Mother-Infant Forensic Psychiatry: The Good, the Bad & the Ugly

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TRAPPED

Structure of the Seminar

1. Background – stats on child deaths and abuse, risks of mental illness and poor parenting
2. Assessment
3. Examples
4. Giving Expert Evidence
5. The Emotional Cost

Perinatal Mental Illness

- Risk of serious mental illness increases thirty fold in the month postpartum
- 15% postnatal depression
- 1 in 600 postpartum psychosis
- Over 70% relapse postpartum for bipolar affective disorder (untreated)

Association of Mental Illness with:

- History of child abuse: intergenerational transmission
- Family history of mental illness
- Poor parenting role models
- Unstable or no partner
- Rape victim/sexually transmitted disease
- Drug Abuse
- Poverty

Specific Parenting Difficulties can arise in Some Disorders:

- Psychosis: acute risks as well as neglect
- Mood and Anxiety disorders: attachment difficulties, suicide-homicide
- Personality disorders: disorganised attachment, abuse and murder
- Drug and Alcohol: neglect, abuse and murder
- Intellectual Deficit: neglect and abuse
- Autism Spectrum Disorder: attachment difficulties and emotional abuse

Child Homicides World-Wide

- Homicides under age 15
  - 2.58/100,000 in low income countries
  - 1.21/100,000 in high income countries
- USA : 1 infant under 1 year killed every day (Spinelli AMJ 2004)
- Australia ninth lowest
  - 0.8/100,000

Child Deaths

- 2.6 per 1000 in high socioeconomic suburbs (where <2% mothers smoke) versus 8-9 per 1000 in Northern NSW and Nth Queensland (33% mothers smoke), 13 per 1000 for Indigenous

Child Deaths NSW 2014

- 28.41 per 100,000: over represented Indigenous
- 485 total(data for 461)
  - 78% natural (mostly first 28 days)
  - 17%(80) injury
    - 49 unintentional (nb MCA)
    - 22 suicide (ages 10-17)
    - 9 abuse related
  - 4%(20) Undetermined (SIDS)

Definitions

- Filicide: parent killing a child
- Infanticide:
  - legal defense in some countries only
  - mother killing an infant (usually) under the age of one
- Neonaticide: killing of neonate within 24 hours of birth

- Highest risk of murder is in the first day of life
- 10% of filicides in first week
- 30% filicides in first year

Neonaticide

- Strong association with young girls, denial of pregnancy, unassisted deliveries, intermittent amnesia
- Families with role confusion, boundary violations and emotional neglect, chaotic and rigid
- Half with abuse histories

From:*M Spinelli 2003*

Neonaticide

METHODS

- Suffocation
- Head Trauma
- Drowning
- Strangulation

Infanticide beyond the first Day

- Risk Factors:
  - Second or subsequent children of mothers<19
  - Mothers <19 years
  - No prenatal care
  - Low level education
  - Diagnosis???

Methods of filicide (Resnick 2007)

	Maternal (90)	Paternal(42)
Head trauma	13	28
Strangulation	14	17
Stabbing	9	14
Shooting	9	7
Suffocation	10	5
Thrown from height	10	2
Gas	9	5
Poison	6	5
Assault	0	7
Starvation	3	0
Burning	0	5
Total (132)	100%	100%

Diagnosis (Resnick 2007)

Schizophrenia	22%
Psychosis (other)	24%
Nonpsychotic	15%
Personality Disorder	12%
Severe depression	11%
Nil	7%
Bipolar	2%
Intellectually Disabled	2%
Neurosis	2%
Delirium	2%
Epilepsy	1%
TOTAL	100%

Abuse in Australian Families

- 1996 - 31,010 reports, 6,798 substantiations, 28,337 active clients 0.67 deaths per active clients (n=19)
- 2010-11 40,466 substantiations (237,273 notifications of which 127,759 investigated)
- 2013-14 54,438 substantiations (304,097 notifications and 137,585 investigations)

Substantiated Abuse by State

State	2009-10	2013-14
NSW	26,248	26,214
VIC	6,603	11,952
QLD	6,922	7,406
WA	652	3,267
SA	1,815	2,737
TAS	963	778
ACT	741	449
NT	1,243	1,634

Types of Abuse 2013-14

- Emotional 16,093
- Neglect 11,194
- Physical 7,906
- Sexual 5,581

NOT all mentally ill parents are a risk to their children

Removals of children from mothers in psychiatric units

- Most common diagnosis schizophrenia, but severity of illness and level of supports the key association

Characteristics of Child

- Female (double) for sexual, physical increased risk for boys
- Rates decrease with age
- Indigenous seven times more likely

The trauma: effect on the child

These result in potential long term impact on neurobiology and psychology

- Those that result from antenatal exposure to drugs, alcohol and DV
- The traumas that resulted in a notification (not an issue if removed at birth) eg xposure to DV
- Separation
- Reunification
- Ongoing parental difficulties
- Failed reunification (each time)

Zero to Three: Who Assesses?

- Family Court psychologists (Family Consultants) and (private) psychiatrists
- Children's Court psychologists and psychiatrists (some private)
- Forensicare
- Paediatric services
- Mother-Baby Hospitals (eg Queen Elizabeth/Tweddle)
- (Psychiatric) Mother-Baby Units

- “The area of child custody assessments continues to fail to meet evidence-based threshold”

Byrne et al (J Chil Psychol&Psych 2005)

Problems

- Legal versus Psychological language
- Varied conceptual basis (psychological theories)
- Little systematic research in dispute/legal/custody setting
- Parental bias in information
- Lack of cross-fertilisation within clinical speciliaties and to law

Attachment

- Should be assessed (Bernet 2002)
- Critical to the IASA protocol (Crittenden et al ‘13)
- It alone should not be used to make decisions re custody
- Who interprets?
- Different attachment to different parent – while one is primary, these are building blocks rather than either /or (Sroufe 2011)
- Attachment is only part of a parenting assessment
- How predictive is it in custody setting?
- Who owns the video?

What is “Good Enough” and how much risk is less than the risk of separation?

- No “no” risk scenarios
  - When are drugs too dangerous, if mother won’t leave when is “some” DV ok to leave children exposed to?
  - Risks also in foster/statecare
- Rights of Child: Attachment needs paramount under age three

The Conundrum

- Child removed for months (one-two years) and in stable care (that can be ongoing)
- Issues for removal “soft” but multiple-DV exposure, “mental health issues” leading to unreliable care/verbal abuse
- Mother
  - in no relationship or another unstable one
  - Improved but still issues (often borderline IQ as well)
  - Only seeing child once a week
- Father
  - May or may not still be in mix

Principles of Assessment

- Physical Care
  - Routine
  - Reading cues/Ability to feed/ settle/identify illness
  - Ability to protect
  - Ability/willingness to access appropriate help
  - Anger management
- Emotional Care
  - Reading cues
  - Reflective functioning
  - Attachment
  - Flexibility
  - Boundaries
  - Taking charge
- Backup plans/safety

Context

- Longitudinal History
  - Own attachment history
  - Illness (physical or mental)
  - Comorbidity nb drug use
  - Personality
  - Relationship history
  - Supports and Protective Factors
  - Intellectual capacity
  - Anger management
  - Forensic history

Children's/Family Court

- Need to manage contradictory information
- Flexible interview process
  - differing parental accounts
- Multiple data gathering methods
  - Interviews with parents, family, teachers, doctors, treating counsellors
  - Parent-child observation
- Formulation …multiple hypotheses possible
- Children's Court broader and a range of experts as needed

PADSDS
10 day residential assessment
0-3years

Advantage – in home over time

Disadvantage – mother must be safe enough or have other adult to care for child

- Safety
- Feeding and nutrition, hygiene
- Routines, sleep/settling
- Care of the unwell child
- Developmental needs
- Interactions and mutual responsiveness

Mother-Baby Hospitals

Advantage- safe and intensive, can have both partners, sometimes an older child

Disadvantage- parent removed from other life stresses and if parent not primary carer, an attachment trauma for the child

Mother-Baby Units 0-12mths, parent with mental illness

- Safety – nb re medication and illness, hospital versus community issues
- Feeding and nutrition
- Routines, sleep/settling – nb flexibility
- Developmental needs – nb flexibility
- Interactions and mutual responsiveness
- Who else can help?
  - Partners and family
  - Community supports, child care
- Attempt to provide best plan for baby ongoing care to family and DHS

Private Psychologists and Psychiatrists

- No agreed assessment practice, includes WAIS, neuropsych assessment, MMPI, and adaptions of AAI, PDI, SSP and COS

What should an assessment include?

- Experts hired by court who are impartial and able to put child first and able to explain to court the significance of findings in lay terms
- Acceptance of complexity and no one rule fits all
- Use of a number of tools: SSP, Attachment Q-sort, AAI/ reflective functioning (Steele)

The answer in any case needs to resolve…

- What is the best option for this child at this time to provide them with a primary carer most able to provide an environment where it is not just physically safe but best has its emotional needs met (with or without support)
- Does the relationship with the other parent need to be an attachment one in the earliest years?
- A matrix for decision making?

Future Direction?

- Dynamic-Maturational Model of Attachment and Adaption (DMM, Crittendon 2016) being used as a basis for a Family Court Protocol to reduce the idiosyncratic nature to proceedings, based on clinicl and neurological underpinnings

International Association of the Study of Attachment (IASA) Protocol

- High level of expertise using standardised assessment tools
- Assessing whole family
- Neutrality- blind to issues before assessment (then reassess)
- Family Functional Formulation

What do I do?

- Interview with the parent (1 – ½ hours if alone, 2 – 2 ½ hrs if other parent attending)
- Own early attachment
  - Five words or phrases (AAI)
- Attachment to Child
  - Five words or phrases (COSI)
  - SSP
- Reflective functioning
  - Why did your parents behave as they did/ what effect did it have on you?

Other options

- Home assessment
- Observation of mother-child in a variety of tasks
- Neonatal behavioural assessment scale

EXAMPLES

Denial of Pregnancy

- The Bad: You will only ever see these after the fact
- The Good: But…sometimes the baby survives
- The Ugly: Can lack remorse

Key aspects to assess

- Were they dissociated at the the time of delivery?
- Maturity nb emotional
- Intellect – problem solving
- If they are to have the baby – supports?

Secret tot killed with mum's fist

A SCHOOLGIRL yesterday admitted punching her baby boy to death minutes after she gave birth in her bedroom.

Lauren Curnow, 17 at the time of the killing, yesterday pleaded guilty to infanticide after admitting killing the child, known as "Baby Curnow".

When interviewed by police, Curnow said she killed her baby to "make it go away".

Curnow, now 18, told police she knew she was pregnant five months before the birth but hid it and did not see a doctor.

She said she was "scared of what they would think" and wore lose-fitting clothing to disguise the bulge.

A charge of murder, for which she could have faced life in prison, was dropped. The maximum sentence for infanticide is five years behind bars.

Infanticide is a lesser charge where a woman wilfully causes the death of her baby when she has not fully recovered from the effects of giving birth.

Patrick O'Neil

The Ballarat Magistrates' Court was told the baby was born on August 17 last year.

The teen cut the umbilical cord with scissors, wrapped the baby in a blanket then punched him repeatedly. Baby Curnow died from multiple fractures to the head.

Her mother discovered the baby's body soon after but drove her two other daughters to netball before taking her daughter and the dead baby to hospital.

The schoolgirl was a Year 12 student at Ballarat Secondary College while pregnant and lived with her parents and two sisters in the Ballarat suburb of Wendouree.

She became pregnant in December 2003 to her boyfriend at the time, a fellow student at her school who did not know about the pregnancy.

On August 17, Lauren Curnow felt ill and did not go to school. That afternoon she gave birth alone while kneeling on her bed.

After wrapping the baby in a blanket Curnow punched the bundle several times, laid the baby on the ground and went to take a bath.

Her mother, Debra Curnow, arrived home, found a large amount of blood on the bed and discovered Baby Curnow dead on the floor.

"I could not see any visible sign of life," she told police. "He was very limp, nor could I feel any warmth on him at all."

She changed the bedding and then took the baby's body to the bathroom and cleaned it.

Mrs Curnow drove her two daughters to netball while her daughter slept then drove Lauren to Ballarat Base Hospital where the baby's body was examined by a doctor.

Curnow initially claimed she fell on the baby after giving birth.

But after police said her story did not match the forensic report she admitted punching her baby to death.

Ms Curnow, who is on bail, will face the Supreme Court in late April.

Keli Lane vs Punishing Karen

Assessing those that kill

- Try to understand why: Complex motivations that need to be made clear to the court
- More often grey than black and white

Psychosis/Severe Depression

- The Good:
  - They often (though not always) present, and can be quite dramatic
- The Bad:
  - They can hide/mask their symptoms
- The Ugly
  - They can kill themselves and their children

Andrea Yates

- She was seeing a psychiatrist
- She wasn’t compliant
- The voices were telling her not to tell the psychiatrist about them—and she hated her antipsychotic side effects

Could the tragedy have been prevented?

- Longer inpatient treatment
- Depo
- Not being left alone with the children

Abuse

- Good: child is alive
- Bad: child is traumatised and their parent struggled to manage them when “well”
- Ugly: there isn’t time to “reparent” the parent—sometimes there is no good answer

Abuse – but who did it and is failing to protect enough to stop custody?

- 5 week old infant seen by MCHN who was worried-asked mother to take to GP.
- GP couldn't see, MCHN rang and insisted she take child to hospital
- Child shown to have two tibial and one ulna fractures
- Father admits he dropped child when caring for 3 days earlier- he maintains and mother supports it was an accident.

- Mother denies problems in childhood- sister tells of mother violent and alcoholic
- Mother avoidantly attachment, no supports and unable to manage byself
- Child hysterical at access – can be calmed by everyone except the parent

Giving Expert Evidence

- The Report – clear, concise…and *kind*
  - *Don't always believe what you are told…*
- You know more than the court about mothers, babies, mental illness and parenting – you need to inform the court
- You don't decide – the judge does. But they need the best possible information so they do so wisely
- They need a lot of education in some cases…

The Emotional Cost

- “I’m not looking forward to this court case.”
- “Neither am I. I feel an intense sadness for (mum) and (baby).”

- Making sense of the parent who doesn't love their child – understanding and not judging
- "Heart of Gold" : You can't always recommend reunification even if they love their baby
- Holding the risk – what if you do recommend reunification and they kill their child?
  - The two psychotic patients who met in the forensic hospital and then had a child

Crittenden's 10 ideas of an integrative approach to treatment:

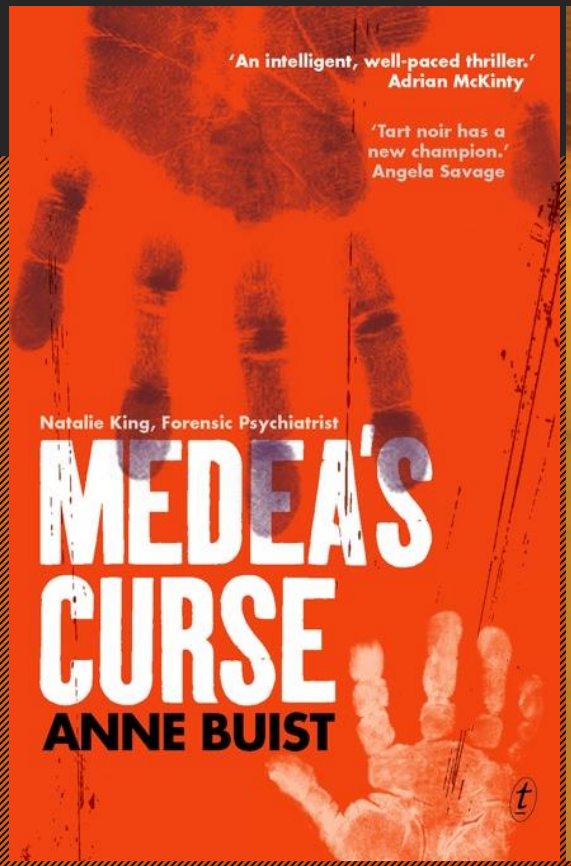
- Do unto parents as you would have them do to their children
- Accept the complexity of psychological and behavioural problems
- Recognise the crucial importance of attachment relationships in both development and treatment
- Define parenting problems as interpersonal and strategic responses to perceived danger and combine child protection and mental health services to address parenting problems

continued

- Assess families, formulate the family situation and reassess and reformulate as treatment progresses
- Embrace discrepancy personally – only way for therpaiists to know themselves and safest way to help others
- Deliver services to families through transitional attachment figures who have access to a wide array of therapeutic approaches

continued

- Embrace discrepancy in treatment as the means to personalise treatment/make more effective
- Combine child, adolescent and adult services as human mental health services
- Fund unlimited family services, use informal community services and limit expenses of out-of-home care (not the reverse)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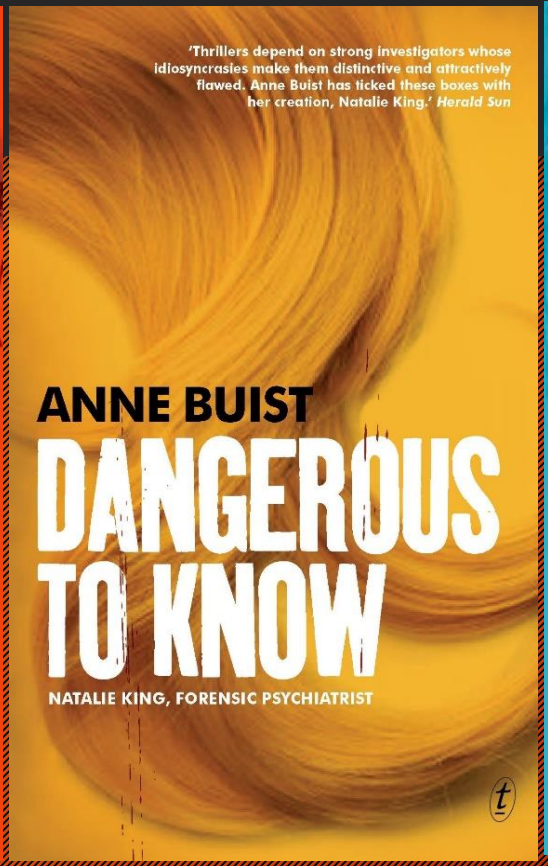
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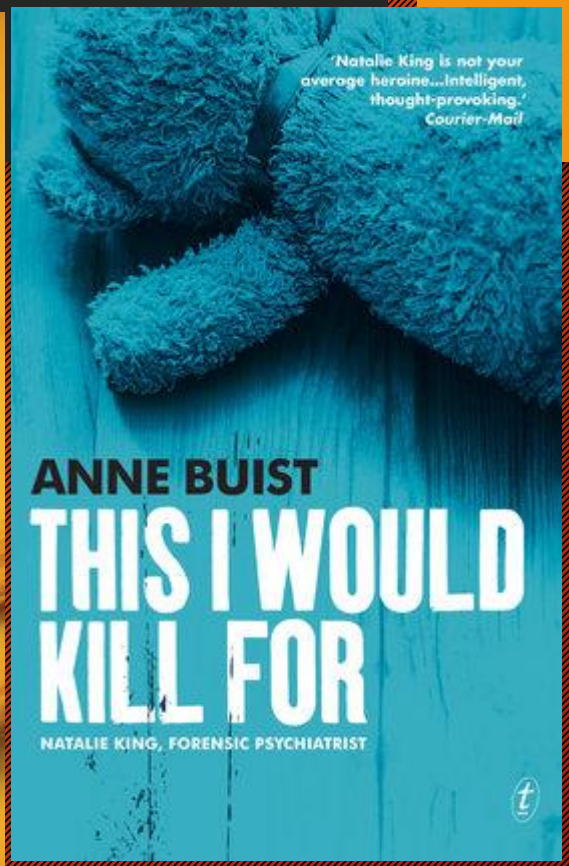
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Major references

- Byrne et al *Journal of Child psychology & psychiatry (2005) 115-127*
- McIntosh J *Ch 4 More than a Question of Safety. Family Court Review Vol 49(3) July 2011*
- *Crittenden P. Raising Parents: Attachment, Represenation and Treatment 2015*