National Framework 2021-2031 are:

1. Children and families with multiple and complex needs.
2. Aboriginal and Torres Strait Islander children and young people experiencing disadvantage or who are vulnerable.
3. Children and young people and/or parents/carers with disability experiencing disadvantage or who are vulnerable.
4. Children and young people who have experienced abuse and/or neglect, including children in out-of-home care and young people leaving out-of-home care and transitioning to adulthood.

AAIMH calls upon infants to be recognised in Commonwealth strategies, initiatives, and reforms as a vulnerable priority group in their own right due to the critical importance of the biopsychosocial developmental period from conception to age three years, the disproportionate effect of harm during this period, and the overrepresentation of infants in all child protection populations.

Infancy is as different a developmental stage to childhood development as childhood is to adolescent development and should be addressed directly.

Policy: Invest in the infant mental health workforce at all levels of the early years Framework.

Why: Commensurate with the importance of the disproportionate impact of adverse childhood experiences (ACEs) and exposure to toxic stress from conception to age three, early years services have the greatest opportunity of positive impact when they are delivered by professionals who have knowledge and skills in understanding and addressing the relational, developmental and wellbeing needs of infants and their families.

AAIMH is implementing the *Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* across Australia. The Competency guidelines are a workforce development framework to ensure that those working with infants and their families, including early childhood educators, family support workers, researchers, policy makers, clinicians (eg. nurses, General Practitioners, Psychiatrists, Psychologists, Social Workers) are familiar with and can obtain core competencies in infant mental health appropriate to their work.

Due to the complex, interrelated nature of human development infant mental health requires expertise and conceptualizations beyond the capabilities of any one discipline and as such adopting an infant mental health lens to the early years is a common interdisciplinary approach for breaking down professional 'silos.

A common theme throughout all Commonwealth strategies, initiatives and reforms that interact with the early years is the need to develop coordinated models of care and service delivery that seeks to improve information sharing, data development and analysis and the identification of priority areas that will strengthen the child and family sector and workforce - the AAIMH Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® is a pathway to achieving this.

The AAIMH Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (the Competency Guidelines) are a guide for practitioners and professionals across various areas of work such as early childcare and education, community child health, medicine, nursing, allied health, social work, child protection, mental health, policy, research and law.

A roadmap for training and professional development, these guidelines describe competencies in infant mental health work. They detail the specific skills, knowledge base and practice for work with infants (from birth to 36 months) and their families in four categories across the continuum of care:

- Infant Family Worker: focus on promotion
- Infant Family Practitioner: focus on prevention and intervention
- Infant Mental Health Practitioner: focus on clinical intervention and/or treatment
- Infant Mental Health Mentor: focus on leadership

The AAIMH Competency Guidelines® reflect AAIMH's commitment to building the capacity of the infant and family workforce to deliver quality services during the all-important first 1000 days of life, in an environment of nurturing relationships.

Policy: Implement a 'trauma informed approach" to the design and delivery of the National Early Years Strategy with future Commonwealth strategies, initiatives, reforms and early years workforce acknowledging that a complete picture of an infant and parent's life situation - past and present – is needed to provide effective health, welfare, education and community services.

Why: A trauma informed approach is sensitive and compassionate to an infant and family system's experiences and potentially can improve engagement with services, treatment adherence, and better health and wellbeing outcomes including better health and wellbeing outcomes for the early years workforce. It can also reduce avoidable care and excess costs for health, welfare, education, and community services.

A trauma informed approach will also assist the workforce crisis by reducing burnout, vicarious trauma and contribute to recruitment and retention (https://mhcc.org.au/publication/trauma-informed-care-and-practice-ticp/)

5. **What could the Commonwealth do to improve outcomes for children – particularly those who are born or raised in more vulnerable and/or disadvantaged circumstances?**

Uphold the rights of infants in all Commonwealth policies and health, welfare, education, and community services that engage with infants and their families throughout the early years (see WAIMH Statement on Infant Rights, Appendix II).

- Ensure safe, attentive and attuned care within a context of continuity of relationships (See AAIMH Continuity of Relationships Position Statement, Appendix I).
- Address the needs of infants and young children who experience family violence through proactive prevention strategies, provision of safe refuge and immediate access to infant mental health services, particularly while in refuge. (See AAIMH Infants and Family Violence Position Statement, Appendix III).
- Proactive antenatal engagement with each parent, family, community and organisational stakeholders.
- Equal paid parental leave for each parent.
- Delivering policies that promote affordable housing and drive down cost of living pressures.
- Baby leave available for family and community stakeholders.
- Facilitate early engagement with universal child and family health services and where there has been late engagement with perinatal or infant health services referral into short-term or long-term targeted infant and infant mental health service is accessible support for vulnerable families.
- Ensure families have sufficient financial and material resources to enable good enough care of infants and young children.
- Accessible, affordable, flexible and high quality childcare (See AAIMH Early Childhood Education and Care Position Statement, Appendix IV).
- Invest in an infant mental health literate and competent early years workforce.
- Active identification of vulnerability and proactive intervention.
- Coordinate services that are designed to support families with infants and young children. Models such as ‘Whole of family team’ be extended.
- Support place-based initiatives and family community centre approaches and/or activities that facilitate relationship building, parental resilience, education sessions, recreation and play opportunities for infants, young children and their families – playgroups, swimming lessons, library, story-time etc

6. What areas do you think the Commonwealth could focus on to improve coordination and collaboration in developing policies for children and families?

D.W. Winnicott once famously said 'there's no such thing as a baby', reflecting that infants and young children do not exist by themselves but always in relation to someone else. Many of our policies and services are funded to provide services to an individual rather than a group such as a family, or a relationship, such as caregiving. This is fundamentally counter to human development.

When policies are focused upon the infant first, coordination and collaboration follow, because this reflects the pathway of development. For example, an infant who has experienced family violence needs first to be safe and free from violence. This means that they need a safe refuge and an attuned and attentive caregiver. For the caregiver to be able to provide attuned and attentive care they need to be safe and have their physical and mental health care needs attended to. Similarly, when a baby is born they need attuned and attentive care from a small number of stable caregivers. This means that they need each parent or caregiver to be available and supported.

Examples of infant led practice to improve coordination and collaboration:

1. Maternal Early Child Sustained Home Visiting (MECSH) services aim to promote responsive parental care and positive parent-infant attachments thus promoting supportive home environments – for families at risk of/or engaged with the child protection system such an infant mental health/child and family health approach could help keep infants, children and their families with complex psychosocial needs safe, supported and together.

   There are many models of sustained Maternal Early Child Sustained Home Visiting (MESCH) home visiting services across Australia and all of them have intake exclusively in the antenatal and immediate post-natal period.

   Vulnerable families at risk of/or engaged with child safety services are often identified as having late or poor engagement with universal infant and child family health services in the early years. Accepting 'late' referrals into modified MESCH sustained home visiting services is a 'new way of thinking' to promote the health and wellbeing of infants and young people.

2. A family systems and infant mental health approach that is a trauma-informed, health promotion and family partnership model of family sustained home-visiting care that aims to identify and ameliorate cumulative adverse childhood experience (ACE) risks for infants and children through responsive parental support and the building of parental capacity - referral into modified and targeted family sustained home-visiting/MESCH programmes would not be restricted to the antenatal or immediate post-natal period but rather at any time over the early years (0 to 5 years) for targeted or sustained perinatal and infant mental health, infant development and family services – currently there are no such universal child and family health programs with a workforce who have education in perinatal and infant mental health that offer this service.

3. Infants and young children at risk of/or engaged with the child protection system urgently need family and kinship networks to be safe and supported.

   Re-thinking old systems and adopting an infant mental health promotion model of care for infants and young children exposed to adverse childhood experiences and cumulative toxic stress is evidenced in the *Family Matters Report 2021* who noted that that in 2019 forty-two percent of all Aboriginal and Torres Strait Islander children were living in kinship care with investment nationally in prevention, supporting families to stay safely together, and restoration of families (16 cents in every child protection dollar) substantially disproportionate when compared to child protection intervention and removal of children (84 cents in every child protection dollar).

FamilyMattersReport2021.pdf

4. Early Childhood Court Teams.

   Special infants and early childhood court approaches have been implemented internationally and produced positive outcomes for infant and their families involved with Child Protection Services.

   Infants and young children and their families involved with specialist early childhood courts exit out of home care and achieve permanency more frequently, experience fewer repeated incidents of maltreatment and greater engagement with services. There are substantial cost savings for all jurisdictions through reduced time involved with services and subsequent improvements to health and wellbeing across the lifespan.

   This model could be introduced to the Federal Circuit Court to provide better outcomes for infants of separated families.

ZERO TO THREE | Early Connections Last a Lifetime

Principles

7. What principles should be included in the Strategy?

All policy and service delivery should be consistent with the World Association for Infant Mental Health principles of the rights of infants (see Appendix II).

Infants should be identified in all policies and service delivery by name to remove the ‘baby blind spot’.

All early years policy and service delivery should be targeted towards identifying and meeting the needs of the youngest in the family because the youngest is usually the most vulnerable.

Infants’ connection with family should be prioritized and maintained wherever possible (AAIMH Continuity of Relationships Position Paper, Appendix I).

Infants' rights, relationships and needs are unique to them and should be considered separately from their parents.

Evidence-based approach

AAIMH welcome the evidence-based approach underpinning the National Early Years Strategy and recognising the importance of Aboriginal and Torres Strait Islander knowledge bases, recognising there are gaps in current evidence and data, a key priority under the current Closing the Gap Agreement.

The public health model identifies areas of risk in children's development and prevents problems before they occur by addressing that risk. The model provides different levels of support, from universal services available to everyone to highly targeted offerings. Universal services include things like our health and education systems; targeted (or secondary) services include policies such as parental leave; and tertiary services address acute issues such as child protection.

The ecological systems theory developed by Urie Bronfenbrenner shows a child's development is influenced by their surrounding environment, which ranges from a child's immediate environment, through their family, community, and up to the influence of society.

The Nest conceptualises wellbeing as six interconnected domains that support each other to help children both thrive in childhood and reach their full potential as they grow. To have optimal wellbeing, a child needs to have their needs met in all six domains, in an ecological model based on Bronfenbrenner's ecological systems theory.

The OECD frameworks for measuring wellbeing. The first is a general wellbeing model that considers diverse experiences and living conditions of people and is built around three components, including current wellbeing, inequalities in wellbeing outcomes and resources for future wellbeing. A second more recent framework developed by the OECD is an aspirational model to pinpoint the aspects of children's lives that should be measured to best monitor their wellbeing. It is centred on the idea that children should be able to both enjoy a happy childhood and develop skills and abilities that set them up for the future.

8. Are there gasps in existing frameworks or other research or evidence that needs to be considered for the development of the strategy?

Research gap into the role of fathers.
Many of the existing policies unintentionally reinforce the stereotype of mothers as responsible for meeting the needs of the infant and fathers as a 'helper'. They do this by referring to the mother as the sole caregiver parent and either not mentioning that there is another parent, the father, or assuming that he is a 'secondary carer'. The lack of research on fathers' role in relation to infants is sometimes cited as a reason not to include fathers in policy guidance however 'fathers' as a category are not included in calls for targeted research by national or state research funding bodies.

Research gap into a family systems approach.
Research is lacking into the impact of policies and interventions on the family as a system – serving two (or more) generations and the costs and benefits of intervening in different parts of the family system that will ultimately improve the health and wellbeing of infants and children throughout the early year.

Challenges for the Australian health, welfare and education systems are that they are primarily driven by a Western individualist approach that automatically separate infants from their relationships. One example of this in practice is government funding attached to the index patient/client rather than the infant and the family system.

Adopting an intergenerational approach requires a considerable shift in thinking.

- emphasising care *and* education verses emphasising care *or* education;
- promoting responsive parenting, family life and leadership skills verses early years services providing information to parents;
- services assuming partnership/responsibility includes both parents/carers verses old thinking of requiring participation/responsibility of mother; agencies providing access to education to education, economic supports, and social/mental health services verses early years services simply giving referrals to services;
- and using data for continuous improvement of services as opposed to using data for compliance.

Building Children's Potential - A Capability Investment Strategy (aracy.org.au)

Lack of research on efficacy for Australians.
Many jurisdictions in Australia have implemented policies and programs based upon evidence of effectiveness from other countries without determining if the program's evidence applies to Australian families. We note the risk this poses to Australian infants and their families in implementing policies and services that are not fit for purpose. AAIMH calls for greater investment in determining applicability of international programs in the Australian context.

AAIMH also calls upon greater Commonwealth investment to develop an evidence base for Australian policies and programs already implemented and in development.
https://mhcc.org.au/publication/trauma-informed-care-and-practice-ticp/

The Nest.
AAIMH welcome and congratulate the Australian Research Alliance for Children and Youth (ARACY) for the research, development and evidence base of The Nest and The Common Approach as a framework to guide the National Early Years Strategy and early years workforce in engaging with families and promoting the health and well being of infants and young children.

Together with an infant mental health lens (with the 'infant' at the centre of The Nest) and AAIMH's research and position papers:

- AAIMH Continuity of Relationships Position Paper
- AAIMH Early Childhood Education and Care Position Statement
- AAIMH Infants and Family Violence Position Statement

- AAIMH Competency Guidelines®

there is great scope for strategic partnerships and translating evidence-based research into early years infant mental health practice that will ensure a pathway for not only infants and young children to be valued, loved, and safe; have material basics; are healthy; are learning; are participating; and have a positive sense of identity and culture but also a pathway for the development of an infant mental health literate health, welfare, education, and community workforce.

References available upon request

Appendix I: Continuity of Care Position statement

Australian Association for Infant Mental Health

Continuity of Caregiving Relationships for Infants Involved in Child Protection

1. Purpose of AAIMH

The Australian Association for Infant Mental Health Ltd (AAIMH) is a not-forprofit organisation of professionals from a range of disciplines including health, education, and welfare, dedicated to the field of infant mental health. AAIMH's mission is to work for all infants and young children from pre birth to age three to ensure their social, emotional, and developmental needs are met through stable and nurturing relationships within their family, culture, and communities. This is achieved by assisting families, professionals, and communities to build nurturing and strong relationships with their children, and to be aware of the causes and signs of mental, physical, and emotional stress in infants.

2. Purpose of position paper

The purpose of this position paper is to describe AAIMH's position on the vital importance of continuity of relationships for infants involved with statutory child protection services in Australia. The literature generally uses the term permanency planning to describe approaches aimed at promoting stability and continuity to case planning for infants subject to child protection intervention. AAIMH prefers to use the term continuity of relationships to highlight the significance of relational continuity to the wellbeing of infants.

The paper aims to serve as a guide for policy makers and staff working in the justice system, child protection services, out of home care (OoHC) service providers, family support services, non-government organisations (NGOs) and all those involved in decisions affecting the continuity of relationships for children involved in the child protection system. While much of the position paper is relevant to all children, the focus of this paper is on infants (from prebirth to three years of age). AAIMH believes that the best interests and subjective experience of the infant, should be the primary consideration for all decisions involving their care, safety, and welfare.

3. Defining permanency, permanency planning and its goals

There are four generally accepted dimensions of permanency:

- Legal: the legal arrangements of a child's guardianship and contact arrangements
- Physical: stable living arrangements
- Relational: the opportunity to experience positive, caring, and stable relationships with a predictably available caregiver or caregivers
- Cultural: ongoing connection to culture through connection with family, community, and spiritual practices

(PSP Learning Hub, 2020; Stott & Gustavsson, 2010)

Although there is no universally accepted definition of permanency planning, it is generally viewed as a systematic, goal directed and timely approach to case planning for all children subject to child protection intervention, with the aim of promoting stability and continuity (Osmond & Tilbury, 2012). Permanency planning can be incorporated across the continuum of care options; preservation, restoration, kinship, foster or residential care and adoption.

The focus on permanency planning in child protection systems often concentrates on legal and physical permanence (McSherry & Malet, 2018). This is highlighted by state and territory governments introducing timeframes for permanency placements to occur, as well as outcomes being measured by the time taken to achieve a particular placement type and stability of placement rather than broader aspects of child wellbeing (Goldsworthy & Muir, 2019; Osmond & Tilbury, 2012). This is in contrast to the strong evidence base that suggests continuity of relationships and feeling a sense of safety, belonging and commitment is what improves outcomes for infants and children (AIFS, 2021).

4. A new language: Continuity of Relationships

AAIMH believes the best interests of the infant are met when the community around them focuses on supporting and maintaining their relationships with important caregivers, particularly through periods of adversity. For this reason, we use the term 'continuity of relationships' to guide practice in this field, instead of permanency planning.

5. Context

The number of children subject to child protection intervention and entering OoHC in Australia continues to rise (AIHW, 2020). Infants under one year of age are around twice as likely as other age groups to have at least one child protection substantiation, with emotional abuse and neglect being the most common primary and co-occurring types of substantiated maltreatment (AIHW, 2021).

OoHC refers to alternative living arrangements for children who are unable to live with their biological parents (AIHW, 2020). A number of different living arrangements are included under

the umbrella term OoHC; including foster care, relative or kinship care, family group homes, residential care, and independent living (Commonwealth Government, 2011). There is a paucity of research concerning the unique experience of infants in OoHC, however international and Australian research highlights that children in OoHC have poorer outcomes compared to their peers in terms of mortality rates, their physical and mental health, as well as their cognitive and learning ability (Miron et al., 2013; Paxman, Tully, Burke, & Watson, 2014; Segal et al., 2021). This may be related to the abuse and/or neglect experienced with their biological parents before removal, the trauma associated with being removed from biological parents, the unstable nature of OoHC and the high rates of abuse in OoHC (Trivedi, 2019). Any change of caregiver, or the unpredictable availability of caregivers may disrupt the development of attachment in the first years of life, with lifelong implications.

While the personal cost associated with OoHC for infants and families is immense, there is also a significant financial cost to society. Providing child protection services at the state and territory level cost $7.5 billion in 2020-2021, an increase of 6.2% on the preceding year. Of this expenditure, care services accounted for the majority of the spend (60.3% or $4.5 billion (Productivity Commission, 2022). A conservative estimate of the lifetime financial cost to Australian society of new cases of child abuse (including physical, sexual, and emotional abuse, neglect and experiencing domestic and family violence) has been calculated as $16.1 billion and a non-financial cost of $62.3 billion (Deloitte Access Economics, 2019).

Under the Australian Constitution, legislative responsibility for investigating and responding to child protection concerns rests with state and territory governments. Although this means there are eight distinct child protection systems across the country, there are significant consistencies in their approaches. Children are generally placed in OoHC as a last resort when they are unable to live safely with their parents. This nearly always involves engagement with state or territory-based Children's/Youth Courts. All states and territories incorporate continuity of relationship principles in case planning processes with the intent of achieving stable long-term care arrangements for all children in OoHC (AIHW, 2016).

In response to the rising number of children entering OoHC, states and territory governments have also increasingly amended relevant child protection legislation, introducing definitive time frames for permanent placements to be established. These reforms are aimed at stopping drift, where children remain in temporary OoHC placements for prolonged periods and/or experiencing multiple OoHC placements (Freitas, Freitas, & Boumil, 2014).

6. The needs of infants in OoHC: A human rights perspective

The United Nations (UN) Convention on the Rights of Children describes the civil, political, social, economic, and cultural rights of children. Australia ratified the UN Convention in 1990 (United Nations, 1989). Accordingly, Australia has legal obligations to ensure that all children have the right to experience the conditions for optimal health, growth and development and that society has an obligation to ensure that parents have the necessary resources to raise children (Reading et al., 2009). Further to this, the World Association for Infant Mental Health (WAIMH) Position Paper on the Rights of the Infant highlights the unique considerations of the infant. Infants are completely dependent on the availability of consistent and responsive care from specific adults for the adequate development of their basic human capacities. As a result, they are in need of special safeguards and care; including legal protection and continuity of attachment relationships being valued and protected, especially in the context of child protection concerns (WAIMH, 2016).

Both documents highlight that the needs and rights of children, and especially infants, are often overlooked amid conflicting priorities with the rights of parents and other complexities.

The ideas and values behind these documents are not abstract and can be used to develop specific policy approaches and interventions to best support the needs of infants involved in the child protection system and OoHC. Viewing abuse and neglect as a violation of an infant's basic human rights allows the infant's perspective to be prioritised, with the subjective experience of the infant being at the centre of decision making for infants in OoHC (Sketchley & Jordan, 2009).

7. Cultural Considerations

All families have a unique culture that they use to interpret experience, generate behaviour, and interact with the wider world. Infants are born into this culture, and it provides them with a sense of who they are. They respond to these unique cultural differences from birth, including customs and traditions around language, behaviour, social norms, values, and systems of belief (Fleer, 2020). When families enter the child protection system, consideration needs to be given to developing an understanding of the family's unique individual cultural experience. Understanding the family's cultural context will support determining the best interest of the infant. When the decision to remove an infant is made, where possible theses values, beliefs and traditions of the family should be maintained, and directly incorporated into care plans. When working with families, reflective practice is essential to developing an awareness of how an individual's own culture and biases can shape assumptions about the culture of others (Dolman, Ngcanga, & Anderson, 2020).

8. Cultural considerations specific to First Nations Infants

First Nations children continue to be grossly over-represented in child protection and OoHC systems. They are removed from their families at a higher rate and are reunified with family less frequently (AIHW, 2020). Nationally, the rate of First Nations infants in OoHC is ten times the rate of non-First Nations infants (O'Donnell, Taplin, Marriott, Lima, & Stanley, 2019). For First Nations infants, cultural identify is central to their welfare, contributing significantly to the infant's social, spiritual and moral wellbeing, and physical and mental health (SNAICC, 2005). Culture and family are inextricably linked. Culture and spirituality are part of the meaningful ways in which First Nations infants interact with their families, community, and country. Keeping infants connected to family and community is the only way to keep infants culturally and spiritually strong (SNAICC, 2005).
First Nations infants are spiritually connected to their culture from pre-birth, and so any disruption causes significant issues for growth and development. Separating infants from country and culture causes spiritual sickness for the infant and family, and often re-traumatises a community who have suffered from harms caused by colonisation and past practices of removal. For First Nations infants, removal from country, community and culture is akin to a wound that needs a healing approach and can cause lifelong problems if such healing is not received.

Consequently, cultural and spiritual identity for First Nations infants is intrinsic to any assessment of what is in the infant's best interest (ALS, 2020). While all jurisdictions in Australia have policies to maintain First Nations children's identity and connection to culture, in practice they are often placed with non-First Nations families and their connection to culture can be lost (O'Donnell, Taplin, Marriott, Lima, & Stanley, 2019). Too often, the debate in Australia has pitted rights to culture in opposition to the infant's right to safety. However, safety and culture are not mutually

exclusive, but are mutually complimentary, with culture contributing to safety and wellbeing (SNAICC, 2018).

First Nations infants begin their involvement with the child protection system and OoHC with an identity that is grounded in connection to family, community, and country. In First Nations communities, everyone is responsible for raising the infant or child, and continuity of relationships includes having a cultural network of people to assume various responsibilities. Maintaining these connections, even when contact with biological parents may not be possible, needs to be a priority to ensure maintenance and promotion of culture. Being removed from this represents a significant trauma, often occurring in the context of intergenerational trauma caused by many factors, including the historical forced removal of children (ALS, 2020; SNAICC, 2018).

When a First Nations infant is removed from their parents to ensure their safety, broader cultural definitions of kinship need to be considered. Consideration of who is kin for an infant is the responsibility of the family and by those with cultural authority for the infant. This can include biological blood lines that have been passed on from generation to generation, but also culturally defined relationships that reflect specific bonds and obligations. These expanded cultural definitions need to be meaningfully embraced by services working with First Nations infant's and families. Active efforts need to be made by engaging with families, communities and local First Nations controlled organisations in placement decision making, especially in identifying, locating and assessing potential kinship carers (SNAICC, 2018).

9. The evidence for the value of continuity of relationships (not specific to infants)

International reviews have highlighted that there is increasing evidence that continuity of relationships is more important to placement stability and children's wellbeing than any measure of legal permanence or the type of permanency order (Boddy, 2013; Devaney, McGregor, & Moran, 2019; McSherry & Malet, 2018).
A number of recent international systematic reviews have concluded that for children requiring OoHC, continuity, placement stability and wellbeing outcomes for children in kinship placements are significantly better than for their peers in nonkinship placements, including adoption (Bell & Romano, 2017; Goering & Shaw, 2017; Rosenthal & Hegar, 2016; Winokur, Holtan, & Batchelder, 2018). This has also been supported by recent Australian publications from POCLS (DCJ, 2021; Delfabbro, 2020). The authors suggest that these findings may be related to the sense of emotional safety, security, and commitment that children in kinship care may be more likely to experience (Bell & Romano, 2017; Rosenthal & Hegar, 2016; Winokur et al., 2018).

Continuity of relationships through OoHC, and specifically continuity of care with predictable, reliable, and committed caregivers improves outcomes (Casanueva et al., 2014; Granqvist et al., 2017). This needs to be considered in the context of the extensive research documenting the harmful effects of disrupted placements on infants (Casanueva et al., 2014; Smyke & Breidenstine, 2009). Integrating this with the current knowledge of attachment and early childhood development, decisions can be made that better prioritise the needs of infants (Miron et al., 2013).

Although there is largely agreement on the critical importance of attachment and continuity of relationships in early life as an important foundation for lifelong healthy social, emotional, and cognitive development, child protection policies and practices generally fail to differentiate services for infants and older children (Chinitz, Guzman, Amstutz, Kohchi, & Alkon, 2017; Critchley, 2020a, 2020b; O'Donnell et al., 2019). Therefore, few child protection practices have

the relational focus needed to promote sensitive caregiving to traumatised infants, their parents, or caregivers (Chinitz et al., 2017).

10. Attachment and early child development

The first two years of life are a crucial period for the establishment of attachment. Infants have an innate drive to form attachments with caregivers. As long as there is opportunity for substantial and sustained physical contact, infants will form an attachment relationship with a small number of caregivers (Zeanah, Shauffer, & Dozier, 2011). However, the nature of this attachment can vary, depending on the characteristics of the caregiving and the infant's experiences and interactions with the caregivers.

Infants develop through their relationships with parents and other regular caregivers. Consistent, responsive, and sensitive caregiving relationships provide the foundation for healthy brain development and increase the likelihood of lifelong health and wellbeing. Conversely, abusive, inconsistent, unreliable and insensitive caregiving relationships damage the developing brain, having lifelong consequences for learning, behaviour and physical and mental health (AIFS, 2017; National Scientific Council on the Developing Child, 2012). These early attachment relationships form the foundation for how children view themselves, the world and approach future relationships with others (Van Der Voort, Juffer, & Bakermans-Kranenburg, 2014).
In the first few months of life, the caregiver-infant environment helps to shape the infant's physiological regulation and biobehavioral patterns of response. By 7 to 9 months of age, infants have the capacity to form selective attachments. From this point to around 18-24 months of age, continuity of caregiving is essential for healthy development (Gauthier, Fortin, & Jéliu, 2004). If an infant is placed in OoHC during this period, or the primary caregivers change due to placement changes, this will constitute a disruption to these attachment ties and be a significant loss from the perspective of the infant, regardless of the nature of the attachment relationship (Zeanah et al., 2011). If the move is abrupt, with no overlap between the caregivers, this is likely to constitute a trauma for the infant.

Such trauma can have lifelong consequences, affecting physical and mental health, interpersonal relationships, behavioral adjustment, emotional regulation, and cognitive development. (Casanueva et al., 2014; Rutter & O'Connor, 2004; Smyke & Breidenstine, 2009). Providing new caregivers to the infant will initially be a source of stress, particularly if the new caregivers are not familiar to the infant. This relationship can remain a source of stress if the caregivers are unaware of and/or insensitive to the infant's signs of distress and unable to support the infant to regulate. Or the relationship can be a source of healing if the caregivers are able to nurture the infant and be a source of comfort (Casanueva et al., 2014). Each time an infant is placed into a new and unfamiliar caregiving environment, trauma can be re-experienced and exacerbated (Casanueva et al., 2014).

While also prioritising infant safety, child protection system decision making processes need to consider the 'extensive harms' (Trivedi, 2019, pg. 560) associated with removal itself and the availability of consistent and predictable caregivers (Forslund et al., 2021; Trivedi, 2019). Rupture of attachment relationships can constitute a severe trauma for infants, with possible long-term consequences for the child's wellbeing (Forslund et al., 2021; Gauthier et al., 2004). This is even true in cases of abuse and/or neglect when the attachment figure is a source of fear or harm (Granqvist et al., 2017).

It is important to note that infants can and do develop a limited number of attachments within a network of potential attachment figures. However, infants are likely to demonstrate preference for one caregiver over another if more than one is available. This network of persons can be an asset and protective factor for infants involved in the child protection system. When considering alternative caregiving arrangements, the infant's broader attachment network should be considered as offering safe, alternative familiar attachment figures. Removal from an attachment network entails the loss of several attachment relationships.

Given this evidence, it is essential that planning is informed by attachment theory as well as an understanding of early childhood development. An infant who receives safe, consistent, responsive, and sensitive enough care from a network of predictably available caregivers is more likely to develop a secure attachment with each caregiver in the network. It is important to note that some infants more than others are particularly sensitive to their early environment, although early in life it is not possible to determine which are the most vulnerable (Zhang et al, 2021). Infants with at least one secure attachment are more likely to have better educational and social outcomes, and have better mental health (Van Der Voort et al., 2014). Infants need the time and opportunity to form attachments with one or more regular caregivers. Importantly, infants who have experienced early relational trauma, frequently at the centre of substantiated abuse and neglect cases, will need extensive support to optimise their recovery (Granqvist et al., 2017). Early childhood is a critical time for the establishment of attachment relationships, and the importance of a stable, predictable and 'good enough' care giving environment during this period cannot be overstated.

See below for further details:

Three Core Concepts in Early Development:
https://developingchild.harvard.edu/resources/three-core-concepts-in-earlydevelopment/

Young Children Develop in an Environment of Relationships
https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wpcontent/uploads/2004/04/Young-Children-Develop-in-an-Environment-ofRelationships.pdf

11. AAIMH's position on Continuity of Relationships

Policy Level:

1. AAIMH emphasises the importance of relational stability and predictability during the crucial first three years of life when vital systems of relational capacity (attachment), stress response and emotional and behaviour regulation are being established.

2. AAIMH supports a public health approach to child protection, addressing the broader social determinants that influence families, parenting, and early childhood development. Priority should be given to key factors that families and children need to thrive with the aim of preventing the need for involvement with statutory child protection services (Productivity Commission, 2019). A unified and coordinated national approach is required to protect Australia's children. The National Framework for Protecting Australia's Children creates a solid foundation for this, but serious investment and system reorientation is required to meet its goals and achieve real change for children and families (COAG, 2021).

3. AAIMH supports a family service orientation or therapeutic approach to supporting vulnerable families. All levels of government need to prioritise prevention and early intervention services (secondary services), especially for expectant vulnerable parents. These services need to be adequately funded and resourced, founded on evidence-based programs and implemented as early as possible, prioritising preservation and restoration efforts. This should be done in partnership with the family, and focused on the individual needs and strengths of the family (AIFS, 2014). Evidence suggests that intensive family support services or intensive family preservation services are effective in preventing children from entering care up to 2 years after the intervention (Bezeczky et al., 2020). In the antenatal period, screening for specific risk factors and providing individualised interventions that target parenting and child development, amongst other factors, have been reported as successful (Parkinson, Lewig, Flaherty, & Arney, 2017).

4. AAIMH supports the five core principles for the Aboriginal and Torres Strait Islander Child Placement Principle (SNAICC, 2018). Organisations need to be supported to work collaboratively and with flexibility to ensure First Nations children can maintain and develop their cultural and spiritual identity.

5. AAIMH supports the National Standards for OoHC, especially Standard 1 Stability and Security and advocates for continuity of safe, sensitive and response caregiving relationships (Commonwealth Government, 2011).

6. AAIMH supports the UN Convention of the Rights of Children and the WAIMH Position Paper on the Rights of the Infant. These documents highlight the specific vulnerabilities of infants and should be used as a guide for policy makers to develop child protection policies and practices that recognise the unique needs of the infant.

12. The Subjective Experience of the Infant

7. The subjective experience of the infant and the infant's best interests should be the principal consideration in any planning decisions. Each infant is an individual, with unique needs and circumstances, and thus requires a tailored, flexible approach. The most appropriate arrangement for an infant may be determined by developing a shared understanding of the individual infant's situation, their unique relational and developmental needs, and how they interact with caregivers, family, and culture.

8. First Nations infants are born into culture. Severing their connection to culture should be viewed as seriously as removal from parental care.

9. Early childhood is a critical time for the establishment of attachments. Infant removal from primary caregiver should only occur when there is compelling evidence that abuse and/or neglect is occurring, and when the fully adequate provision of evidence-based supportive interventions has been exhausted or can be judged with confidence to be futile (Granqvist et al., 2017). AAIMH believes that the decision for infant removal can be made when careful analysis of information and evidence concludes there is a strong likelihood of the infant suffering serious physical, developmental or psychological harm if they remain in the care arrangement.

10. When an infant is removed, evidence-based interventions for both the infant and carer should be implemented as soon as possible, with the aim of achieving swift reunification. There is sound evidence that attachment based interventions, when delivered with other services that address a family's unique challenges, can break intergenerational cycles of abuse (Granqvist et al., 2017). During the process of assessing the carer's capacity to change with support from evidence-based interventions, ongoing contact between the infant and the carer(s) needs to be maintained. However, the frequency of contact must be based on the infant's needs and routine. Moreover, reunification should only be contemplated if there is evidence of sufficient and sustainable change in the caregiving. A prolonged assessment merely defers case plan decisions, which is not in the infant's interests.

11. Decisions around care need to consider the unique attachment and developmental needs of the infant, including the impact of preservation or rupture of attachment relationships. When infant removal from the biological family is being considered, the priority should be the infant's physical and emotional safety and identifying caregivers who can provide safe, consistent, and predictable care while there is assessment and therapeutic work with the biological family. These caregivers must be supported to be not just the instrumental caregivers, but also the primary attachment figures for the infant (Zeanah et al., 2011). Evidence demonstrates that naturalistically occurring reparative experiences (safe, stable, predictable, and sensitive caregiving relationships) can support the reorganisation of attachment and promote infant wellbeing (Granqvist et al., 2017).

12. Planning decisions need to focus on continuity of relationships. Frequently, the focus is on the legal and physical aspects of case planning to the detriment of relational continuity. Considerable research has highlighted the detrimental effects of disrupted caregiving relationships on infants (Casanueva et al., 2014; Smyke & Breidenstine, 2009). Evidence suggests focussing on relational continuity is more likely to lead to placement stability and improved well-being for children (DCJ, 2021; Forslund et al., 2021; Zeanah et al., 2011). Relational continuity should be valued and maintained. Placement changes should only occur when continuing the placement is likely to be harmful and when an identified placement is likely to better meet the infant's emotional needs (Zeanah et al., 2011). Continuity of family, culture and spiritual connections need to be prioritised through any necessary placement changes.

13. When changes in placement are required, transitions should be aimed at minimising harm to the infant. Substantial overlap of caregiving between caregivers is required as new attachments are developed, and the maintenance of contact with former caregivers should be supported. This will require cooperation from all caregivers, and it should be clear to the infant who carries day to day parental responsibilities (Zeanah et al., 2011). The nature of contact with birth family needs to be based on the individual needs of the infant, the capacity of the family to prioritise the needs of their infant and the principle that a network of attachment figures is valuable for children. When restoration is a possibility, visits need to be frequent and based on the infants' daily routine and developmental needs, while nurturing the parent-infant relationship. This includes the use of targeted trauma informed therapeutic interventions, to support the parent infant relationship and build parenting capacity and self-efficacy. When restoration is not possible, the best interest of the infant is served by strategies that support the child and parents to have as good a relationship as possible, but prioritising attachment to their new primary attachment figures. This implies that the birth family needs to be in agreement with and respect the new caregivers. If possible without jeopardizing the stability of the new relationship, healthy lifelong relationships with biological family should be encouraged to meet the child's need for a sense of identity, and support should be available to caregivers and biological families to assist them to develop a collaborative relationship (Forslund et al., 2021).

System Level:

14. Professionals working with infants involved in child protection systems require training in relational and developmentally informed assessments of parentinfant interactions and caregiving. When preservation or restoration seems possible, intensive family interventions focused on improving the parent's caregiving and relational capacity should be provided and the response to these incorporated into the assessment process before final decisions are made about caregiving arrangements. Family and kinship networks should be included in interventions to strengthen the attachment network.

15. Professionals working in child protection services and other services supporting infants and families require ongoing professional development and support, including access to regular reflective supervision. These practitioners need to have the opportunity to regularly meet with a sensitive, trained supervisor to become aware of and reflect on how this work affects them on both a professional and personal level. Without this awareness, they may react to the stress and the strong feelings that this work may activate in them and may be less able to

build and maintain safe, effective, and healthy working relationships with these infants and families (Collins-Camargo & Antle, 2018; Harvey & Henderson, 2014).

16. AAIMH does not support the use of legislation as the primary or sole means of planning for infants in OoHC. Legislative reforms should be used as a platform to focus services on family support, prioritising preservation, and restoration with biological parents if such care can become safer and more adequately responsive to the child. In situations where this is not feasible, supporting relational security with an alternative primary attachment figure should be prioritised.

17. AAIMH acknowledges the value of concurrent planning (where more than one case plan is pursued to achieve a timely and stable long term care arrangement). However, concurrent planning must not undermine attempts at preservation or restoration. Services need to be adequately resourced and funded to provide comprehensive support services to vulnerable families when biological parents express a willingness and demonstrate a commitment to addressing inadequate and unsafe care practices.

18. All levels of government should develop a coordinated and integrated approach to delivering long term funding and support to kinship, foster and other long term care providers. Many children in OoHC have complex needs and have been affected by trauma. Foster, adoptive and kinship carers often require comprehensive training, resources, and ongoing support to provide the therapeutic environment these children need to thrive, regardless of the legal status of the care arrangement.

19. A therapeutic approach which includes trauma informed care (TIC) is required across child protection systems. This includes TIC training, workforce development and support, screening, and assessment, as well as evidencebased treatment and trauma focused services. Treatments need to be made available across the continuum of care options; preservation, restoration, kinship, foster or residential care and adoption (Bunting et al., 2019).

20. AAIMH recognises the limited data available both internationally and in Australia on how infants involved with child protection services fare in both the short and long term. AAIMH advocates for increased attention and funding on research focused on infants in care and the outcomes of that care.

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Appendix II: WAIMH Statement of the Rights of Infants

WAIMH Position Paper on the Rights of Infants

Edinburgh, 14-18 June, 2014 (amended March 2016)

14. Preamble and Rationale

We, as professionals and members of the World Association for Infant Mental Health (WAIMH) who work with infants and parents within different cultures and societies, affirm that there is a need to recognize specific Rights of Infants, beyond those which have already been specified in the United Nations Convention on the Rights of the Child (UNCRC, adopted 1990). We fully support the United Nations Convention on the Rights of the child, and the subsequent document from the United Nations Committee on the Rights of the Child, General Comment Number 7, published in 2005, concerning the implementation of children's rights in early childhood. We affirm that the UNCRC in addressing the rights of children, does not sufficiently differentiate the needs of infants and toddlers from those of older children, in that infants and toddlers are totally dependent upon the availability of consistent and responsive care from specific adults for the adequate development of their basic human capacities. There are unique considerations regarding the needs of infants during the first three years of life which are highlighted by contemporary knowledge, underscoring the impact of early experience on the development of human infant brain and mind. Drawing attention to the particular needs and rights of the child in the first years of life is needed for several reasons. An alltoo-common view is that the baby is "too small to really understand or to remember" and thus the baby's perspective is often not appreciated by health professionals and even by parents. Infants have unique nonverbal ways of expressing themselves and their capacities to feel, to form close and secure relationships, and to explore the environment and learn – all of which require appropriate nurturing since they are fundamental for building a lifetime of mental and physical health. Moreover, infant needs and rights are often overlooked in the midst of conflicted priorities for rights of older children and parents (such as in custody disputes). Further, specifying the unique needs and rights of the child in the first years of life is needed in order to motivate infant oriented actions and policies at both community and societal levels. In spite of the existence of the CRC, many societies around the globe still pay insufficient attention to infants, especially in times of stress and trauma.

Photo: Adobe Stock.

Additionally, consideration of infant needs and rights could guide policies of supports for mothers, fathers and caregivers, and in giving value to babies in contexts of risk and violence.

As indicated in the WAIMH by-laws, our aims include "…to promote education, research, and to promote the development of scientifically-based programs of care, intervention and prevention of mental impairment in infancy". Our forming a Declaration of Infants Rights represent a significant step WAIMH Board has actually decided upon, that is to be action-oriented and to take explicit ethical stance and advocacy positions.

This Declaration is divided into two parts: the Infant's basic rights, that should be endorsed everywhere, regardless of society and cultural norms, and the principles for health policy that are more sociocultural context-dependent.

I. Basic Principles of Infant

15. Rights (Birth to three years of age)

1. The Infant by reason of his/her physical and mental immaturity and absolute dependence needs special safeguards and care, including appropriate legal protection.
2. Caregiving relationships that are sensitive and responsive to infant needs are critical to human

development and thereby constitute a basic right of infancy. The Infant therefore has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected-- especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers and professionals in their recognition of relationship-based attachment behaviors.

3. The Infant is to be considered as a vital member of his/her family, registered as a citizen, and having the right for identity from the moment of birth. Moreover, the infant's status of a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability.
4. The Infant has the right to be given nurturance that includes love, physical and emotional safety, adequate nutrition and sleep, in order to promote normal development.
5. The Infant has the right to be protected from neglect, physical, sexual and emotional abuse, including infant trafficking.
6. The Infant has the right to have access to professional help whenever exposed directly or indirectly to traumatic events.
7. Infants with life-limiting conditions need access to palliative services, based on the same standards that stand in the society for older children.

II. Social and Health Policy Areas to be informed by these Principles:

1. Policies that support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life.
2. Policies that minimize changes in caregiver during the early years of development.
3. Policies that promote the provision of informational support to parents regarding the developmental needs of their infants and young children.
4. Policies that recognize the importance of facilitating emotional support for mothers, fathers, and caregivers, as an important component of fostering the optimal development and well-being of the infant.
5. Policies that promote access to evaluation and treatment of risks to development by trained professionals who are culturally sensitive and knowledgeable about early development and emotional health.
6. Infants with life-limiting conditions need access to palliative services.
7. The provision of adequate circumstances, including time for mothers, fathers, caregivers to get to know their infants and become skilled in providing for their infant's care and comfort, throughout the support of their family and community. The right for parental leave, and its duration, should be valorized by the society, in a

Appendix A.

WAIMH endorses the 10 principles of the UN Convention on the Rights of Children (as passed by the General Assembly of UN in 1989, and activated in Sept. 1990 with 54 Articles in total) that is:

1. The child shall enjoy all the rights set forth in this Declaration. Every child, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.
2. The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.
3. The child shall be entitled from his birth to a name and a nationality.
4. The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post-natal care. The child shall have

way that fits its contextual reality.

8. The provision of access to relevant early educational and psychological opportunities and programs that promote good-enough relationship experiences and thus, enhance cognitive and socio-emotional development.
9. Policies that ensure the provision of prompt access to effective mental health treatment for mothers, fathers, and caregivers that alleviates infants' suffering and insure optimal development for the child.
10. Policies that allocate resources for training and supervision for caregivers in babies' institutions, foster care professionals and foster parents, as well as resources for assessing and treating foster care infant's emotional and developmental status.

the right to adequate nutrition, housing, recreation and medical services.

5. The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.
6. The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

7. The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture and enable him, on a basis of equal opportunity, to develop his abilities, his individual judgement, and his sense of moral and social responsibility, and to become a useful member of society. The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents. The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavor to promote the enjoyment of this right.
8. The child shall in all circumstances be among the first to receive protection and relief.
9. The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form. The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.
10. The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

Additionally, WAIMH endorses the points published in 2005 by the UN Committee on the Rights of the Child as "General Comment No. 7", that emphasizes the need to include all young children i.e. at birth throughout infancy, during the preschool years, as well as during the transition to school. Through this general comment, the Committee made clear that young children are holders of all rights enshrined in the Convention and that early childhood is a critical period for the realization of these rights, where parents and state parties play a major role. Assistance to parents is also mentioned as a right of the young child. A special section is dedicated to young children in need of special protection.

Appendix B.

As a background for the Declaration of Infant's Rights, WAIMH also endorses the United Nations Millennium Development Goals that include:

1. The eradication of extreme poverty and hunger.
2. The achievement of universal primary education.
3. Gender equality and women's empowerment.
4. The reduction of child mortality.
5. Improvement of maternal health.
6. Combating HIV/AIDS, malaria and other diseases.
7. Ensuring environmental sustainability.
8. Ensuring global partnerships for development.

16. Key documents underpinning the Declaration

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United Nations (2005). The UN Committee on the Rights of the Child's: General Comment 7: Implementing Child Rights in Early Childhood.

United Nations Human Rights Office of the High Commissioner Europe Regional Office (2011). Rights of Vulnerable Children under the Age of 3, Ending Their Placement in Institutional Ca

Australian Association for
Infant Mental Health Inc.

Infants and family violence

Position paper 6

November 2016

The Australian Association for Infant Mental Health Inc. (AAIMHI) aims to improve professional and public recognition that infancy is a critical period in psycho-social development, and to work for the improvement of the mental health and development of all infants and families.

17. Definitions

AAIMHI defines infants as children aged from 0 to 3 years.

Within Australia, the Family Law Act (Section 4AB) came into effect in June 2012 and defines family violence as "threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful" (FCA, 2013, p. 4). This includes behaviours which involve physical and sexual assault, stalking, derogatory taunts and acting with intention to do so, damaging property, causing death or injury to an animal, depriving financial support, isolating family members or depriving them of their liberty. For the purposes of this Act, a child is exposed to family violence if the child **sees** or **hears** family violence or otherwise **experiences** the effects of family violence" (p.4.). Essential to defining family violence is the supposition that there exists "a relationship between those involved … Regardless of age, violence between family members is more common than violence between acquaintances or strangers" (Tolan, Gorman-Smith, & Henry, 2006, p. 559).

18. Background to AAIMHI's position

The incidence of family violence across the globe is endemic, with research indicating that women and children are largely the victims (WHO, 2013). Pregnancy and the immediately postnatal period have been identified as a time of increased risk of partner violence (Chhabra, 2007; McFarlane, Campbell, Sharps, & Watson, 2002; Menezes-Cooper, 2013). Due to their total dependency, infants are more likely than any other age group in childhood to be present during episodes of family violence. This puts them at greater risk of harm, injury and death, than any other childhood age group (AIFS, 2014; AIHW, 2012a; Brandon et al., 2008; Frederico, Jackson,

& Jones, 2006; Jordan & Sketchley, 2009; Zeanah & Scheeringa, 1997) This is also widely recognised by Australia Child Protection Services, alongside other forms of harm, abuse and neglect in infants 12 months and under (AIHW,

2012a, 2013). Infants also make up the largest cohort of children entering women's refuges as a result of mothers fleeing family violence (AIHW, 2012a, 2012b; Shinn, 2010). Relational

violence and trauma experienced by infants has far-reaching detrimental consequences for development across their entire lifespan (Lieberman, Van Horn, & Ippen, 2005; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 1996; Schore, 2005; Schwerdtfeger & Goff, 2007; Shonkoff, 2010; Siegel, 2012; Van der Kolk, 2014).

Infants exposed to family violence face more than the risks of physical harm. The infant brain is at a critical, rapid and formative stage of development. Family violence can damage the developing brain of the infant (Cirulli, Berry, & Alleva, 2003, p. 80). These infants are more likely to experience compromised mental health, face poorer social/emotional development, educational/employment outcomes as well as engage in substance use and engage in or reexperience violence in their adult relationships (Bosquet Enlow, Egeland, Blood, Wright, & Wright, 2012; Holt, Buckley, & Whelan, 2008). Family violence impacts the infant's developing relational template which acts as the foundation for all subsequent expectations of relational experiences (Jones & Bunston, 2012; Osofsky, 1995; Schore, 2001a; Thomson Salo, 2007; C. Zeanah & M. Scheeringa, 1997). When family violence occurs, the infant can experience their caregiver/s as both the source of their fear and as well their comfort, compromising their ability to assess just where to go to for safety and protection (Hesse & Main, 2000; Jordan & Sketchley, 2009; Siegel, 2012).

Additionally, research indicates that violence within the adult parental and/or intimate relationships increases the occurrence of depression within mothers and negatively impacts their perception of their infant (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Martin et al., 2006). This then impinges on how the infant attaches to their mother. When a mother remains in a violent relationship the likelihood of the young child developing an insecure attachment increases (Levendosky, Bogat, & Huth-Bocks, 2011; Levendosky, Lannert, & Yalch, 2012). Infant's relationships with their fathers are also negatively impacted by violence (Lieberman, Ghosh Ippen & Van Horn, 2015; Stover & Morgos, 2013; Bunston, 2013; Fletcher 2015).

Despite the plethora of evidence supporting the critical need to provide effective interventions to address trauma in the early years, infants remain the least likely to receive direct or effective services in addressing the impacts of family violence (Fantuzzo & Fusco,

2007; Jordan & Sketchley, 2009; Lieberman, Chu, Van Horn, & Harris, 2011; Newman 2015; Bunston 2015; Toone 2015).

Further to this, whilst national advertising campaigns have focused on 'the learnt' nature of men committing violence against women, and acknowledge that children are present and do feel the impacts of violence, there is yet to be any significant 'cut across message' to attend to the general lack of understanding about the impacts of family violence on infants. Our society at large and the national bodies who collect and disseminate research about family violence as well as impact service directions remain centered on adults, and to a lesser degree children. Infant mental health literature is largely excluded.

19. Statement of AAIMHI's position on infants impacted by family violence

AAIMHI welcomes the increased public policy focus on children affected by family violence, the calls for national family violence screening protocols for perinatal and health services and the call for increased funding for services to help children recover from violence (Mitchell 2015, COAG

Advisory Panel on Reducing Violence against Women and their Children 2016, State of Victoria 2014-16).

Given that infants are however more likely than any other age group to be present when violence occurs (including in utero) and are at the greatest physical and developmental

vulnerability, AAIMHI calls for enhanced and urgent attention to addressing the needs of infants and very young children.

AAIMHI recommendations for service systems:

1. To recognize the specific needs of infants and ensure that their unique ways of expressing themselves in the context of their caregiving relationships and culture (their 'voice'): informs any decisions made on their behalf (WAIMH 2016).
2. For infants and their families to have access to high quality culturally sensitive clinical intervention, provided by specialist infant mental health practitioners to help infants return to a positive developmental trajectory after the impact of violence.
3. For specialist infant mental health consultation to be available to family violence, adult and child health, police, child protection, homelessness, early education and homelessness services to help them identify and respond to the needs of infants and their families after violence.
4. For infant mental health education to be provided to all adults involved in making decisions for infants after violence, including expert court psychologists and witnesses to equip them to make informed decisions about the particular needs of infants recovering from violent trauma.
5. For local and international infant mental health research and expertise to be incorporated into national advertising campaigns, research dissemination bodies, and service design to ensure that system reforms adequately address infants' recovery from violence in their own right.

The evidence is unequivocal. The impact of family violence on the developing infant individually, and the implications for society generally, is that we cannot afford to continue to expect infants to wait. The risk we take in only focusing on adult responses and older, verbal children is that we may well be too late.

Note: For parents, carers and community members supporting stressed infants after violence: please see AAIMHI companion document *Helping infants through trauma after family violence.*

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Australian Association for Infant Mental Health

Early Childhood Education and Care (ECEC)

Position Paper 4

October 2020 – reviewed.

The Australian Association for Infant Mental Health (AAIMH) aims to improve professional and public recognition that infancy is a critical period in psycho-social development, and to work for the improvement of the mental health and development of all infants and families.

21. Definitions

For the purpose of this paper, Early Childhood Education and Care (ECEC) is defined as feepaying, regulated, centre-based or family day care for children under the age of three years. The definition of a 'carer' used by AAIMH for this paper is a person who is paid to educate/care for the child and who is doing so for children in a group setting.

AAIMH notes that in the ECEC sector, the professional terms for staff are 'educator' or 'teacher.' However, in this paper we emphasise the paramount importance of the care-giving relationship, so the term 'carer' is used. AAIMH acknowledges the invaluable role ECEC professionals have as educators and carers for the youngest and most sensitive members of our society. AAIMH also recognises the role fathers play in child raising and supports the operational definition of 'parental care' over the term 'maternal care'.

22. Background to AAIMH's position

Balancing work, education and family life is a significant issue for most Australian families and ECEC is an important part of this process. The consideration of the placement of very young children in ECEC is underpinned by several important issues relating to parental employment and study, parental leave and allowances, social expectations of parenthood, as well as the needs of infants and very young children. Most children have some experience with ECEC before starting formal schooling with a noticeable increase in access over the last two decades. The percentage of 0-4 year olds attending

ECEC has increased from 18% in 1999 to 35% in 2017 (Australian Institute of Health Welfare, 2019). Concerns and questions around the influence of ECEC on young children's development therefore have relevance not only to children and families, but society as a whole.

Research examining the effects of ECEC on infants and children over the last thirty years or so appears to have occurred in several phases. Initially researchers focused on widespread concerns about the adverse effects of ECEC on children's development. However, as rates of maternal employment increased and more children were placed into non-parental care,

the focus shifted towards examining the variations in the effects of care depending on different factors such as the child's temperament, family characteristics and service characteristics. Recent research into the effects of ECEC on child development has focused on the mediating role of quality of care which can either impede or enhance child adaptation, adjustment and development.

23. Attachment and ECEC

Attachment theory has been described in psychology as one of the most relevant developmental constructs ever investigated (Sroufe, Egeland, Carlson, & Collins, 2005). Attachment theory is focused on how young children's early relationships affect their ongoing development. Attachment is a deep and enduring emotional bond that connects one person to another across time and space (Bowlby, 1980a). Attachment does not have to be reciprocal and is unique to each relationship. In children, attachment is characterised by specific behaviours such as proximity seeking, communicative behaviours and contact maintenance to the caregiver when upset or threatened in order to achieve emotional and physical safety. It has been described as a characteristic phenomenon of human infants, as almost all infants are able to attach to a caregiver (Bowlby, 1980b). However, there is variation in the nature of attachment relationships. Depending on the characteristics of the carer's response, the infant will form a specific pattern of attachment. The quality of this attachment relationship will depend on the responsiveness and sensitivity of the carer (Bowlby, 1980a). Young children can also have multiple attachment figures, developing a hierarchy of attachment figures (Benoit, 2004). The most important factor in determining this hierarchy is not the amount of time spent with the child or who provides the tasks of caring, but who interacts with the child and responds sensitively to their needs (Bowlby, 1980a). Overtime, repetitive experiences within early relationships generate what is termed an 'internal working model' (IWM). The IWM is the individual's mental representation of the worthiness of self and the availability of others. The IWM is central to the process of interpreting experiences, learning from the past and guiding and influencing future experiences (Siegal, 1999).

Attachment theory is well supported by a large body of evidence examining the association between early attachment patterns and later outcomes (Raikes & Thompson, 2008). Children with a secure attachment history have a strong developmental foundation, with more positive social and emotional outcomes, including the ability to regulate their emotions, better social competence and a higher sense of self-worth. As all biological systems in the body interact with each other and adapt to the context in which a child is developing, this has significant consequences for long term outcomes including learning, behaviour, and both physical and mental health. Early experiences set the foundation for lifelong learning, behaviour and health. The child that feels safe and secure, is better able to regulate

their emotions, and has a sense of self-worth is in a much stronger position to focus their resources on learning and exploring their world (Bowlby, 2008; Phillips & Shonkoff, 2000).

Research examining children's attachment behaviour in day care settings has suggested that carers may be alternative attachment figures for children when their parents are temporarily unavailable (Howes & Spieker, 2018). Evidence suggests that when children enter into ECEC they direct attachment behaviours towards their carer and that these relationships may be of a different quality to the attachment relationship they have with their own parents (Ahnert, Pinquart, & Lamb, 2006).

24. Effects of non-parental child care

The large body of research examining the effects of formal, non-parental child care on children's development, especially attachment, delivers mixed findings and is at times controversial. Trying to determine the impact of early non-paternal attachment experiences is complex and challenging from a research perspective because of the interplay between developmental change across time, and the openness to multiple environmental influences (Aviezer & Sagi-Schwartz, 2008). The issue itself is also highly emotive. What is clear from the evidence is that the quality of a child's home life and nature of interactions with their primary carer have by far the greatest impact on early development, and that the effects of even high quality ECEC, positive or negative, are modest at best (Australian Institute of Health Welfare, 2015; The Center on the Social Emotional Foundations for Early Learning, 2009). Research suggests that a mother's sensitivity and responsiveness during interactions with her child as well as her capacity to reflect on relationships are the best predictors of the child's overall developmental outcomes, and that ECEC features (such as quality, quantity, age of entry, and type of care) have less influence (Rutter & Azis-Clauson, 2018; The Center on the Social Emotional Foundations for Early Learning, 2009). However, ECEC of high quality, in terms of high quality relationships with carers, has consistently been demonstrated to improve developmental outcomes for children from vulnerable populations (Australian Institute of Health Welfare, 2015; Gialamas, Mittinty, Sawyer, Zubrick, & Lynch, 2015).

25. Quality of childcare

The importance of high quality ECEC cannot be over-stated with virtually all research indicating that high quality care regardless of setting or provider is associated with more positive outcomes for children compared with low quality care (Gialamas, Mittinty, Sawyer, Zubrick, & Lynch, 2014; Productivity Commission, 2015). It is important to note that the aspect of ECEC quality with the strongest association with improved developmental outcomes is the quality of the caregiving relationship (Gialamas, Mittinty, et al., 2014) (Gialamas, Sawyer, et al., 2014). Studies have also demonstrated that it is not only the quality but rather the frequency of positive caregiving interactions between carer and child that was related to more secure attachment relationships, as well as improved cognitive and social and emotional outcomes (Howes & Spieker, 2018). This finding that children require more frequent positive interactions with their carer is important in the context of staff-child ratios and the amount of time a carer has available to dedicate to each child. Research suggests that children in poor quality care may be exposed to some developmental risk; however, these studies have mostly been done in other countries where the quality of care is quite variable (Rutter & Azis-Clauson, 2018). The Australian ECEC sector is heavily regulated, and most ECEC services provide high levels of care, meeting or exceeding the National Quality Framework (NQF) (Australian Children's Education and Care Quality Authority, 2020b). When considering research findings, it is important to

note that the definition of quality varies between studies and needs to be clearly defined. High quality ECEC for the purposes of infant mental health should include frequent, warm, responsive interactions as well as other more measurable factors such as staff-child ratios and group sizes (Howes & Spieker, 2018).

26. Statement of AAIMH's position on ECEC

The science of early development has clearly established the first few years of a child's life as critical for building the foundations of lifelong learning, behaviour, health and wellbeing (Centre on the Developing Child, 2007). This aligns with the well-established economic rationale for investing in high quality ECEC services, especially those targeting vulnerable children (Heckman, 2011). Approaches to ECEC need to ensure that the developmental needs of young children are prioritised, and prevail over parental and social-economic characteristics, the aims of labour force and income support policies, and other political considerations. This includes providing parents with the opportunity and choice to decide if they want their child to access ECEC or remain solely cared for by the family network. AAIMH considers access to high quality ECEC services designed to meet the individual emotional and developmental needs of every child as a fundamental right of all infants, toddlers and young children, and crucial to maximizing developmental opportunities in the early childhood years.

AAIMH recognizes the value of regulating ECEC services according to standards that mandate that infants' and very young children's psycho-social, mental health and learning needs are met. AAIMH supports the NQF, Early Years Learning Framework (EYLF) and the Australian Children's Education and Care Quality Authority in ensuring that ECEC is regulated (Australian Children's Education and Care Quality Authority, 2020a; Department of Education and Training, 2019). However, AAIMH is concerned that currently 19% of Australian ECEC services do not meet the standards set in the NQF, and advocates that high quality ECEC should be available to all infants and young children irrespective of social or economic standing (Australian Children's Education and Care Quality Authority, 2020b).

AAIMH endorses the concepts of 'belonging', 'being' and 'becoming' as described in the EYLF. These principles respect the infant and young child as an individual, emphasise the importance of warm, responsive relationships and provides for stimulating and developmentally appropriate environments in the ECEC setting. The EYLF recognises carers' relationships with children as central to supporting children's learning, with Outcome 1 being focused on children feeling safe, secure and supported. The framework also rightly recognises parents as the child's first educators (Department of Education and Training, 2019).

ECEC services have a significant role in promoting the mental health of young children in their care. The most salient environmental influence for infants and young children is their care giving relationships. AAIMH strongly supports the NQS Quality Area 5 focus on two related areas: educators developing and maintaining respectful and equitable relationships with each child (Standard 5.1); and educators supporting children to build and maintain sensitive and responsive relationships with other children and adults (Standard 5.2) (Australian Children's Education and Care Quality Authority, 2020a). Interpersonal interactions are the primary source of experiences that shape the architecture of the developing brain. Similar to interactions with parents/primary carers, carers and their working

environments are literally shaping the brains, the emotional regulation capacities and current and future physical and mental health of children in their care (Centre on the Developing Child, 2007). High quality ECEC depends on warm responsive relationships and reciprocal positive interactions between carers and children in the context of a safe and stimulating environment. When children feel safe and secure in their environment, they are better able to devote their time and energies to learning. AAIMH advocates for the application of attachment theory in all aspects of ECEC services. AAIMH encourages the development of secure secondary attachments with carers for children in ECEC to enable children to experience educators as a secure base from which to explore and learn.

AAIMH takes the following position on the issue of attachment and ECEC:

- Children's attachment needs must always be met, monitored and maintained.
- Warm, responsive, care-giving relationships are the foundation of ECEC.
- An individualised approach to the care of children: Attachment theory highlights that not all children will develop a secure attachment to their primary care giver/parent and therefore will not be at the same starting point when they enter ECEC. This is especially true for children from vulnerable populations (The Center on the Social Emotional Foundations for Early Learning, 2009). Attachment theory also highlights that relationships are unique and there is the possibility of modification of styles with new experiences over time. Carers need to be supported to facilitate experiences and engage children in a manner responsive to their individual needs that can promote secure attachment.
- Higher numbers of staff to children than currently mandated by the NQF (1:3 for infants less than twelve months and 1:4 for children aged twelve months to thirty six months) in order to facilitate secure attachment with carers. (American Academy of Pediatrics & American Public Health Association, 2019).
- For very young infants (less than 6 months old) one-to-one care from an appropriately trained carer should be considered.
- Working conditions, training, development and support should be reviewed regularly to reduce staff turn-over and ensure continuity of care.
- Staff should engage in reflective practice and ECEC services should encourage selfawareness and questioning of values and attitudes and examine their processes from the perspectives of the child, the worker and the system itself.

AAIMH considers the following to be essential components of high quality ECEC:

- Services that meet or exceed the standards described in the NQF.
- The ability of carers to establish warm and responsive/sensitive care-giving relationships, evidenced by the number of warm interactions during each session.
- Training and ongoing professional development within infant mental health and attachment theory for all carers and support staff. This includes a strong focus on emotional education, and refining carers' observational skills and facilitating their emotional availability with children in the group setting.

- Supportive working conditions for staff, including appropriate remuneration that recognises the knowledge, skill and responsibility required to deliver high quality ECEC.
- Primary care-giving and continuity of care for children.
- Small group sizes (maximum six infants less than twelve months and maximum eight children aged twelve months to thirty six months) and with optimal ratios as above.
- Engaging with families**:** When carers get to know the families of children, they get to know the child. This can assist the carer to fit into the child's understanding of the world and develop strategies to meet the child's individual learning and developmental needs.
- Children with special needs, previous trauma or a disability, require care that is respectful and knowledgeable, responsive and understanding of their particular situation and needs *(see an individualised approach above).*

27. ECEC for children from Indigenous and culturally and linguistically diverse (CALD) backgrounds

While addressing the developmental needs of all children in non-parental care is essential, failure to do so for children from Aboriginal, Torres Strait Islander and different cultural backgrounds carries additional risk. Meeting only the general needs of these children is not enough and ECEC care services and the community at large should work towards enhancing and improving the developmental opportunities available to these children while they are in non-parental care. This should include:

- Valuing their culture and background by including different aspects in daily activities where possible.
- Organising collections of multicultural resources at the service.
- Learning sign language and common phrases.
- Using parents and other family members and support agencies as cultural facilitators and interpreters.
- Employing bilingual staff.
- Supporting all children in understanding and acceptance of diversity.
- Developing links with communities in their area.
- Recognising, understanding and supporting the unique position Indigenous people and children have in Australian society.

AAIMH advocates for the development of specially staffed ECEC services in areas of disadvantage where support for parents in parenting, health and social issues can be integrated. AAIMH advocates for investment in Australian longitudinal research into the effects of non-parental child care on the development of children aged birth to three years old. Aboriginal children and children from different cultural backgrounds, especially refugee children, require additional attention.

28. References

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Appendix IV: Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®

Category	Brief description
Infant Family Worker (IFW) Focus on promotion See page 6.	Workers, Practitioners and Professionals who are in a position to strengthen the social and emotional development of infants. *For example: early childhood educators, child health nurses, parenting course facilitators, community support workers and others* **Qualifications/experience:** two years work experience with infants and toddlers from birth to 36 months or certificate/diploma from an accredited provider.
Infant Family Practitioner (IFP) Focus on prevention and intervention See page 14.	Professionals and practitioners whose work experience comes from providing services with a primary focus on the social-emotional needs of infants and toddlers, with attention to the relationships surrounding the infant/toddler. *For example: child health nurses, nurse practitioners, allied health professionals (OT, speech therapists, physiotherapists, psychologists, social workers) and others* **Qualifications/experience:** Bachelor's degree and a minimum of two years paid post-Bachelor's professional work experience providing services that promote infant mental health.
Infant Mental Health Practitioner (IMHP) Focus on clinical intervention and/or treatment See page 24.	Professionals whose role includes intervention or treatment of the infant/toddlers' primary caregiving relationship. *For example: child psychiatrists, GPs, psychologists, clinical social workers, marriage and family therapists, early intervention practitioners, mental health clinicians and consultants, social workers and others* **Qualifications/experience:** Master's degree and two years post-graduate, supervised work experience
Infant Mental Health Mentor (IMHM) Focus on leadership See page 34.	Professionals who have a Master's and/or Doctoral degree in a relevant field, or are a qualified medical doctor, and meet the requirements in any of the following three categories: **Clinical:** Meets the specialised work experience criteria specified for Infant Mental Health Practitioners plus three years post-graduate experience providing infant mental health reflective supervision/ consultation and other leadership activities at regional or state level. **Policy:** Three years post-graduate experience as a leader in policy and/or programme administration related to the infant/family field and other leadership activities at regional or state level. **Research/Academic:** Three years post-graduate experience as a leader in university-level teaching and/or published research related to the infant/family field and other leadership activities at regional or state level.