Australian Association for Infant Mental Health

Continuity of Caregiving Relationships for Infants Involved in Child Protection

Purpose of AAIMH

The Australian Association for Infant Mental Health Ltd (AAIMH) is a not-for-profit 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.

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.

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).

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.

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).

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).

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).

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).

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 non-kinship 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).

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-early-development/

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

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.

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 parent-infant 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 evidence-based 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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