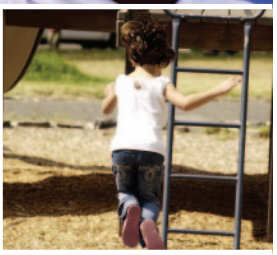
human services

Victorian Cradle to Kinder and Aboriginal Cradle to Kinder

Practice guide



State Government Victoria

Victorian Cradle to Kinder and Aboriginal Cradle to Kinder

Practice Guide

Authors:

Sue Couper, Project Consultant and Project Manager, Berry Street, Take Two
Annette Jackson, Adjunct Associate Professor and Director, Berry Street, Take Two
Dr Nicole Milburn, Infant Mental Health Consultant, Berry Street, Take Two
Carly Black, Manager, Research and Information, Berry Street, Take Two

In conjunction with:

Pip Lyons, Manager, Early Parenting Services, Department of Human Services
Susanna Sibillin, Senior Program and Policy Officer, Family and Early Parenting Services, Department of Human Services

Acknowledgments:

The guidelines have been developed in partnership with Cradle to Kinder and Aboriginal Cradle to Kinder service providers: Anglicare, the Queen Elizabeth Centre, the O'Connell Family Centre, Rumbalara Aboriginal Cooperative, Victorian Aboriginal Child Care Agency (VACCA), Melbourne City Mission, the Bridge Youth Service, Goulburn Valley FamilyCare, Quantum Support Services, Kildonan UnitingCare and Cara Inc. The authors thank them for their feedback and reflection on the guidelines.

The authors would also like to acknowledge a number of other contributors who gave valuable feedback and contributed their expertise in the creation of this document. These contributors included:

Dr Stefan Gruenert, CEO, Odyssey House, Kerrie Crawford, VACCA, Lucy Romano, VACCA, Dr Peter Lewis, Manager, Policy, Research and Communications, VACCA, Dr Robyn Mildon, Director of Knowledge Exchange and Implementation, Parenting Resource Centre
And from Berry Street: Tenille Abell, Jenny Bartlett, Joanna Bock, Les Corlett, Gillian Cross, Jenny Howard, Amanda Jones, Frances Loder, Margaret Kascamanidis, Sarah Waters, Kristen Williams.

If you would like to receive this publication in another format, please phone 1300 650 172 or email c2k@dhs.vic.gov.au@dhs.vic.gov.au, or contact the National Relay Service 13 36 77 if required.

This document is also available on the Internet at http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/children,-youth-and-family-services/cradle-to-kinder-program

Published by the Victorian Government Department of Human Services, Melbourne, Australia, May 2013.

ISBN 978-0-7311-6599-5 (online).

Authorised by the Victorian Government, 50 Lonsdale Street, Melbourne.

(1371112) October 2013.

Contents

1. Preliminary Information

1.1 Purpose of the guide

The purpose of this Practice Guide is to provide relevant information for practitioners and their managers, to support the delivery of the ante- and postnatal family and parenting support programs, Cradle to Kinder and Aboriginal Cradle to Kinder. The guide includes evidence based and research informed material to support effective and consistent state wide implementation of these programs.

1.2 Development of the guide

The guide has been developed in consultation with provider agencies and key stakeholders. It reflects the knowledge and experience of early parenting programs, family services programs, trauma and attachment-informed therapeutic programs, infant mental health, family preservation and other specialist areas. It encompasses the theoretical, research and policy context that underpins the Cradle to Kinder and Aboriginal Cradle to Kinder initiatives. The literature and sources of information used provide a guide for further reading.

1.3 Definitions

Aboriginal and Torres Strait Islander

Throughout the Guide "Aboriginal" is used to refer to Aboriginal peoples and Torres Strait Islander peoples.

Parent

The term "Parent" is used to describe the mother, father and other caregivers of the child.

Practitioner

'Practitioner' is used to describe staff delivering the Cradle to Kinder program and includes the key worker.

Cradle to Kinder and Aboriginal Cradle to Kinder Programs

Unless otherwise specified, 'Cradle to Kinder' is used in the Guide to refer to both the Cradle to Kinder and the Aboriginal Cradle to Kinder programs.

1.4 How to use the guide

The Cradle to Kinder Practice Guide has been developed to support practice in the Cradle to Kinder and Aboriginal Cradle to Kinder services. The guide provides the policy and evidence context for the development of the Cradle to Kinder programs, as well as operational information that includes the program framework and requirements.

The Guide provides practitioners with a model for practice that aligns with the Best Interests Case Practice Model. It brings together elements from the available evidence to guide and support Cradle to Kinder practitioners to intervene effectively to support the safety, stability and wellbeing of children across the critical early years of development. The Guide can be used as a practical resource for practitioners, facilitating reflective practice and supporting reflective supervision. It also includes a list of complementary publications and a reference list that acts as a guide for further reading.

2. Introduction

2.1 Program description

Cradle to Kinder is a targeted ante- and postnatal support service that provides intensive and longer-term family and early parenting support to vulnerable young mothers (aged less than 25 years) and their families. The program provides support to families commencing from before birth and continuing up to the time the child reaches 4 years of age. Within the target group of vulnerable young mothers, priority access is given to groups who are known to find it difficult to maintain engagement with services. This ensures that parents receive the early parenting support they need during the critical early years of their child's development. The priority groups for the Cradle to Kinder programs are Aboriginal women, women who are or have been in out-of-home care and women with a learning difficulty.

2.2 Program objectives

The Cradle to Kinder program aims to assist vulnerable parents and their children, starting from before birth, by providing an integrated and coordinated service that is focussed on positive child outcomes and responds to the individual needs of the family over time. The long-term relationship with a consistent and trusted worker enables the parents to make positive life changes, build skills and establish social connections that will lead to independence.

As stated in the Cradle to Kinder program framework (refer to Section 4 below), the objectives of the program are to:

- Improve child health and optimise child development and wellbeing from pre-birth up to four years of age
- Promote child safety and stability
- Strengthen parenting capacity
- Strengthen parent/carers' mental health, communication and problem solving skills
- Increase the family's connection to their culture and community
- Promote positive parent-child relationships and attachment
- Promote the family's financial and social self-reliance

2.3 Program rationale

Current evidence attests to the beneficial impact of positive early parenting experiences on life outcomes for children. Sensitive, responsive care in the early months of a child's life is especially important for their healthy development and increases positive behavioural and emotional adjustment later in life (Old, Sadler and Kitzman 2007). We know that children's health, safety and development can be compromised by a range of adverse experiences during pre birth and the early years of life. The range of complex personal, family and social life issues experienced by highly vulnerable parents can impede them providing the positive, safe and nurturing care environment that they would hope to provide for their infant. Parents dealing with poor physical and mental health, intellectual disability, poverty, insecure housing, family violence, alcohol and other drug misuse or lack of social support and connectedness can experience constraints to adequate parenting, especially when these factors occur in multiple combinations.

The rapid and critical nature of early brain development means that infants are particularly vulnerable to the impacts of inadequate care and support. Even before birth, babies can experience the adverse effects of their mother's poor diet, drug and alcohol use, or her experience of family violence. Maternal stress experienced during pregnancy can cause physiological stress responses in the foetus, which affect the amount of oxygen and nutrition received by the unborn child (Rice, Jones and Thapar 2007).The mother's experience of family violence during pregnancy can also cause genetic changes to the foetus that influence the stress response system (Radtke et al. 2011). Other peri-natal complications due to parental substance abuse may include withdrawal symptoms when the baby is born and premature births (Kroll and Taylor 2003, Tunnard 2002).

There is evidence that parenting is more challenging and critical during the period of infancy than at any other time, due to the total dependence of the infant on the parent for survival. "Children grow and thrive in the context of close and dependable relationships that provide the love and nurturance, security, responsive interaction, and encouragement for exploration (Shonkoff and Phillips 2000)." In the context of a consistent and nurturing parent-child relationship, feelings and experiences are shared. It is the reciprocal nature of the relationship, where emotions are communicated in both directions between the parent and the child, that is considered critical to the child's healthy development and, without which, development can be severely disrupted.

Vulnerable families often require additional support from the child and family service system to provide an optimum care environment for their children. However, those parents most in need of support are often the parents who find it difficult to get the help they need early enough so as to avoid the critical breakdowns that then require protective interventions (Department of Human Services 2012). Despite an extensive range of available services, families have found navigating the system daunting. Service responses are often time limited and many have not provided the intensity of support or range of trained staff required to support families with complex problems. Highly vulnerable families can find it difficult to acknowledge and seek assistance from support services for fear of being judged or of Child Protection being involved.

It is well recognised that a balanced approach between focussing on underlying issues and building parenting capacity is required. If issues such as mental illness, family violence and drug and alcohol misuse remain unaddressed, attempts to improve parenting capacity and actual parent functioning are likely to be unsuccessful.

Engaging parents in achieving whatever goals are required to ensure the safety and wellbeing of their child and themselves, including changing specific behaviours, is a crucial part of achieving change. The preferable time for engagement with family and parenting support services is before birth or in the immediate post-birth period (Wulczyn, Barth et al. 2005). The period before birth is often a time when parents are highly motivated to make positive life changes in preparation for the birth of their baby and are more receptive to accessing support and information (Carbone, Fraser et al. 2003). Evidence indicates that working with the family during the transition phase before birth provides increased time to engage the family in the program and provide practical help in preparation for birth. Capacity for flexible and practical support is a powerful motivator for engagement and is reported by parents to increase satisfaction with services. Working with the family before birth provides an opportunity to support the developing parent-child relationship. Assisting parents and families to tune into and understand the infant's capacity for communication and social interaction from birth can impact

positively on the quality of the primary care-giving relationship, as well as strengthening the infant's interactions with the other significant people involved in the child's care. This increases the likelihood of the child being nurtured and protected.

Working pre-birth also provides an opportunity to facilitate access to specialist therapeutic treatment and support services in order to address underlying issues for the parents during this period of increased motivation for change. For example, women who misuse alcohol and other drugs can be linked in with specialist pregnancy care services, such as chemical dependency units, in order to help them improve their health and promote a safe and nurturing care environment for their baby pre- and post-birth. Parents can be helped to begin or continue the healing process from past experiences of loss, grief and trauma. These experiences can impede their capacity to form the strong emotional bonds with their child that provides the context for the child's healthy development.

The most effective parenting programs for the highly vulnerable are those that provide an individualised response to the needs and life circumstances of children and their parents. Multidisciplinary teams are required to provide the range of skills to better meet the complex support needs of vulnerable families. Collaborative partnerships between services enable an integrated service response and reduce the problems experienced by families in trying to navigate stand alone services. Just as the complex problems experienced by families occur in multiple combinations across many domains, services need to be inter-linked in order to provide a multi-faceted response. Positive outcomes from interventions are also heavily reliant on the quality of the relationship between the professional and the family and the ability of the service to work in partnership with families (McAuley, Pecora et al. 2006). Working in partnership with families implies mutual respect, honesty, self determination and empowerment.

Longer term commitment to providing family and parenting support facilitates the development of trusting relationships between families and workers, and the overall service. This stable and secure relationship becomes a powerful model for the developing parent-child relationship. Providing an intensive service response, with the capacity to sustain involvement with vulnerable families across the critical early years of a child's life, is more likely to help them avoid the breakdowns that often result in abuse and neglect of children and that can lead to Child Protection intervention.

Young parents face challenges in remaining engaged in education. This can have an impact on later opportunities for employment and subsequent capacity for financial independence, thereby perpetuating the poverty cycle. There is evidence to suggest that intervening early in the life of parents increases the likelihood of successfully influencing behaviour patterns and lifestyle choices before they become entrenched.

3. Broader System Context

3.1 The Legislative and Policy Context

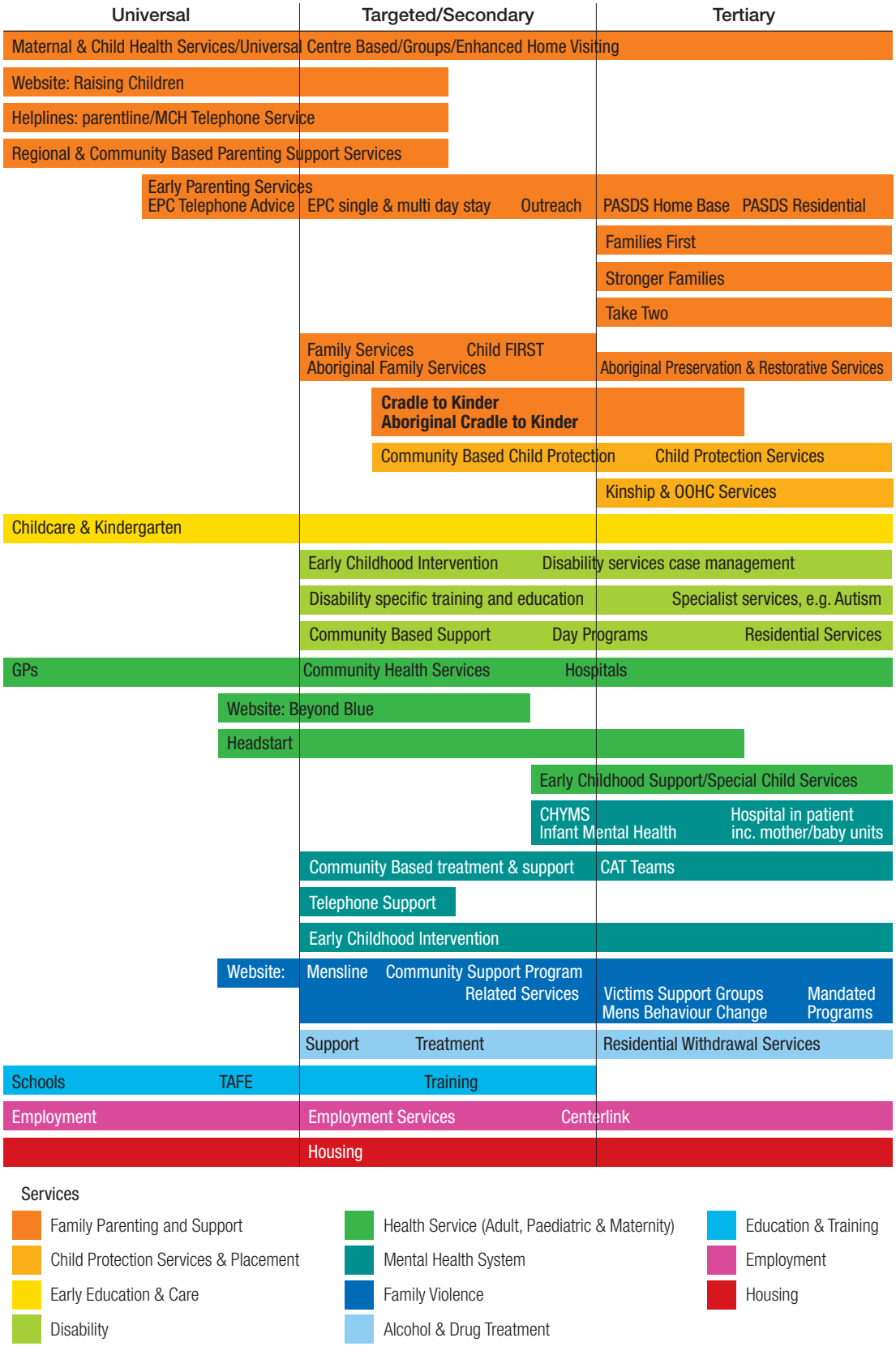
The Cradle to Kinder program is built on the foundation of policy and legislative reforms that acknowledge the challenges faced in effectively meeting the needs of the most vulnerable children in our community.

- The Victorian *Children, Youth and Families Act 2005* (CYFA) and the *Child Wellbeing and Safety Act 2005* identify the importance of safety, stability and development as key foundations for early childhood. These Acts promote a more child focused, integrated and accessible child and family service system which views a child's best interests as paramount in decision-making, with a focus on prevention and early intervention. The Acts also heralded a broadening of thinking to include the consideration of cumulative harm caused by patterns of family behaviour over a period of time.
- All Cradle to Kinder service providers are required to be registered as a "community-based child and family service" under the CYFA and to meet specified quality standards. From 1 July 2012, these are the Department of Human Services Standards (Department of Human Services 2012). Organisations are externally reviewed against these standards once every three years by one of a panel of independent review bodies endorsed by the department. *The Department of Human Services Standards* enable programs and services to both internally assess strengths and use emerging practice to reflect on and refine the way services are delivered, and to have an external critique of its service delivery that builds community confidence. <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/Community-service-organisations/registration-standards-for-community-service-organisations>.
- The Best Interests Case Practice Model (BICPM) provides a unifying foundation for how practitioners across child, family and placement service settings work with families and their children, including from before birth (Miller 2012). The BICPM underpins the Cradle to Kinder practice model described in this guide.
- The *Program requirements for family and early parenting services in Victoria (Department of Human Services 2012)* set out the expectations and requirements that guide, support and inform the quality service delivery of the Cradle to Kinder program. These program requirements are underpinned by legislative and policy requirements and provide service providers with detailed information about how to deliver services in order to meet their obligations under their service agreement with the department.
- The *Children, Youth and Families Act 2005* (Vic) and the *Child Wellbeing and Safety Act 2005* (Vic) require that services are culturally responsive and inclusive of children and young people from Aboriginal and other cultural backgrounds. The Acts state the need for services to keep Aboriginal children and young people connected to their culture and community.
- The responsibility for all services to respond to Aboriginal families is further reinforced by the *Victorian Aboriginal affairs framework 2013-2018* (Department of Planning and Community Development 2012)which underpins and defines efforts to raise the life expectancy and quality of life for Indigenous Victorians. One of the six strategic actions identified in the framework is to improve maternal and early childhood health and development. (<http://www.dpcd.vic.gov.au/indigenous/about/taskforce-on-aboriginal-affairs>)

- *A Strategic framework for family services (Department of Human Services 2007)* and the *Supporting parents, supporting children: A Victorian early parenting strategy (Department of Human Services 2010)* establish a priority to integrate and collaborate across services to improve access to services and to effectively respond to vulnerable families. The strategies place a particular focus on Aboriginal families and families from culturally diverse communities. Both strategic frameworks include a commitment to intervene early and work in partnership with families to promote an optimum care environment that supports the health, safety and wellbeing of children.
- Most recently, the Victorian Government has released *Victoria's vulnerable children: Our shared responsibility directions paper*, that sets the agenda for broad transformational change across the current service system in order to better respond to the challenge of improving outcomes for vulnerable children (Department of Human Services 2012). The Cradle to Kinder and Aboriginal Cradle to Kinder programs are specifically referred to under the section action area, "Enhancing education and capacity building", as part of the strategy of "Addressing risk factors in early pregnancy and infants".
- The current Victorian Department of Human Services policy platform, *Human Services: The case for change (Department of Human Services 2011)*, sets out the vision for an integrated service response across specialist health and human services to improve outcomes for the most vulnerable members of our community.
- *Protecting children is everyone's business: National framework for protecting Australia's children 2009-2020* (Council of Australian Governments 2009), sets out the national and long-term approach to ensuring the safety and wellbeing of Australia's children. It aims to focus Commonwealth, State and Territory governments and the non-government sector on their shared responsibility to reduce the incidence of child abuse and neglect.
- The United Nations *Convention on the rights of the child* states that every child has a right to safety and wellbeing. The *Victorian Charter of Human Rights and Responsibilities* and the accompanying legislative framework, the *Charter of Human Rights and Responsibilities Act 2006*, sets out the rights and responsibilities that apply to all Victorian children.

3.2 Cradle to Kinder as part of the service system continuum

As a secondary service with a focus on diversion from Child Protection, Cradle to Kinder needs to collaborate with universal services, other secondary services and sometimes tertiary services, either in relation to the parents' needs or the child's.


Universal
Targeted/Secondary
Tertiary
Maternal & Child Health Services/Universal Centre Based/Groups/Enhanced Home Visiting
Website: Raising Children
Helplines: parentline/MCH Telephone Service
Regional & Community Based Parenting Support Services
Early Parenting Services
EPC Telephone Advice
EPC single & multi day stay
Outreach
PASDS Home Base
PASDS Residential
Families First
Stronger Families
Take Two
Family Services
Child FIRST
Aboriginal Family Services
Aboriginal Preservation & Restorative Services
Cradle to Kinder
Aboriginal Cradle to Kinder
Community Based Child Protection
Child Protection Services
Kinship & OOHC Services
Childcare & Kindergarten
Early Childhood Intervention
Disability services case management
Disability specific training and education
Specialist services, e.g. Autism
Community Based Support
Day Programs
Residential Services
GPs
Community Health Services
Hospitals
Website: Beyond Blue
Headstart
Early Childhood Support/Special Child Services
CHYMS
Infant Mental Health
Hospital in patient
inc. mother/baby units
Community Based treatment & support
CAT Teams
Telephone Support
Early Childhood Intervention
Website:
Mensline
Community Support Program
Related Services
Victims Support Groups
Mens Behaviour Change
Mandated
Programs
Support
Treatment
Residential Withdrawal Services
Schools
TAFE
Training
Employment
Employment Services
Centerlink
Housing
Services
Family Parenting and Support
Child Protection Services & Placement
Early Education & Care
Disability
Health Service (Adult, Paediatric & Maternity)
Mental Health System
Family Violence
Alcohol & Drug Treatment
Education & Training
Employment
Housing

3.3 Program Governance

Coordinated governance of the Cradle to Kinder programs occurs at both the statewide and local area levels.

Statewide program coordination

Coordination of the Cradle to Kinder implementation is provided by the Department of Human Services through the Early Pathways Unit within the Service Design and Implementation Group, in conjunction with peak bodies, key advisory groups and sector stakeholders. At a statewide level, the department is responsible for facilitating a coordinated, consistent approach across all service provider agencies to the implementation, delivery and improvement of the programs, with a specific focus on embedding evidence-based practice and fostering a culture of ongoing quality improvement.

Local area program coordination

i) The Department of Human Services Local Areas

At a local area level, the Department of Human Services has a range of regulatory and statutory responsibilities for funded community service organisations delivering integrated the Cradle to Kinder programs, such as managing service agreements and monitoring service performance and quality. Local agency connections teams are also responsible for facilitating strategic and sustainable connections between local organisations that promote efficient practices, processes and quality client services and outcomes, as well as improving sector capacity and development.

ii) Child and Family Alliances

Child and family alliances are the governance structures established to help child and family services operate effectively at a local area level. Alliances are responsible for catchment planning, operational management and service coordination. Cradle to Kinder and Aboriginal Cradle to Kinder service providers should be members of their local Alliance. Other members of the Alliance include partners from Child FIRST, all funded family services providers, Child Protection, the Department of Human Services and, where capacity exists, the local Aboriginal Community Controlled Organisation (ACCO).

The relationship between all Alliance partners is supported by a memorandum of understanding (MOU) that describes the roles and responsibilities of partners in the Alliance. The purpose of the MOU is to *"express a commitment by the parties to collaborate with each other to provide an integrated response to meeting the needs of vulnerable children and families in the catchment."* MOUs generally include the expectations of member organisations and a set of principles and accountabilities. They document individual agency responsibility for the overall establishment and ongoing maintenance of effective collaborative working relationships between Alliance partners.

iii) Local Cradle to Kinder Advisory Groups

The Cradle to Kinder program is delivered by services that have been formed through consortiums of various organisations that each have their own organisational structures and governance arrangements. These organisations have particular areas of expertise in working with vulnerable young people who are parents and/or vulnerable infants. They offer a significant contribution to the success of these initiatives and are responsible for operationalising the statewide model within their local areas.

Individual consortia are responsible for establishing local advisory groups to provide additional strategic support for the operation of Cradle to Kinder. Sustained and collaborative partnerships with key stakeholders are essential for the identification, provision and ongoing development of services to the target families for Cradle to Kinder programs. The formation of the advisory group assists in strengthening local service development and planning processes and promotes opportunities for shared responsibility for achieving the service objectives. Consortia are responsible for agreeing the terms of reference, determining the membership and frequency of meetings to ensure alignment with existing local strategic networks and processes, including Child and Family Alliances, Early Years Networks etc. Local advisory groups are closely linked to the Alliance and in many instances will have common membership. Cradle to Kinder local advisory groups can provide valuable input into the catchment planning and service coordination process of the Alliance.

Local advisory groups provide an avenue for the involvement and specialist input of representatives that reflect the local community and target groups, including culturally and linguistically diverse communities, adult focussed services and other early childhood service providers.

The key partner members of local advisory groups for Cradle to Kinder include:

- Child Protection and Child FIRST/Family Services
- Family and Early Parenting Services
- Out-of-home care and leaving care services
- Maternity services (including Koori Maternity Services)
- Hospital Aboriginal liaison officers
- Aboriginal Health Services
- Providers of peri-natal mental health initiatives, for example the Peri-natal Emotional Health Program (rural and regional areas) as well as Mother Baby units
- Primary health services, including General Practitioners, Paediatricians and providers of a broad range of health information and counselling services
- Local government services including Maternal and Child Health services and other early childhood education and care services, including Best Start, playgroups, child care and kindergartens
- Aboriginal Community Controlled Organisations
- Specialist services, including housing support, family violence/Indigenous family violence services (including services for men), youth services (including youth justice), alcohol and other drug services, mental health services and disability services
- Providers of education, training and employment services.

4. Practice Model

4.1 Program Framework

A program framework for Cradle to Kinder and Aboriginal Cradle to Kinder was developed by the Department of Human Services, in consultation with service provider agencies and other internal and external stakeholders. Its purpose is to establish an overarching framework for the delivery of the programs, with clear linkage between the overall program objectives, the specific casework activities undertaken by services with clients and the outcomes for families, both short-term and long-term, that are anticipated will result from these activities. The Framework also provides details for how these outcomes for families will be measured and establishes the context for the evaluation and ongoing quality improvement processes.

Cradle to Kinder – Program Framework

Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To improve child health and optimise child development from pre-birth up to 4 years of age.	**Engage** parents with antenatal and postnatal care services. **Provide information** on nutrition during pregnancy and breastfeeding. **Share information** regarding healthy foetal development, early brain development and child developmental milestones in a culturally informed way **Assess** child development and make appropriate **referrals** to specialist children's services. **Engage** parents with child and maternal health services. **Provide parenting support** to promote play and learning opportunities for the child. **Provide support** in developing routines for the child. **Undertake** therapeutic assessment of and **access** appropriate specialist mental health support for the child. **Engage** parents/carers and the child with early childhood services. **Support** the child's development of healthy sibling and peer relationships.	Improved maternal health through better access to antenatal and postnatal care and services. Reduced impact of AOD use on developing foetus and child including FASD. Improving parents' capacity to provide a supportive home environment for the child through increase parental knowledge, skills and confidence to provide care for their child. Child accesses early childhood and other universal services. Child is engaged in, and benefits from, learning opportunities that results in improved knowledge and skills.	Child demonstrates optimal physical health, social and emotional development and language and cognitive development. Parents demonstrate age appropriate parenting skills.	Number of attendances at scheduled antenatal visits. Number of visits to maternal child health nurse – at each of key developmental stages. All child immunisations are completed. Parents make use of community health services to promote their child's health. Child attains age appropriate development milestones. Documented observation of parent-child relationships demonstrates improved understanding of the child's needs. Child is engaged in age appropriate learning and educational activities. Number of parents reporting increased confidence and competence in their parenting skills.

Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To promote child's safety and stability.	**Assess** risk to the unborn or newborn child and **refer** to appropriate children's services. **Provide information** on baby temperaments, early brain development, shaken baby syndrome, SIDS, Neonatal Withdrawal, FASD, etc. **Assess** and **support** parents in ensuring car and home safety for the child. **Support** engagement with anger management and men's behaviour change programs. **Explore** secure housing options and **refer** to appropriate services. **Assess** and **identify** indicators of family violence, developing appropriate safety plan. **Provide information** and **support** to access legal rights (e.g. intervention orders, parenting orders) **Support** opportunities for parent and child to have positive connections with family and community, to strengthen stability of relationships.	Child remains living safely within the family home. Reduction in level and length of involvement by Child Protection with families. Reduction in level/length of homelessness experienced by the family. Safety in the home.	Parents/families provide a family environment free from child abuse and neglect. Parents/families provide a family environment free from family conflict and violence.	Number of reports to Child Protection. Length of involvement by Child Protection with families. Number of consultations with Child Protection. Reduction in incidents/ absence of family violence. Proportion of parents experiencing homelessness that receive support to access stable housing. Proportion/number of families who maintain safe and stable accommodation over the life course of the program. Reduction in number of accidental injuries to the child. Proportion/number of parents reporting they have a social network that they have access to.

Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To promote positive parent-child relationships and attachment.	**Explore** parent' feelings, expectations, hopes and fears regarding pregnancy and parenthood. **Explore** parenting role models and own childhood experiences. **Foster** development of parents' emotional understanding and regulation skills. **Psycho-education** around attachment. **Model** and **support** optimum parent-infant and parent-child communication and interaction (e.g. sensitivity, reciprocity, in reading and responding to cues, growth fostering capacity). Notice with the parents the infant and child's interactions and reflect together about these as communications of the infant or child's personality and inner world. **Refer** to parenting classes, where appropriate.	Improving parent-child relationships with both parents including: Building secure child attachment, stronger parental attunement to the child's needs and improved responsiveness to the child's needs. Parent sees the infant and child as a person in their own right.	Children reach their optimum level of development across all domains. Children remain in the care of the family. Children have age-appropriate levels of self control Children are able to relate well to others in an age-appropriate manner. Children have strengthened attachment networks.	Observations of parent-child interactions NCAST PCI Teaching scale Outcomes Star measurement tool.

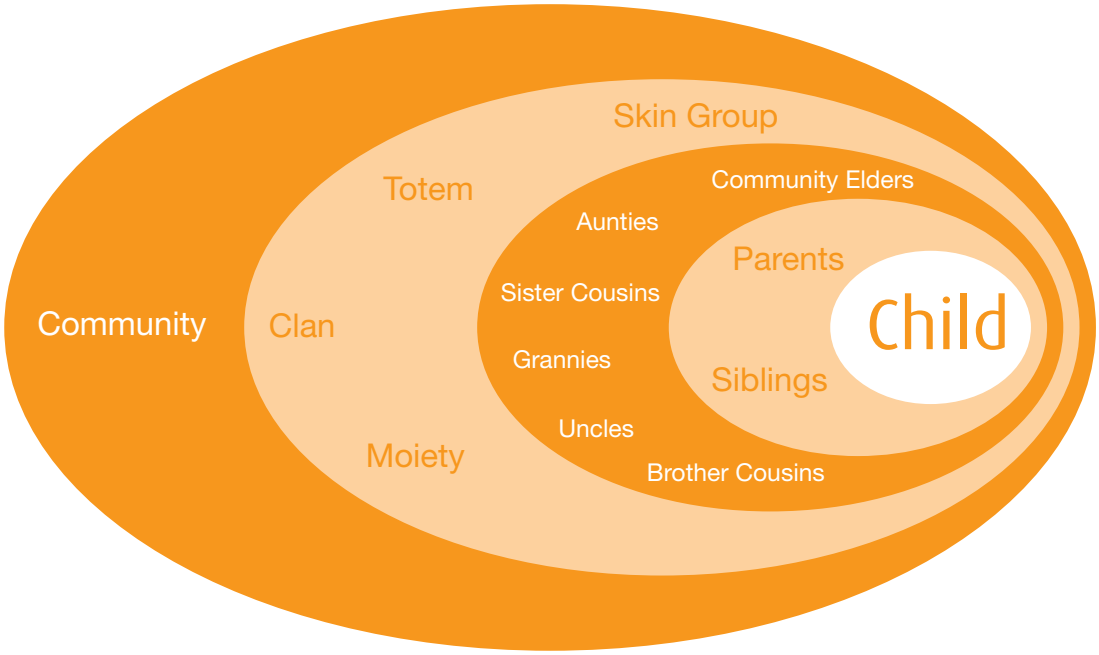
Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To strengthen parenting capacity.	**Assess** and **identify** indicators of mental illness, problematic drug/alcohol usage and significant life trauma. **Undertake** case planning that facilitates referral to and engagement with specialist adult services (e.g. adult mental health services, drug/alcohol agencies). **Psycho-education** around parenting. **Explore** beliefs and **provide strategies** regarding boundary setting. **Explore** support options for parents/carers with disabilities and make **referrals** to appropriate services. **Explore** parental/carer expectations of the child and their possible impact on parenting. Support culturally appropriate parenting approaches.	Parents linked into formal supports to address areas of risk and vulnerability. Increased parenting involvement by the father/male carer.	Age appropriate parenting skills demonstrated by both parents. Reduction in vulnerability and risk within the family. Parents' resilience in responding to life stressors is enhanced.	Number of young parents/carers exiting care into secure housing. Reduction in problematic drug/ alcohol usage.

Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To strengthen parents' mental health, communication and problem-solving skills.	**Explore and strengthen** parent' informal sources of emotional and practical support. **Support** parents in strengthening relationships with wider family/community members. **Support** parents in identifying and reducing risk taking behaviours. **Involve** parents in goal setting and case planning processes. **Support** family decision making processes that support the child's safety and development. **Support** development of communication and relationship skills between parents.	Relationship and goals established with key worker. Improving physical and emotional health for the parent. Reduction in risk-taking behaviours by parents. Parents able to make decisions that are in the best interests of their child. Improved sense of self efficacy for parents.	Both parents have healthy relationships with each other and family/community members. Family is self-sustaining and able to access support when appropriate.	Number of client hours. Parent demonstrates capacity to make decisions in best interests of the child. Proportion/number of parents reporting they have a social network that they have access to.
To increase family's connection to their culture and community.	Workers completed cultural awareness and understanding training. **Assess** and **foster connections** to cultural support systems. **Promote** parent' usage of community resources. **Explore** and **increase awareness** of trans-generational patterns within families and their impact.	Parents demonstrate knowledge of community services and feel empowered to access these. Establishment of additional support systems including occasional respite care/kinship support. Service experienced as culturally safe by families.	Reduced marginalisation and social isolation by the family. Family experiences a sense of connection and belonging to their culture, community and identity.	Number of referrals to and engagement with community services. Parents and wider family/community report having access to a positive social network. Participation by Aboriginal families in activities that foster knowledge of their history and culture. Participation by CALD families in activities that foster knowledge of their history and culture.

Program Objective	Program Activity	Short-term Outcome	Long-term Outcome	Outcome Measure
To promote the family's financial and social self-reliance.	**Provide** financial support to meet material needs (e.g. cots, food, housing). **Provide information** and **support** in developing life skills. **Provide information** and **support** in identifying and accessing education and employment opportunities. **Support** the development of financial literacy, budget management skills. **Provide information** and **support** in accessing appropriate Centrelink payments and support. **Strengthen** relationships with extended family and community.	Parents demonstrate the development of a range of life skills. Increased ability of parents/carers to meet material needs of their child. Parents enrol in and/or maintain engagement with education or vocational training.	Family is financially independent. Both parents exercise economic and social self-determination. Parents stay in education longer and are able to access skills training and employment.	Number of parents accessing and sustaining training and employment opportunities. Level and type of flexible support packages provide to families. Number of parents able to maintain secure housing.

4.2 Defining the client

This model depicts the child at the centre of the work and in the context of both the parent-child relationship and relationships with their family, community and culture.



Source: *Based on NSW Office of Children's Guardian Aboriginal material and adapted by VACCA*
www.kidsguardian.nsw.gov.au/accreditiation/polocies/policy

The client in the Cradle to Kinder program is considered to be the family. The child is at the centre of the work and is the focus of the intervention. The primary consideration when making decisions is the child's best interests. In recognition of the influence of relationships on infant development, the child is viewed in the context of the multiple relationships and interactions they have with their primary caregiver, parents, family and community. Commencing work before birth and in the early post-birth period does not mean that the focus is solely on the woman and child, as the whole of the family and, in some instances, the community may be included in the intervention. From the earliest phase of the intervention, Cradle to Kinder practitioners engage other family members and particularly fathers in the process of coming together to prepare and plan for how to support the safety, stability and development of the child.

The Cradle to Kinder model has an intentional focus on both the parents as primary attachment figures as well as extended family members, in recognition of children's capacity to develop multiple attachment relationships. What is important is the quality of contact the child has with familiar people, particularly those who have skin to skin contact.

Children have a very special place in Aboriginal family and community, where strong kinship connections and networks are integral to providing guidance and support throughout the early years. In Aboriginal families and in many other cultural groups, parenting responsibility is shared with family and community members. In families who have a cultural expectation of shared and collective models of parenting, being isolated from their family and community can pose a real challenge to them meeting the demands of an infant without the support of others. For young parents who have been placed out of their parents' care, accessing the support of others with a special interest in the child can also be difficult and is a major focus of the Cradle to Kinder program.

Cradle to Kinder is targeted to young parents, many who are adolescent and might themselves be the subject of court orders. This situation can create the challenge of "the child parenting the child". Becoming a parent at a young age will mean the adolescent leaving some of her childhood behind as she takes on adult responsibilities. This also applies to adolescent dads. They will need to be responded to in a developmentally informed, age respectful and role respectful way. When working with young parents, Cradle to Kinder practitioners are sensitive to the developmental pathway of the young parent but the developmental needs of the infant remain paramount. The priority focus on the infant is based on our understanding of the critical and foundational nature of development in the early years and the impact of the primary care-giving relationship in determining outcomes.

For the purpose of data collection, the client is defined as the mother. The child is defined as the child who is the subject of the referral e.g. for a family referred prior to birth, the child is the unborn baby. Data is recorded for other family members, including fathers and siblings, as indicated by the Department of Human Services approved data systems.

4.3 Defining the target group

The target group for the **Cradle to Kinder service** is young pregnant women, aged under 25 years at point of referral to the service:

- where a Report to Child Protection has been received for their unborn (or newborn) child, where the referrer has significant concerns for the wellbeing of the unborn (or newborn) child, or
- where there are a number of indicators of vulnerability and/or concerns for the wellbeing of the unborn (and newborn)child and the woman is not involved with the Child Protection system.

Within this defined target group, priority of access is given to adolescent women, young women who are, or have been, in out-of-home care, Aboriginal women and women who have a learning difficulty. Priority of access will also be given to young women and their families who have previously been receiving Cradle to Kinder services but who have moved to a new Cradle to Kinder catchment.

The target group for the **Aboriginal Cradle to Kinder service** is young pregnant Aboriginal women or women pregnant with an Aboriginal child (under 25 years):

- where a report to Child Protection has been received for their unborn (or newborn) child, and where the referrer has significant concerns for the wellbeing of the unborn (or newborn) child, or
- where there are a number of indicators of vulnerability and/or concerns for the wellbeing of the unborn child and the woman is not involved with the Child Protection system.

Within this criteria, priority of access will be given to:

- adolescent Aboriginal women
- young Aboriginal women who are, or have been, in out-of-home care
- Aboriginal women who have a learning difficulty
- young Aboriginal women and their families who have previously been receiving Cradle to Kinder services and have now moved to a new catchment where Cradle to Kinder is provided.

The Aboriginal Cradle to Kinder program may also provide services to some Aboriginal families within the target group who live outside the Child FIRST catchment but within the catchment area of the Aboriginal organisation.

For both the Cradle to Kinder and the Aboriginal Cradle to Kinder programs, where demand for the service allows, pregnant women with an intellectual disability of any age may also be given access to the program.

Referrals may also be accepted when vulnerable young women first present to services (such as the local hospital or maternal and child health service) up to six weeks after the birth of their baby.

The target group is not restricted to first time parents, as parenting issues may be experienced and may in some instances escalate with the addition of each new child. Where there are older siblings in the family, the program will work with siblings as well as the new baby.

The rationale for focussing on younger mothers is that intervening earlier in the life of the mother/parents provides an opportunity to break the intergenerational cycle of disadvantage before behaviours or lifestyles become entrenched and their child's health, development or safety is put at risk.

Making the most of the opportunity to engage women and their families in services prior to the birth of their baby is a unique and valuable feature of Cradle to Kinder. The period before birth marks a major time of transition and can increase motivation to engage with services and to address issues impacting on the health of the unborn baby, as well as providing time to help parents prepare for the parenting relationship with their baby. Intervention while the baby is in-utero can also ameliorate the adverse affects on the foetus of environmental stressors such as drug and alcohol abuse, stress and trauma.

4.4 Working with Aboriginal Families

Culture for Aboriginal people enhances a deep sense of belonging and involves a spiritual and emotional relationship to the land that is unique (Victorian Aboriginal Child Care Agency 2008). Culture and the maintenance of culture are seen as central in caring for Aboriginal children and supporting child development (Larkins 2010). Denying cultural identity is seen as detrimental to attachment, emotional development, education and health (Robinson, Miller et al. 2012).

Cultural competence, sensitivity and respect are essential in any intervention with families. For Aboriginal and Torres Strait Islander children and families, the impact of historical and ongoing dispossession, marginalisation, racism, colonisation, poverty and the stolen generations have led to high levels of unresolved trauma, depression and grief in the community (Human Rights and Equal Opportunity Commission 2007). The individual, community and social impacts of trauma have had devastating effects on the capacity of many families to parent and has resulted in the over representation of Aboriginal children in Child Protection statistics, with Aboriginal children seven to eight times more likely to be the subject of a report to the Department of Human Services (Cummins, Scott et al. 2012). It is important to recognise that, despite this devastating history, many Aboriginal families in Victoria are resilient, thriving and strong within their culture (Department of Education and Early Childhood Development 2010).

Some of the key individual, family and community problems linked to unresolved trauma that have been associated with increased rates of child abuse and neglect in Aboriginal communities include alcohol and drug abuse, family violence, social isolation and over-crowded and inadequate housing (Bromfield and Miller 2012).

A recent study identified that the Aboriginal community in Victoria also experience higher levels of stress in their lives, at almost double the rate for non-Aboriginal Victorians. Seventy nine per cent of Aboriginal people aged over 15 years living with children in the home reported that they (or family or friends) had experienced one or more major life stressors in the past 12 months. Exposure to life stressors (for example, the death of a family member or close friend, serious illness or alcohol/drug related problems) can contribute to poorer outcomes for children and families (Department of Education and Early Childhood Development 2010).

Becoming a parent is a time when most people reflect on and explore issues about their family of origin and childhood experiences in order to build on their understanding of their own identity. Young parents, particularly those involved in the out-of-home care system, might be unsure about their personal and cultural identity. Providing cultural connection for Cradle to Kinder clients is critical to supporting their identity and promoting safety, stability and healthy development for them and their infant. For mainstream service providers, providing cultural connection for Aboriginal clients requires significant input from Aboriginal Community Controlled Organisations (ACCOs) and is part of a broader and comprehensive process of becoming culturally competent.

In working with Aboriginal children and families, Cradle to Kinder service providers must:

- Identify the Aboriginal and Torres Strait Islander status of all family members and seek information about the involvement of any Aboriginal services
- Explore the role of extended family, clans and kinship networks when undertaking assessments and casework planning/action
- Actively engage and sustain engagement with Aboriginal services

- Establish referral pathways between mainstream and Aboriginal services
- Develop joint agreements about sustainable strategies to maximise the active participation of Aboriginal services in critical decision making, planning, design, operation and the strategic management of mainstream services within the sub-regional catchment, especially where there is no Aboriginal service established
- Develop effective partnerships with Aboriginal Community-Controlled Organisations (ACCOs) in the planning and strategic management of mainstream services
- Develop service models in partnership with ACCOs and Aboriginal communities to meet the needs of Aboriginal families and to promote greater engagement of Aboriginal families in family and early parenting services.
- Incorporate the principles outlined in the Aboriginal cultural competence framework. *"Aboriginal services will provide secondary consultation, skill development and support in delivering culturally competent service to Aboriginal children and their families who may choose to use mainstream services (Victorian Aboriginal Child Care Agency 2008)."*
- Develop strategies to support the cultural needs of Aboriginal families, in particular Aboriginal children and young people with heritage from outside Victorian borders.
- Give consideration to issues of intergenerational trauma, grief and loss for all families, with attention to the community wide experiences for Aboriginal families.
- Develop an understanding of broader Aboriginal cultural identity and, where required, consult with culturally specific services and/or local communities
- Provide learning opportunities to enhance the cultural knowledge of staff in working with Aboriginal children, families and communities.

Practice resources

Aboriginal Cultural Competence Framework 2008

Working and walking together: Supporting Family Relationship Services to work with Aboriginal and Torres Strait Islander families and organisations 2010 (SNAICC)

Building Respectful Partnerships: The Commitment to Aboriginal Cultural Competence in Child and Family Services 2010 (VACCA)

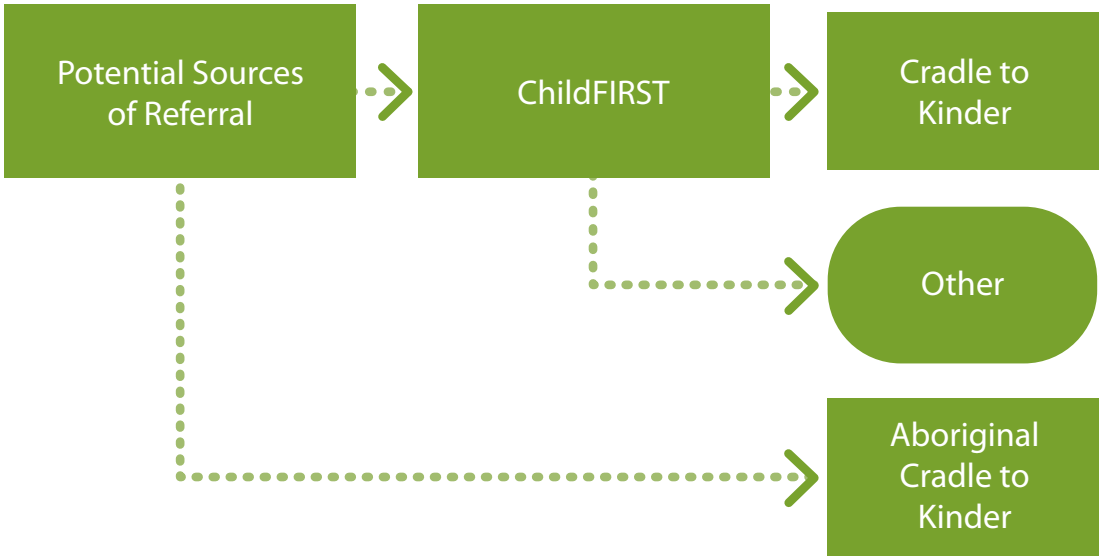
Working with Aboriginal Children and families: A Guide for Child Protection and Child and Family Welfare Workers 2006

Making Tracks 2013

5. Service Delivery Framework

5.1 Intake process

5.1.1 Referral pathways



Families are referred to the Cradle to Kinder program through Child FIRST. Cradle to Kinder is one of a range of service options that will be considered by Child FIRST and discussed with the referrer. Anyone in the community, including families themselves, can refer to Child FIRST. Families may then be referred to Cradle to Kinder if it is the program considered to best meet the needs of the family, as assessed by Child FIRST and the Cradle to Kinder service.

For the Aboriginal Cradle to Kinder program, referrals can be made directly by external agencies, by families themselves or through Child FIRST. Families can be referred internally from within the ACCO when the young, pregnant woman is already involved with another program offered by that organisation. Child FIRST should be notified of any direct or internal referrals to the Aboriginal Cradle to Kinder service.

Multiple gateways into services are a critical aspect of successfully engaging those families who are most in need of the program. It is important that the Cradle to Kinder service is promoted broadly across the service system, especially to services who are working with pregnant young women. Sustained and proactive participation in local area early years service networks and relationship-building across child and adult-focussed sectors is required to promote access for vulnerable families.

Referrals into Cradle to Kinder from the priority groups vary according to the local community in which the service is located. Referrals should reflect the profile of the local community and, where they do not, further networking and relationship building by the Cradle to Kinder service provider is required to explore and address possible barriers to accessing the service. For example, if there is a high number of vulnerable Aboriginal families in a catchment not serviced by an Aboriginal organisation, and numbers of Aboriginal women in the Cradle to Kinder program are low, this may indicate a problem with access to the service. Service providers would then need to review organisational strategies that support and sustain culturally respectful relationships with Aboriginal organisations.

5.1.2 Relationship with the Child and Family Services Alliance

All Cradle to Kinder and Aboriginal Cradle to Kinder consortia should be represented on their local Child and Family Alliance, at both strategic and operational levels. The decision about the type of membership each individual Cradle to Kinder and Aboriginal Cradle to Kinder service provider will occupy will be a matter for the Alliance to negotiate with the service provider/s. It is, however, expected that, at a minimum, the lead Cradle to Kinder/Aboriginal Cradle to Kinder service provider in the catchment will be a member of the Alliance's strategic governance group, so that they can fully participate in decision making, particularly in relation to functions such as catchment planning. Similarly, it is expected that at least one Cradle to Kinder/Aboriginal Cradle to Kinder service provider will be a member of the operational governance group within the Alliance.

Cradle to Kinder and Aboriginal Cradle to Kinder service providers need to establish processes for ongoing communication with Child FIRST, particularly in relation to:

- Service capacity and vacancy levels
- Planning for families to exit the Cradle to Kinder service
- Sharing practice knowledge and expertise regarding infants

5.1.3 Relationship with Child Protection

The Cradle to Kinder and Aboriginal Cradle to Kinder service providers will establish and maintain a strong working relationship with relevant local Child Protection teams. The relationship is framed by the Alliance governance structures, regular meetings and any other communication that may take place.

Cradle to Kinder service providers, as registered community-based child and family services under the CYFA, may consult with the Senior Child Protection Practitioner (Community Based), in instances where Child Protection are not currently involved with the family, as per section 38 of the *Children, Youth and Families Act 2005* (Vic). The Senior Child Protection Practitioner (community based) has responsibility for unborn reports and as such will be an important liaison regarding potential referrals to Cradle to Kinder programs prior to birth.

Throughout the family's involvement with the Cradle to Kinder and Aboriginal Cradle to Kinder programs, the Cradle to Kinder service provider is expected to consult with Child Protection where appropriate and, where required, report any escalation of concerning behaviours that may place the parent(s) or the (unborn or newborn) child at unacceptable risk. Following a report being made, by either a Cradle to Kinder service provider or from another source, Child Protection may seek information from the Cradle to Kinder practitioner regarding the family's engagement with the program and observations of the child's safety, stability and development in the parents' care. On the basis of information gathered and the assessment made during Child Protection's intake phase, a decision will be made whether the report requires further investigation. Following the birth of a baby who has previously been subject to an unborn report, Child Protection may decide to investigate these concerns to ensure sufficient safety planning and support have been put in place for the family and newborn child.

Where there is ongoing involvement by the family with Child Protection (including where court orders are in place and/or the child has been placed in out-of-home care), the service provider will work with the allocated Child Protection practitioner to agree upon a case plan for the family, based on a care team approach. This may involve maintaining a level of contact with the family until decisions are made in relation to ongoing involvement with Child Protection services and/or the longer term placement of the child.

Under Section 10.5 of the *Child Protection and Integrated Family Services statewide agreement (Shell agreement) 2010*, case management responsibilities transfer to Child Protection once a matter is accepted for a protective investigation (Department of Human Services 2011). Whilst primary case management transfers to Child Protection, the Cradle to Kinder practitioner will remain an active member of the care team and continue to participate in care planning for families.

Where the Aboriginal Family Decision Making (AFDM) program is involved with the family, the Cradle to Kinder service will work collaboratively with that program.

The Cradle to Kinder program may remain actively involved with a family if the children are placed out of their parents care for a short period of time. Should the child/children become subject to a protection order (made by the Family Division of the Children's Court), discussions should occur with Child Protection and the family with respect to the protective concerns for the children (i.e. the reason the children were removed from their parents' care). This will be to determine the appropriate support required by parents to address those concerns and enable the children to be returned to their care. Consideration should be given to offering additional time and resources to the family to provide the greatest opportunity to address concerns and facilitate access visits, if safe to do so, in order to promote the parent-child interaction and bonding. Referrals may be required to other support services and arrangements made to facilitate transport to appointments. The Cradle to Kinder practitioner may be requested to provide information to Child Protection to form part of a report for Children's Court (Family Division) hearings.

Decisions should be made on a case by case basis with respect to the appropriateness of the Cradle to Kinder service continuing to actively work with a family. In most instances, Cradle to Kinder will stay involved with the family where planning for reunification of the family is anticipated within a reasonable time frame. If it is planned for children to remain in out-of-home care for an extended period of time (whilst reunification is attempted), or if Children's Court processes are delayed through contested hearings, it may be more appropriate to refer to other community services with capacity to provide support to the family.

For further information regarding the relationship between Cradle to Kinder and Child Protection, please refer to the *Child Protection and Integrated Family Services Statewide Agreement ('Shell Agreement')* (Department of Human Services 2011).

5.1.4 Criteria for referral to Cradle to Kinder

The criteria for the referral of pregnant women and their families to Cradle to Kinder are that:

- The mother is aged less than 25 years at the time of the referral being made.
  Please note that there is no age criteria applied for the referral of pregnant women who have a learning difficulty, if there is capacity to provide the service.
- There is concern for the safety and wellbeing of the unborn or newborn child.
- The family will benefit from a long-term intervention
- The family resides within the Child FIRST catchment area

The program is prioritised for:

- Aboriginal women and/or women pregnant with an Aboriginal child
- Adolescent women
- Women who are currently, or have been, in out-of-home care
- Women with a learning difficulty

5.1.5 Responding to families outside the catchment

Local area catchment sites for Cradle to Kinder have been selected based on identified need for the program. This selection process utilised a range of data sources including the number/rate of 'unborn reports' to Child Protection, local birth numbers/rates and indicators of economic disadvantage. There is limited discretion for Cradle to Kinder service providers to consider referrals from immediately outside the catchment area (e.g. in circumstances where a young person may be temporarily accommodated outside of the catchment area, prior to permanently returning to the Cradle to Kinder catchment area). Out-of-area referrals should only be considered where there is capacity to deliver this service in a way that will not negatively impact on the quality of the service that is offered to the family and will not divert resources away from other families accessing the Cradle to Kinder service from within the designated catchment area (e.g. staff time spent in travelling to meet with the out-of-area client). As Cradle to Kinder services are funded to provide a service to families within a particular catchment area, local area-based the Department of Human Services staff will monitor the level of out-of-area referrals on a regular basis.

Flexibility will be required to retain families who have already engaged with the service but are forced to move out of the catchment area – on either a temporary or permanent basis - due to unstable housing. The decision as to whether or not to continue offering a service to the family should be made on a case by case basis, taking into consideration the distance of the new residence from the catchment area, the resource capacity within the service and the availability of other service options in the new locality.

If there is a significant demand for the service from outside the catchment, Cradle to Kinder service providers will provide feedback to the Department of Human Services to inform statewide service planning for the Cradle to Kinder program and the child and family services system more broadly.

5.1.6 Intra program referrals

In order to support continuity of service provision, women and their families who have previously been receiving Cradle to Kinder services but have moved to a new Cradle to Kinder catchment area, are given priority access to the program in their new locality. The new Cradle to Kinder service must do all they can to accommodate the family immediately upon receipt of the referral, thus ensuring continuity of engagement.

Intra-program referrals for allocation to the Cradle to Kinder service are made via Child FIRST. There may be circumstances where the new Cradle to Kinder service provider cannot accept the referral due to capacity issues. In this instance local area arrangements for waiting list management and service allocation within Child FIRST will apply.

Cradle to Kinder practitioners, who have an established relationship with the family, will provide advocacy and introduction into the new service location. The usage of creative methods and technology (e.g. “Skype”) can be helpful in supporting initial contact for the family when the new locality is geographically distant from the original service location. The referring Cradle to Kinder service should continue to provide support to the family as they transition into the new service, in order to ensure continuity of engagement with the program. The same support should be offered to the family if capacity issues result in the family being offered an alternative service in the new locality.

When families move to an area not serviced by Cradle to Kinder, the family should be referred to the Child FIRST service in that catchment area so they remain engaged in the child and family services system. Working in partnership with the family, active linkage and advocacy support (e.g. joint visits, face-to-face introductions, information-sharing as part of intake meetings) are most likely to help the family engage with another service.

5.2 Case Practice Model

This section should be read in conjunction with the *Best interests case practice model: Summary guide* (Miller 2012) and other specialist practice resources.

5.2.1 Best Interest Case Practice Model

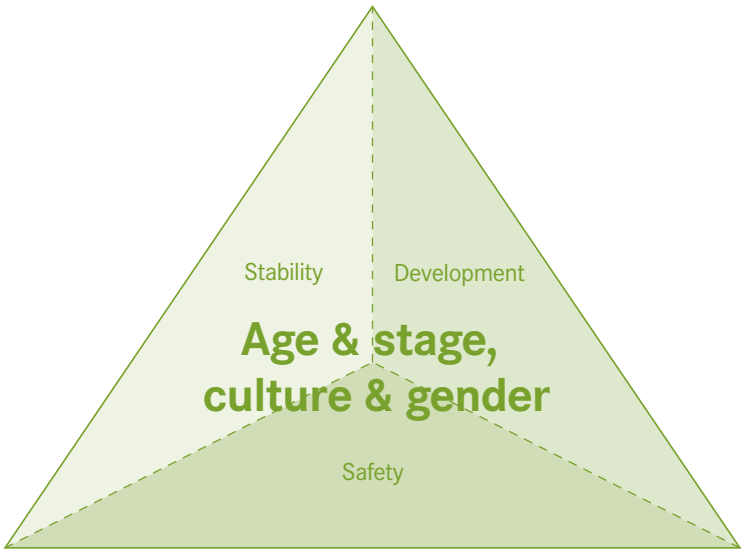
The *Children, Youth and Families Act 2005* (Vic) requires that services work in a way that reflects the best interests principles and uses the best interests framework to meet the needs of vulnerable children and their families. This framework encourages a consistent focus on safety, stability and development, viewing each dimension of a child’s life through the lens of age, stage, culture and gender.

The best interests of a child are protected and promoted by ensuring a child's right to:

Safety – including providing a safe and nurturing environment that meets a child's physical, social and emotional needs and protects them from harm;

Stability – including connectedness to family, primary carers, school, their peer group, community and culture

Development – including health, emotional and behavioural development, education and learning, family and social relationships, identity, social presentation and self-care skills.



Source: *Best interests case practice model: Summary guide* (Miller 2012), page 2

The best interest principles reflect the need to consider the child's longer term development, placing a strong emphasis on identifying and addressing any early indicators of cumulative harm.

Cumulative harm refers to the effects of multiple adverse or harmful circumstances or events in an individual's life that diminish and harm an individual's sense of safety, stability and wellbeing. It may be caused by an accumulation of a recurring adverse circumstance or event, such as ongoing exposure to family violence, or by multiple circumstances or events, such as the interplay between parental mental illness, substance abuse and family violence. The notion of cumulative harm is particularly relevant to infants where the impact of neglectful, unresponsive parenting can disrupt the attachment relationship, with long-term consequences for how children learn and form relationships with others.

Cradle to Kinder programs utilise The Best Interests Case Practice Model which is applicable to Child Protection and all Community Service Organisations delivering family and placement services. The model is trauma informed and involves the development of respectful partnerships with the child's family and others of significance to the child. It is outcomes-focussed and is based on developing a practice culture that is committed to reflective practice.

Source: *Best interests case practice model: Summary guide* (Miller 2012), page 5

5.2.2 Principles of Practice

The Cradle to Kinder service must be delivered in ways that are:

Relationship based, child focussed and family centred: The child is at the centre of our work and all decisions and practices are carried out with the child's best interests in mind. In working with infants and their families, the relationship between the parent and the infant is a focus of support and intervention. Building positive relationships with families provides a strong basis for effective practice and acts as a model for positive relationships. A relationship based approach facilitates partnering with individuals, families, communities, professionals and other services.

Ecological and systemic: The practitioner needs to see the child in the context of relationships with their family and community and as influenced by factors in the environment. The focus of practice is the "person-in-environment". This part of the model establishes the need for the practitioner to look at the interactional nature of development and the broader influences on families, including psychological, physical and social factors. An ecological perspective directs attention to the impact of social disadvantage and poverty on the lives of children.

Culturally competent: Being connected to culture is a recognised protective factor for children and culture is a component in every aspect of what defines a child's best interests (Frederico, Long et al. 2012). For Aboriginal communities, the possible loss of culture needs to be seen as a risk factor in the assessment process. For Aboriginal families, culture and the maintenance of culture is central to the healthy development of their children. Aboriginal culture is inherently inter-relational and inter-dependent and includes a holistic consideration of educational, physical, emotional and spiritual needs. It is important that interventions respect this broad understanding and see the family needs holistically. Service providers and

practitioners can create culturally safe environments by seeking guidance on how to provide the service and being aware of the impact of culture on the way the service is delivered (Victorian Aboriginal Child Care Agency 2010). Practitioners should seek from the family their definitions of who is "family" and who forms "community" for the child as well as who should be involved in assessment, intervention and planning processes for the family.

There is an imperative to develop culturally competent practice with Aboriginal families, given our national history and their current over-representation in the Child Protection system. However, there is also a need for culturally respectful and culturally informed practice with families who come from other culturally and linguistically diverse communities. The approach of working with the community and demonstrating a willingness to learn and work collaboratively with community representatives is a useful approach across all cultures.

Developmentally and trauma informed: Practice is informed by the developmental impact of neglect and abuse trauma on the child. This is of extreme importance when working with infants due to the impact of the cumulative harm of neglect and abuse and the critical nature of neurological development in the early years. Practitioners need to have excellent knowledge of early childhood development and skills in assessing the developmental capabilities and needs of the child. There has been an explosion of knowledge about the impact of neglect, abuse and trauma on neurobiology and it is critical that practitioners have a good working knowledge of this research base. The *Child development and trauma specialist practice resource* brings together and explores multiple theoretical perspectives and relevant available research. The Cradle to Kinder target group includes parents who have experienced the impacts of trauma in their own lives. This, in turn, may impact on their capacity to parent and work with services. The sections within this practice resource on both infants and adolescents (12-18 years) are applicable to practice within the Cradle to Kinder service and are available from <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource>

Gender aware and analytical: Issues of gender are particularly relevant to families involved in Cradle to Kinder during pregnancy and early childhood. Practitioners need to be aware of possible issues of power and gender involved in the conception of the pregnancy and also to the potential alienation of fathers from involvement in the process of pregnancy, birth and the early postnatal period. Family violence is prevalent in Australia and is largely perpetrated by men on women. Pregnancy and the early post-birth period mark a time of increased risk of intimate partner violence and a time of extreme vulnerability for the mother and child. Practitioners need to assess and understand the dynamics of power, hierarchy and gender in relationships. Evidence demonstrates that 'mother blaming' remains an issue and practitioners need to avoid making the woman solely responsible for relationship factors or parenting practices that result from the dynamic of family violence that exists within the family. Women who are in violent relationships often struggle to focus on the needs of their child and to be emotionally available to them, due to concern for her own safety and her need to prioritise the demands of her violent partner.

Dynamic and responsive: Intervention with families is a dynamic process, with each stage informing the next one. The process is not linear but cyclical in nature. Information gathering and analysis informs the assessment and formulation of the action plan, but can be influenced at any time by further information becoming available, changes in the family's situation,

feedback from family members or other practitioners and a review of outcomes. The dynamic nature of the early childhood period places rapidly changing demands on parents thus practitioners must remain alert to the changing circumstances and needs of the child and their family over the extended period of the Cradle to Kinder intervention.

Based on professional judgement: The process of good analysis relies on up to date professional knowledge and is essential in forming accurate assessments and planning effective interventions with families. Evidence indicates that whilst practitioners gather and share adequate available information, it is a failure to critically and accurately assess the information that poses the greatest risk to children (Munro 2002). Historical information and recurring patterns of behaviour, along with current information should inform the analysis. Careful consideration needs to be given to the severity of the harm, vulnerability of the child, strengths and protective factors in the family and community and the likelihood of further harm occurring. Assessment needs to consider information gathered from a broad range of perspectives and contexts, including family and community members, other professionals, specialist assessments and practitioner observations.

Strength based: Strengths based practice has a focus on building skills and proficiency rather than focussing on problems and shortcomings. The practitioner looks for and acknowledges what families do well and helps them build on what works to overcome problems. The overall emphasis is on finding solutions rather than getting weighed down by problems. Working in a strengths based way does not mean avoiding difficult conversations and challenging unhelpful behaviour and practices. Parents and family members should be involved in identifying goals that are clear, concrete, behavioural and measurable. Parents need to know when they have been successful and receive meaningful feedback that helps to build confidence. Communication needs to be open, transparent, respectful and courteous at all times. Seeking to explore and understand their context, validating good intentions and inviting responsibility, rather than blaming, will help parents to face up to behaviour they might be ashamed of or defensive about.

Outcome focussed: The model encourages a culture of learning based around reflection and review of the outcomes and processes of practice. The Cradle to Kinder model has defined and measurable outcomes expressed in the program framework. The tools used to measure outcomes are the Family Outcomes Star, NCAST Parent-Child interactions teaching scale and data collected as per the program data set. Outcomes should be analysed on a case and service basis to improve outcomes for program participants and inform program and service development strategies. Regular supervision, based on reflection and learning, and opportunities for professional development are critical elements of quality service provision to vulnerable families and children. Encouraging a reflective learning culture enables the practitioner to stand back from the emotion of the day-to-day work with families in order to think and understand the use of self in influencing outcomes for families. Reflecting on practice is also a dynamic and cyclical process that, when performed regularly across organisational and service platforms, informs assessment and planning processes. Systematic implementation of reflective practice is a powerful and effective way of influencing planning, not only at the case management level, but also at the service and organisational level. Analysis of any emerging themes should be fed back into administrative processes so as to inform organisational development strategies. Evaluation of service delivery strategies and a process of continuous improvement is arguably the most powerful evidence of program effectiveness (Wulczyn, Barth et al. 2005).

5.2.3 The Cradle to Kinder Intervention Phases

5.2.3.1 Information gathering

The initial phase of information gathering for Cradle to Kinder takes place within Child FIRST in order to identify that the family meets the criteria for Cradle to Kinder and that the program best suits their needs. Local catchment intake and assessment processes are followed and include:

- An initial assessment by Child FIRST in close consultation or jointly with a Cradle to Kinder practitioner.
- For referrals from Child Protection, consultation with the Senior Protective Practitioner (Community Based) is required and local area intake processes apply. The Shell agreement provides the framework for arrangements between Child Protection and Cradle to Kinder service providers at the local level (Department of Human Services 2011).
- For direct referrals to the Aboriginal Cradle to Kinder program, the initial phase of information gathering and assessment is carried out by an Aboriginal Cradle to Kinder practitioner.

A key service requirement of Cradle to Kinder is that the service provider gathers information to complete a multidisciplinary child and family needs assessment. This assessment takes into consideration information and assessments from other professionals and services. Identified gaps in information at the point of assessment may indicate services and professionals that will be required to form part of a care team that will best meet the needs of the family.

Information gathering is a dynamic and ongoing process and continues throughout the life of the intervention. The sustained nature of the Cradle to Kinder intervention and the rapidly changing nature of early childhood development and subsequent parenting demands, mean that situations are likely to change frequently, revealing new information. Whilst each stage of the process triggers the need for further information, Munro (2002) discusses the importance of a systematic approach to information gathering, especially in the initial stages, so as to identify gaps and inform assessment. Organising information into easily understood key points also supports quality service provision. Information missing from Child Protection case files, such as information related to the parent's mental health, is a common finding. This highlights that, with the parent's consent, information should be sought from a range of sources, including Child Protection, Mental Health services, Alcohol and Drug services, Aboriginal services, Family Violence services, and out-of-home care services (Lewin and Abdrbo 2009). In the absence of the parent's consent, Cradle to Kinder providers (as registered community-based child and family services under the CYFA) have the authority (under section 36 of the CYFA) to obtain information from these services for the purpose of assessing risk to a child. It is good practice, however, to obtain the parent's consent prior to seeking information from other agencies as this respectful, partnership-based approach supports the ongoing engagement of families with the service.

One of the most important aspects of information gathering is related to the parenting interactions observed over time and in different contexts. Having an opportunity to understand the interactions and responses of parents across multiple time points and contexts provides a rich understanding of how day-to-day life is for the child and parents.

Information gathered from history taking, other professionals and assessment scales, such as NCAST, provide information about the capacity of parents and children, but it is often the way that personal and other life stressors impact on and are represented in the parent child interactions and parenting responses that offer the clearest picture.

Key actions for practitioners in the information gathering phase include (Miller 2012):

- Be clear and purposeful in gathering information and always be mindful of the safety, stability and developmental needs of the infant.
- Where relevant, arrange for a community support worker, cultural consultant and/or interpreter to explore the relevant family, community and cultural history and current situation.
- Provide written and verbal information about the service in appropriate language. Clarify understanding and expectations to promote acceptance of the service.
- Engage the family in listening deeply to what they perceive as their strengths and weaknesses. Listen to their account of what has gone on for them and try to start where the family is at.
- Gain permission from the family to engage with other family and community members and professionals to share and gather information to develop a rich understanding of the situation and circle of available support for the child and family.
- Update information frequently, seek secondary opinions (where appropriate) and work with the care team and the broader services involved to reflect on current practice and inform the review process.
- Keep in mind that information changes over time, both as a result of the changes that occur within the family and in relation to new information revealed by the family as the practitioner's relationship with the family develops over time.

Genograms and Ecomaps

Genograms and ecomaps are useful tools to help the worker explore and gather information from the family. A genogram is a graphic portrayal of the composition and structure of relationships within the family and an ecomap provides a portrayal of personal and family social relationships. Both tools require the participation of the client and therefore encourage a partnership approach. The tools reinforce the notion that the client is the most knowledgeable source of information about their own lives, thereby promoting self-efficacy. Providing a picture of the family system over time can help the individual to stand back and reflect on their family history, structures and connections. It also provides an opportunity to gain insight into the family dynamics and how they affect the current situation.

Through the use of the genogram and ecomap, the practitioner can explore and learn about many aspects of the roles and relationships such as:

- Who the family is: their names, ages, relationships, occupations, and religion.
- Roles in the family and who performs them: Are grandparents, older children or others involved in the parenting? Who is perceived as having the most power in this family?
- Patterns of child rearing: managing behaviour, expressions of affection and approval. How is respect shown in relationships between generations?
- Family communication: Are there identifiable channels of communication? Who communicates to whom and how?

- The relationship system: How do members of this family feel about other members? Who is close to whom in this family? Are there identifiable alliances? What are the major conflicts within the family from the point of view of each member?
- The family through time: What is the family's significant history? What are the significant themes, patterns, events in the family history? What major losses or changes have occurred and how has the family handled them? Are there mental health and AOD issues?
- The family network: What persons or systems are important to the family? Outside the immediate family, where does the family turn for support?
- How does the family "fit" in relation to larger society? What are the experiences of accessing other organisations, schools, work, church, etc.?
- The family's connection to other people in the same culture

A simple guide for completing genograms is included in the Best interests case practice model: Summary guide (Miller 2012) and is available from <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/best-interests-case-practice-model-summary-guide>

Also, the Jesuit Social Services website has a simple guide to completing genograms and ecomaps which are available from
<http://www.strongbonds.jss.org.au/workers/families/genograms.html>
<http://www.strongbonds.jss.org.au/workers/cultures/ecomaps.html>

Social Network Maps

The Social Network Map is an additional practice tool that provides information about a person's perception of their social network and their relationships. It includes information about who is in the person's life, their access to support and level of closeness. When used over time, the Social Network Map provides insights into change, both positive and negative, that is broader than the parents' own difficulties

More information on the utility of the Social Network Map is provided by Tracy and Whittaker 1990.

Active engagement strategies

Engagement strategies in Cradle to Kinder are crucial and workers need to consider not only those which successfully recruit parents into the program but those that retain and motivate families so they can benefit from the program over time. Engagement strategies need to be sustained throughout the life of the intervention, as vulnerable families often find it difficult to either accept the offer of a support program or to remain involved in support programs (Watson 2005). Evidence shows that retention of clients in long-term interventions is a major challenge and the primary responsibility of service providers. Attrition rates for support programs that have been reviewed vary greatly, with many families dropping out of programs before they have had sufficient "dose" of the program to benefit. In contrast to earlier reported findings that working before birth can be a positive engagement strategy (see section 2.3 above), this may not always be the case. Parents can be resistant to the notion that they require parenting support before the baby is actually born. This is particularly relevant

when parents are fearful of child removal if factors such as alcohol and other drug use, family violence and mental health issues become known. Resistance can be minimised if the parents are clear about the benefits of the program and participation is championed by their peers.

> *Olds, Sadler, and Kitzman (Olds, Sadler et al. 2007), in their review of successful programs, suggest that service providers need to be able to answer the fundamental question, 'Why would parents want to spend their time participating in this program?'*

In a review of practice evidence, Watson (2005) found that it is the characteristics of services rather than families that predict retention or attrition most strongly. Service providers need to consider flexibility in service provision, such as using a mix of home based and centre/ office based settings, operating outside normal business hours when required and providing transport for activities outside the home. Strategies that practitioners and agencies can adopt to increase the initial uptake of families into the program (Watson 2005) include:

- Providing quick follow up
- Frequent contact
- Offering support for the parent as well as the child
- Active follow up when the family do not respond to contact attempts
- Providing assertive outreach
- Using a known and trusted agency worker already engaged with the family to support the early engagement period.

Taylor and colleagues (2008) found the following factors were helpful in engaging parents with alcohol misuse issues, who commonly also had problems with family violence and mental illness:

- Attending creatively to intake processes that cause uncertainty and anxiety e.g. by normalising their difficulties and involving children early in the process.
- Clearly articulating expectations and responsibilities of both parents and practitioners at initial meetings.
- Persistently using home visits, especially if families were missing appointments.
- Focusing on building trust so that the families develop confidence in their ability to communicate difficult emotions.
- Robust working together strategies, including sharing knowledge and expertise.

The relationship between families and practitioners has been found to be a vitally important factor in determining the ongoing engagement and perceived value to parents of continued program participation. In the review of literature to identify what practitioners can do to effectively engage families with multiple problems, Watson (2005) identified the following strategies:

- show respect for the family,
- use interactive models of learning that value parents' own ideas and experiences
- empower parents
- start where the family is at
- use supportive and non punitive language
- include the family in decisions
- have a strong understanding of and connection with the broader service network to support timely referral into other services.

This list highlights that, even more than the service, it is the people in the service and their interactions with families that make the difference.

Case study 1

Andrew was an unplanned and unwanted pregnancy. His mother, Sarah, was 19 when she fell pregnant. She had a history of anorexia and anxiety, was addicted to Xanax and regularly took amphetamines. She initially denied the changes happening to her body and was inconsistent in her attendance at antenatal care. Andrew's father also did not want to have a baby. He was also addicted to amphetamines and would binge drink. He seriously assaulted his partner on a regular basis. On one occasion, she attended the local hospital when he tried to murder the baby by hitting her repeatedly in the abdomen. Andrew's mother left her partner several times and went to stay in refuges, but she would always return after a short period of time. She also suffered injury to her legs in a car accident when she was 21 weeks pregnant. The accident was not her fault and she was not drug affected at the time.

The labour and birth were uneventful. Child Protection had become involved when Andrew's mother was brought to the Emergency Department after the serious assault by her partner. This occurred at about the same time as her car accident. Andrew was 22 weeks gestation.

Alison, the Cradle to Kinder practitioner, visited Sarah at home to explain her role and what the service could offer. Sarah was a bit uncertain, but agreed to let Alison come again in about a week's time. During the second meeting, Sarah was able to tell Alison that she was frightened that Child Protection would take her baby when he was born. This had happened to her as a child and she had spent years in several different foster care placements before being returned home when she was about four years of age. She stayed with her mother for a few years and then was placed in care again. As an adult, she had also spent time in residential care. Alison knew some of this history from the referral information but listened carefully and asked questions to help Sarah continue talking. They agreed to meet again the following week.

In the meantime, Alison met with the allocated Child Protection practitioner and they convened a professionals meeting. Invited to the meeting were the Child Protection practitioner, the Cradle to Kinder Practitioner, the family services practitioner and the family violence practitioner. Sarah had been referred to the Family Violence Program by Child Protection at the time of the notification but had not attended. At the meeting, each person explained their roles in relation to Sarah and her baby. The Child Protection practitioner explained that an unborn report had been made to Child Protection and that they would keep monitoring the safety of the baby over the coming months. The family services practitioner said they had been helping Sarah on and off for several years, first as part of her placement in an adolescent residential unit and then in their Leaving Care program. Support offered had tended to be intermittent and, more recently, had focused on securing housing. The family violence practitioner explained that Sarah had not taken up the referral to the family violence program. If Sarah chose to, however, she could access refuge accommodation and a group program at their service.

The Cradle to Kinder practitioner explained that Sarah would be able to stay with her service for up to four years, and that she and Sarah would meet regularly, developing goals as they went. Alison also reported that she had made a tentative but positive start to her relationship with Sarah. A schedule of meetings was established.

Sarah continued to meet with Alison on a regular basis. After about six weeks, Sarah asked Alison to get her a new phone because hers had been broken. Alison said she needed to check with her manager about this and would get back to her. The following week Sarah was not at home at the time of their regular meeting and Alison could not find her. After several days they were able to re-establish contact. During the absence Alison talked about her concerns with her manager and in supervision. They sought secondary consultation from a mental health clinician. They thought about the risk to Sarah and the risk to the baby and discussed the situation with the Child Protection practitioner. In supervision and secondary consultation, Alison reflected on the last meeting with Sarah and they thought together about the meaning of Sarah asking for something and Alison having to say that she needed to check. When Alison finally spoke to Sarah again, she reflected to her that perhaps Sarah had felt that Alison really was not on 'her side' because she had to check with her manager before she was able to get her something that she really needed. Sarah agreed, saying that no one had ever consistently obtained for her the things that she needed and that she had been waiting for Alison to do the same. When Alison had done this, Sarah had thought, 'She's just like all of the others,' and went away for a few days. Alison said to Sarah that it was hard to trust people, particularly after she had spent so much of her life having to fend for herself but that perhaps she did not want this to be the way for her baby. Regular meetings were re-established… (continued below).

Engaging and working with fathers

Evidence shows that fathers' involvement in the lives of their children usually has a positive effect on the wellbeing of children, fathers, mothers and the family. Fathers have a direct influence on the development of children and children respond to and benefit from relationships with fathers (Fletcher 2010; O'Leary 2012, United Nations 2011).

The roles and responsibilities of fathers are undergoing dramatic social change due mainly to changes in socioeconomic factors, family structures and work patterns. Fatherhood is socially constructed and takes many forms across different cultural and family contexts. Men are defined as "father" based on their role, rights and responsibilities. The term 'father' includes biological fathers, non-biological fathers, uncles, brothers and grandfathers. Engaging the mother's partner (whether or not he is the biological father or the mother has a female partner) is also important in terms of understanding the mother's context and who may be a potential support or potential threat to the mother and child.

Men's caring roles are often relatively hidden, with more attention and responsibilities given to women and mothers. Men's caring responsibilities and obligations to children and partners is seldom encouraged or acknowledged and this is further exacerbated for fathers with disabilities, fathers in prison, substance- and alcohol-misusing fathers, young fathers and non-residential fathers.

Case Study 2

Alice was referred when she was pregnant with Joan. Joan's dad, Braydon, was assessed as being unsafe with Joan when she was born and Alice was the primary caregiver. Both Braydon and Alice had intellectual disabilities and Alice had two other children who had been placed in care soon after they were born because Alice and Braydon were unable to care for them. Braydon was very upset to hear that he wasn't going to be able to father Joan and he left Alice.

Alice worked very hard with her Cradle to Kinder practitioner and was able to care for Joan with the help of three days of childcare and respite on some weekends. The Cradle to Kinder practitioner helped Alice to think very carefully about Joan's needs and the ways that Joan would communicate to Alice.

When Joan was 6 months old Braydon came back to see Alice and wanted to resume their relationship. Alice was scared to tell her Cradle to Kinder practitioner because she was frightened that it would mean that Child Protection would take Joan away. The Cradle to Kinder practitioner realised that Braydon was back when she found some of his clothes in the house when she was visiting. She said that she would like to see Braydon again, having not seen him since Joan was born, and suggested to Alice that Braydon be present at their next meeting.

Braydon came with Alice and Joan the next week. The Cradle to Kinder practitioner invited Braydon to talk about his situation and his hopes and wishes for the future. Braydon said that he would like to see Joan and that he really wanted Joan to know her father, especially as Braydon had not known his own father. Alice also wanted to be with Braydon. She had been lonely since he left. The Cradle to Kinder practitioner assured Braydon that fathers were very important to children and that she would help him have a relationship with Joan, even if they were not able to live together. The Cradle to Kinder practitioner suggested that they take some time to work on helping Braydon understand Joan and her needs and see how they go. This plan was discussed at the care team meetings and all were in agreement, provided that there was close monitoring of Joan's safety.

The Cradle to Kinder practitioner worked with Braydon and Joan, helping Braydon to understand Joan's needs and ways that she was able to communicate them to him, such as looking, smiling and pointing when she wanted to play and looking away when she wanted to stop playing. The Cradle to Kinder practitioner also referred Braydon to a special education class for adults with learning disabilities to improve his literacy. After two terms, he was could read simple words and so could write himself notes and reminders about Joan's routine.

Given the young age target for mothers in the Cradle to Kinder program, many fathers will also be of a young age. Young fathers, as with young mothers, are more likely to have their own family history of a young mother, low parental education level, high levels of family breakdown, poverty and parental substance use (United Nations 2011). Engaging young fathers is particularly important as evidence indicates that young fathers (aged less than 17 years)

are the least likely to be involved with their children at nine months after birth (United Nations 2011). The quality of the relationship with the mother during pregnancy was shown to be a stronger indicator of future involvement in the life of the child than socioeconomic issues.

Young fatherhood itself creates additional challenges for young men with associated increases in psychosocial difficulties, antisocial behaviour, low self esteem and criminal offending (United Nations 2011). However, becoming a father has also been shown to provide a unique opportunity and motivation for change in the behaviour of young men. In a study of young unmarried fathers living in poverty in South Africa, the birth of the baby brought about significant changes including decreased time spent out of the home, changed patterns of socialising, less money spent on self, increased social interactions focussed on family and re-connection with their own fathers (United Nations 2011).

The need to provide support to fathers is clear and yet fathers in all contexts tend to be excluded from child and family service provision, particularly vulnerable fathers, male carers and fathers in vulnerable family contexts. In order to improve the positive involvement of fathers with their infants, Cradle to Kinder service providers need to ensure greater inclusion of fathers in service provision and affirm the parents' joint responsibility for the safety, stability and wellbeing of the child. In endeavours to increase support for father-child interactions, it is crucial that service providers remain alert to identifying fathers who pose a risk to children and mothers and continuously prioritise and plan for their safety needs.

There have been many attempts to improve the rate of father engagement in child and family service delivery but to date most have had poor results. In a study to learn how services could successfully engage fathers, Fletcher (2003) found that fathers were more likely to be involved when:

- It is clear that the service or activity will benefit the child
- It is clear that the child will benefit from the activity if it is the father, rather than another person, who performs the activity
- The father clearly understood what he was supposed to do.

The study identified some key ways that service providers can increase the engagement of fathers, including:

- Providing positive images and messages about the benefits of relationships with fathers. Many men report that the only reference to men in services (e.g. in posters on walls, brochures, father specific activities) is often associated with negative issues such as violence and drug and alcohol use.
- Extending the invitation to fathers from the infant or child. For example, in the case of perinatal services, a foot print image of a baby and writing the invitation from the infant's perspective may encourage fathers to engage with the service. Similarly, it may also be helpful to ask toddlers to do a drawing of "Daddy" to use as the invitation and to describe the benefits to the child of the father attending. Many services were in the habit of inviting fathers' involvement from the perspective of doing their share of the parenting or "helping out", whereas identifying the unique contribution of the father may be more appealing.

- Addressing communication directly to the father. In most cases, the term “parent” or “family” was considered by most men to mean the mother and therefore they did not feel that the service was truly requesting their involvement. In order to directly address fathers, the service provider needs to think through what they have identified as the direct benefits of fathers being **constructively** involved.
- Running father specific sessions which directly addresse the unique contributions and role that fathers play in the lives of their children and partners.

The Australian Government has produced a document to guide child and family services in how to include fathers in their services. The document is available from <http://www.fahcsia.gov.au/our-responsibilities/families-and-children/publications-articles/father-inclusive-practice-guide>.

Fathers can also suffer from perinatal depression and the rate of diagnosed anxiety or depressive disorders in new fathers at around 6 weeks after birth is 2-5%. Fathers who are depressed are more likely to have a partner who is experiencing depression, with men experiencing depression in 50% of couples where the woman is depressed. A father’s depression also has an impact on the infant, doubling the risk of emotional and behavioural problems for children, independent of the mental health of the mother (Fletcher 2010). There is growing evidence that anxiety can also be a problem for men in the antenatal and postnatal period. The Edinburgh Postnatal Depression Scale (EPDS or EDS) has been validated for use in postnatal screening of English speaking fathers, to identify those who require additional support and treatment. Fathers are less likely to interact with health and welfare services during the early parenting period and therefore are less likely than mothers to get appropriate treatment. Providing information for men about the possible impacts of becoming a father and the unique contributions to his child’s health and development can be helpful. Beyond Blue, the national depression initiative, provides specific information and support for men’s mental health on their website at <http://www.beyondblue.org.au>. Headspace (the National Youth Mental Health Foundation) has a website that provides information and resources, including the location of programs, at <http://www.headspace.org.au/>

Aboriginal Men’s Health and Wellbeing

Past government policies and practices of forcible removal of Aboriginal people from their lands, removal of children from their families and the loss of cultural traditions and practices have all had a huge negative impact on the health and wellbeing of Aboriginal and Torres Strait Islander men (Working and Walking Together). These policies and practices brought about dramatic changes to the roles of men in families and society. High unemployment rates, low educational attainment, economic disadvantage and racism have added to their disempowerment and the devaluing of their role.

Aboriginal men, like Aboriginal women, have 20 years less life expectancy than their non Aboriginal peers (National Aboriginal Controlled Community Health Organisation and Oxfam Australia 2007). They are overrepresented in the prison population and have high levels of substance misuse and unresolved grief and trauma (Working and Talking Together). Beyond Blue, in a partnership with the Men’s Shed program (<http://www.mensshed.org>), has developed a specific program to respond to the

needs of Aboriginal men. More information on this project is available from <http://www.mibbinbah.org>. MensLine Australia also provides information for Aboriginal men at <http://www.mensline.org.au/Indigenous%20men.html>.

There are many local initiatives aimed at engaging and supporting fathers. For example the "I'm an Aboriginal Dad" program is a three way partnership between the Victorian Aboriginal Health Service, the transition clinic of Mercy Hospital and the Children's Protection Society. This program provides education, individual support and consultation to assist Aboriginal fathers-to-be in playing an active role in their families. The program provides opportunities for fathers to join with other fathers in a "yarning up" circle. The program also provides resources and support for the development of relationships with partners and family members. More information is available at <http://www.cps.org.au>.

The following resources are available for fathers:

Websites

- <www.babycenter.com.au/baby/dads>
- <www.raisingchildren.net.au>
- <http://www.aifs.gov.au/cfca/webresources/fathers.html>
- <http://www.mensline.org.au/Home.html>
- <http://www.newdadmanual.ca>
- <http://www.families.nsw.gov.au/docswr/_assets/ffsite/m100006l13/dadstoolkit.pdf>

DVDs

- Good Beginnings, "Hello Dad", Infant Communication for Fathers <http://www.goodbeginnings.org.au/resources/dvds>
- Sam Holt & Troy Jones, Being Dad - The Baby DVD, Australia's best guide to pregnancy and birth, <http://wwwwww.beingdad.com.au>

Fathers who pose a risk to children

Fathers can have a negative effect on children's outcomes when they are absent, dysfunctional or violent (Australia Dept. of Families 2009; United Nations 2011). Studies have shown an increased risk of death, abuse and neglect for children living in households with unrelated males and non-biological fathers. This pattern of risk is explained by the reduced emotional attachment and economic investment by males for non-biological children.

Men who have untreated mental health issues, problematic alcohol or drug use and/or have violent and antisocial behaviour can pose the greatest risk to the safety and wellbeing of children. Practitioners need to be aware of any patterns of criminal offending and concerns regarding possible sexual offending, seeking consultation with Child Protection as required.

Evidence shows that, in cases of child abuse and family violence, workers neglect to engage with fathers. Fear of violent and abusive men can lead to clouded professional judgement, avoidance and focussing on the mother, including "mother blaming". Failure to engage violent partners in services is a lost opportunity to assist the man in addressing his problems in a way that reduces the likelihood of repeating the same patterns of abusive behaviour in new relationships. There is evidence of positive outcomes (i.e. a reduction in violent and abusive behaviours) for men participating in behaviour change programs that take a cognitive behavioural approach.

Engaging directly with infants

Engaging directly with the infant is an important aspect of gathering information about the child and assessing how the family situation impacts on them (Jordan, Sketchley et al. 2012). Engaging directly with the child in the presence of their caregivers enables practitioners to make comparisons between how the child interacts with their main caregivers and strangers. For example:

- Who does the child go to for attention or to seek comfort?
- How does the infant respond to strangers? Are they immediately and overtly friendly and seeking the practitioner's attention and proximity? Friendly but want to stay close to the parent? Hyper-vigilant? Uninterested and/or unresponsive?
- How does the parent/s respond to the interactions between others and their child?

When working with parents who are particularly vulnerable to low self confidence and self esteem in their parenting role, practitioners need to be cautious and sensitive in engaging directly with the baby or toddler. Parents who are struggling to establish a relationship with their child can feel undermined by their baby's positive and animated interactions with a skilled practitioner. It is important to simultaneously facilitate and reinforce the positive aspects of the parent-child relationship by noticing and describing the child's responses to their parent's behaviour. Speaking for the infant can be an effective way to help parents put themselves in the mind of the child and understand their infant's behaviour, developmental capacity and the impact of their own behaviour. For example: When a baby turns in response to their mother's voice a practitioner can say, "I can hear you Mum and I know your voice from when I was growing inside you. I like it when you talk to me. I feel safe when I can hear that you are near me."

Engaging thoughtfully and sensitively with the baby can be therapeutic for the infant. Cradle to Kinder practitioners can learn from the experiences of clinicians' work in the fields of infant –parent psychotherapy[1] and infant mental health,[2] specifically with regard to direct, therapeutic engagement with the infant. In describing and discussing decades of infant mental health work at the Royal Children's Hospital in Melbourne, Thomson Salo and colleagues (2007) describe

1. The aim of infant-parent psychotherapy is to change the representations of the baby in the parents' mind and change the representations of the parent in the baby's mind to more closely reflect reality (Lieberman, Silverman & Pawl, 2000). Changing the way the baby and the parent think about each other then changes the way they interact. For example, a parent may feel that a baby cries intentionally to cause further stress, 'knowing' that the parent is already having difficulty coping with the demands of parenting. In this relationship, the baby might feel that the parent is always angry and will not come to help the infant, leading the infant to feel abandoned. The intervention would focus on helping the parent think about the experience of the infant and to understand that the infant does not have such malicious intent, thus bringing the parent and infant closer. In Zeanah,C.(Ed)(2000). Handbook of infant mental health, second edition. The Guilford Press, New York.
2. Definition of infant mental health
   ' "Infant mental health" is defined as the healthy social and emotional development of a child from birth to 3 years'; and a growing field of research and practice devoted to the:
   - Promotion of healthy social and emotional development;
   - Preventionof mental healtrh problems; and
   - Treatment of the mental health problems of very young children in the context of their families.

   (Zero to Three, 2012)
   <www.zerotothree.org/child-development/early-childhood-mentalh-health>

the special therapeutic quality of the clinician's gaze, whether as part of an infant observation or a psychotherapy session. The authors describe the gaze as "looking thoughtfully and playfully in order to understand the infant's experience" and suggest that this gaze is often enough for the infant to feel they have received something of value, thereby contributing to the infant's development of self. The infant is thus held in the mind of the practitioner, helping to support and build the parent-infant relationship. The authors also identify the role of an "alive and meaningful contact" with a practitioner to reverse the cycle of despair experienced by infants who seem to have "given up hope". They explain that, rather than undermining the confidence of parents, observing their infant interacting and responding to the practitioner can reassure parents of their child's capacities and resilience.

Working before birth

The phase of pregnancy and becoming a parent represents one of the most significant transition periods in life. Most parents are motivated to be the best parent they can be for their child and this motivation brings with it an opportunity to engage parents in the process of change. It can also be a time of anxiety and fear about the mother's own health, confusion about her changing sense of identity and feelings of discomfort or unfamiliarity with her own body. A young woman whose own experience of childhood was one of trauma and of being removed from her family's care can experience other fears when she discovers she is pregnant. If she has had other children who have been removed from her care these fears are likely to be even further heightened.

It is beneficial to have strategies for engaging the parents before birth by focusing on their hopes and fears for both themselves and their child. Engaging parents before birth provides an opportunity to impact on the intrauterine environment in order to promote the infant's safety, stability and development, both before and after birth. It requires sensitive practice related to:

- Involvement in antenatal care services. Women from the Cradle to Kinder target group are known to have low levels of engagement with antenatal services, often engaging with these services late in the pregnancy. Antenatal care reduces risks to both the mother and the child. Engagement with specialist pregnancy services, such as chemical dependency maternity services, may help the pregnant woman address alcohol and other drug misuse and provide specialist attention to the additional risks and needs of the foetus and newborn baby if exposed to substances during pregnancy and breastfeeding. Children born to mothers who are injecting drug users carry the additional risk of exposure to blood borne viruses. Neonatal withdrawal may need to be carefully managed immediately after birth and later, when prolonged irritability can impact on the establishment of breastfeeding routines and early attachment.
- Exposure of the foetus to cigarette smoke is dangerous and increases the incidence of miscarriage, stillbirth and low birth weight. A national study of peri natal statistics identified a rate of 6% of live born babies of low birth weight (less than 2,500 grams), with this rate nearly doubling (i.e. to 11%) among mothers who smoked during pregnancy (ABS 2007). Smoking is prevalent in the Aboriginal community, with Victorian data indicating that 48% of Aboriginal mothers of children aged 0-3 years had smoked/chewed tobacco during pregnancy (Department of Education and Early Childhood Development 2010). Low birth weight is known to adversely impact on health and developmental outcomes. Smoking during pregnancy and after birth increases the risk of SIDS. Practitioners can use programs such as QUIT to assist parents in understanding the risks of smoking and learn some helpful strategies to support them to stop smoking.

- Exposure of the foetus to alcohol. Alcohol is toxic to the developing foetus and the possible impacts include brain damage, birth defects, poor growth before and after birth, low IQ or learning difficulties, delayed development, social and behavioural problems and problems with hearing, speech and vision. Foetal Alcohol Spectrum Disorder (FASD) is a non- diagnostic term to describe the continuum of effects from exposure to alcohol during pregnancy. Foetal Alcohol Syndrome (FAS) is at the extreme end of the spectrum. A minority of children are born with full or partial FAS. They have identifiable facial features, low birth weight, fail to thrive after birth despite adequate nutrition, have a small head and brain abnormalities. Much more common are children who are born with FAS and who have a range of effects including learning and behavioural problems but their facial appearance is normal (Telethon Institute for Child Health Research). More information is available from <http://alcoholpregnancy.childhealthresearch.org.au/about/fetal-alcohol-spectrum-disorders-(fasd).aspx and http://depts.washington.edu/fasdpn/index.htm>
  There is no known safe amount of alcohol for the foetus. The level of harm is related to the amount of alcohol, frequency of consumption and the timing of the exposure. Stopping drinking at any time during pregnancy reduces the risk to the foetus. Foetal alcohol spectrum disorder is the leading cause of non-genetic disability in Australia (Foundation for Alcohol Research and Education 2012) and should always be considered a possibility in any assessment of developmental delay and disability. Gathering information from women and recording details of consumption of alcohol during pregnancy is essential. Women must be provided with information about the effects of alcohol on the child and supported to give up or reduce drinking levels and intoxication during pregnancy. Drinking rates of mothers is closely related to father's drinking behaviour so engaging fathers in understanding the importance of reducing and stopping alcohol consumption in pregnancy is critical. A resource for practitioners is available from <http://alcoholpregnancy.childhealthresearch.org.au/alcohol-and-pregnancy-resources.aspx>
- Parents' attitude to the child. It is important for practitioners to explore the parents' feelings towards the pregnancy and the developing child. How the mother reacts to and speaks about the foetus provides valuable information about what the baby means to the parent. Enlisting the father in the preparation and plans for the child's birth and parenting cannot occur too soon. A book of practical tools to help practitioners explore and develop parent's emotional readiness for pregnancy is available as part of the *Promoting maternal mental health during pregnancy* program.
- Safety of the mother. Pregnancy and the early post-birth period is a time when women are most vulnerable to family violence (refer section 5.2.2. above.). Asking questions to identify if violence is present such as "Are you ever afraid of anyone you live with?" Has anyone in your household ever tried to push, hit, kick, punch and hurt you?" Refer to *Family Violence: Risk assessment and risk management and practice guides 1-3 (DHS 2012)*.
- Past sexual abuse is known to increase the incidence of difficulties during pregnancy, birth and parenting. Providing information about the processes involved and the possible impacts has been shown to assist women manage distress and integrate past experiences.
- Using a creative approach that centres on self care and pampering for the pregnant woman can help to increase her enjoyment of the experience and facilitate her connection to the infant. Activities such as massage, dance and relaxation can focus on the experience of both the woman and the foetus, thus helping to bring the infant into the mind of the mother. Cradle to Kinder service providers can partner with local community services and businesses to offer personal grooming activities - including facials, hairdressing, manicures and pedicures - that might increase engagement in the program.

Collaborative Practice

Family meetings

It is well established that working in partnership with families leads to better outcomes for children. Involving families as an integral partner in every aspect of the intervention process is central to the best interests case practice model (Miller 2012). Convening meetings with families where the knowledge, perceptions and capacity of extended family and community members is invited and considered, has long been part of good practice. Regularly convened family meetings are a powerful way to engage families and can fundamentally change the way services work with them. Involving families in decision making through family meetings should be a core service activity for the Cradle to Kinder service. The family meeting process emphasises and strengthens partnerships with families and encourages them to arrive at their own solutions and strategies to support the safety, stability and development of the child. Evidence suggests that it is particularly helpful for the family to engage with their broader family and community support system as early as possible in their involvement with services.

Parents, especially young parents, may feel intimidated or overwhelmed by meetings, including those where other family members are invited. Jointly planning the meeting with the parents beforehand (e.g. by working out the agenda together and ascertaining what they want from the meeting) can help allay their anxieties and be more empowering. If there are difficult issues to be discussed during the meeting, good practice would dictate that the parents have had the chance to hear this information beforehand and understand the reasons for raising it in the meeting. Similarly, other family members may feel inhibited to speak honestly in a meeting context. It is therefore important to ensure that there are regular opportunities to speak with extended family members outside of the meeting context. If the parent was a previous client of Child Protection herself, then her and her family's expectations of these meetings may be informed or hampered by these experiences. Highlighting the differences may be useful. In a review of the implementation of formal models of family meetings in Australia, Harris (2007) concluded that engaging families in meetings as part of a collaborative, partnered approach during the course of an intervention was likely to improve participation. This was also true for formal family decision making processes used in protective interventions.

Family meetings, as part of a collaborative way of working with families, should not be confused with or seen as the equivalent of the meetings involving families that have been a core element of Child Protection case planning for many years. Family meetings are usually a less formal process but should be seen as complementary. The model for formally involving family members in Child Protection decision-making processes are currently known as family group conference (FGC) or family decision making (FDM). A new model of family-led decision making (FLDM) will be operational from June 2013, targeting a specific cohort of families as a means of reducing the need for court applications.

There is currently a family decision making program specifically for Aboriginal families. It utilises a co-convenor delivery model, in which departmental facilitators work with independent Aboriginal facilitators to convene a conference. The Aboriginal family decision making (AFDM) program operates in every region and gives effect to case planning for Aboriginal children

who are clients of Child Protection. AFDM is a collaborative process that involves the active participation of family, extended family and community members in decision making about the safety, stability and development of an Aboriginal child. The model has been enshrined in the *Children, Youth and Families Act 2005* (Harris 2008).

Cradle to Kinder practitioners may be invited by the Department of Human Services facilitators to participate in a formally facilitated family group conference or AFDM process to provide information about an infant and family and their service provision to the family. The long-term nature of the Cradle to Kinder program and the family's sustained and consistent relationship with their key worker, provide an opportunity to contribute knowledge of the family over time. This represents a useful perspective from which families and professionals can make appropriate plans and decisions for children.

Other collaborative processes

Care teams

Care teams provide practitioners with an opportunity to work in partnership with families and are *"... an opportunity for key people working with the child and family to come together on a regular basis to reflect, share their thinking and understanding and coordinate each person's role in supporting the child and family"* (Coade, Downey et al. 2008). Although the concept of care teams has arisen from supporting children in out-of-home care they are also now applied to teams wrapped around families to support their goals of caring for their children (Miller 2012; VCDRC 2009).

One of the common aims of a care team is to assist the family and those providing support to the family to create a 'therapeutic web' or safety net for child/ren through the provision of consistent, frequent, repetitive interactions with them (Perry 2006). Care teams can assist participants, including the parent, to 'hold the child in mind', rather than being service system or crisis driven. They are akin to an ongoing working group wrapped around the child and family. Care teams may make decisions regarding day-to-day practice but are not a formal decision-making avenue. Because of the frequency of planned meetings, care teams do not need to be reactive to a crisis, but have more opportunity to be proactive and to comment on positive changes as well as giving attention to ongoing risks (Downey 2009). As noted in the Circle evaluation, the inclusion of parents in the care team meetings was considered a feature of therapeutic foster care that facilitated reunification (Frederico, Long et al. 2012). They have also been noted as a cornerstone for good practice in supporting young people leaving care, which may include when they are parents (DHS 2012). Another underlying concept for care teams is the ecological systems perspective, which emphasises the need to consider not just the individual but the multiple layers and multiple interactions surrounding the child.

An effective care team can result in a number of positive outcomes, such as (Coade, Downey et al. 2008):

- Developing a shared understanding about the child and his or her needs
- Creating the capacity to think and reflect together on the child's and family's needs
- Promoting proactive responses
- Providing opportunities to review the work and consider alternatives
- Supporting the parent with day-to-day parenting
- Enabling robust discussions and differences of opinion to be heard
- Ensuring a holistic and inclusive approach to assessment and intervention.

The implications of care teams for supporting families are varied and include:

- The involvement of the parents (and possibly other family members) as early as possible in the planning process so that they can see themselves as an active participant in the process.
- The adaptation of the case management process so that it is truly inclusive of the parent/s. This includes using care teams as part of the active engagement process where families can ask questions, receive answers, obtain support, feel a sense of belonging and develop greater participation in decision ¬making in relation to their own lives and the lives of their children.

Case conferences and other meetings

In addition to care team meetings, it is a hallmark of good practice that there are regular case conferences, especially when there are other professionals who have a less frequent but nevertheless key role in supporting families. Unlike care team meetings, case conferences may involve some professionals who do not regularly see the family, but who bring additional knowledge, expertise and information in relation to specific aspects of the assessment process. Gathering professionals (and sometimes families) together who bring a mixture of both close and distant working relationships with the family can be invaluable in seeing the family situation from a range of perspectives. Open communication and information sharing is critical in these meetings. If, however, the family's presence would hinder this communication in some way, it may be appropriate at times to have professional-only meetings. Case conferences do not need to occur as frequently as a care team meeting. For example, they may occur on a quarterly or bi-annual basis.

Case conferences can help reduce the possibility of misunderstandings between services that may result from different definitions, goals and interpretations of information. It is important to invite both child-focused and adult-focused services to attend. Joint case planning and case management processes, including case conferences, are major elements of collaborative practice (Darlington and Feeney 2008).

Communication with professionals before and after the meetings can be instrumental in maximising the effectiveness of the meetings, so that everyone is prepared in terms of the information they need to provide and the questions they may wish to ask. Minutes of the meetings act as a reminder of what has been discussed.

5.2.3.2 Analysis and Planning

Analysis

Analysis commences as soon as information comes to light at the beginning of the intervention, particularly regarding considerations around level of risk to the child and worker safety. It is important to carefully gather information from as many sources as possible early in the life of the case in order to provide a rich and complete view of the family's situation. Analysis involves thinking critically about the available information to make sense of what is known and identify where gaps in knowledge still exist. Practitioners need to bring an open mind and adopt a formal and systematic approach to analysis as new information becomes available. Analysis and planning is a continuous process and will occur throughout the Cradle to Kinder intervention.

Analysis calls on the practitioner's professional knowledge, understanding and judgement to identify the strengths and potential challenges for the family and how this might impact on the child's safety, stability and wellbeing. Knowledge and understanding is informed by collaboration with the family and other involved professionals, secondary consultations, assessments undertaken and the related evidence base. Professional judgement integrates the knowledge and understanding at hand and analyses this information to form a balanced and accurate view of the situation. This logical analytical process should provide a clear rationale for planning and action. However, as Munro (2002) points out, emotion can often stand in the way of a practitioner taking a balanced and rational approach. Research shows that, once practitioners have formed a certain view of the situation, they become very attached to that view and can be resistant to changing their opinion, even in the light of new information.

The most critical objective of the analysis is to gain an understanding of how the unique intersection of problems and strengths in the family impact on the child's needs being met (Bromfield, Sutherland and Parker 2012). A parenting capacity assessment needs to consider the broader impacts of complex personal and social issues on the child. It is not enough, however, to simply diagnose problems (Mildon, Matthews and Gavidia-Payne 2003). In order to determine whether a child is at risk of abuse and neglect, it is more important to assess parent–child interactions, the quality of the home environment, the parent's perception of their child's behaviour, the parent's social support networks and the parent's ability to think about their child from the child's perspective. The parents' day-to-day functioning may be different from their potential functioning, therefore understanding what impacts - positively or negatively - on the parents' functioning enables the practitioner to plan interventions that aim to reduce risks to the child and strengthen the parents' potential.

The complexity of problems in the target families for the Cradle to Kinder program can be overwhelming for practitioners as they need to negotiate the tension between engaging and working collaboratively with families, motivating and challenging families to change and prioritising the developmental needs of the infant. Evidence shows that, when working with infants, practitioners can tend to be overly optimistic, whilst the opposite is true for practitioners working with adolescents, who tend to be pessimistic. It is essential that practitioners challenge their own perspectives and views through their contact with the family and other professionals throughout their involvement with the family. This is especially important due to the longer term nature of the Cradle to Kinder intervention, when it is possible that a practitioner's partnership and close working with the family can create bias or cause a loss of objectivity. When a practitioner empathises with a family's situation, it can be very difficult to remain open to changes that are occurring and that might challenge the view that the practitioner originally formed of the family's capacity and constraints. This can be particularly difficult when parents are cooperative with the service, appear motivated and are doing their best to change but where the actual change in parenting and circumstances is either inadequate, will take too long and/or is not sustained in such a way as to provide consistent enough support for the safety, stability and healthy development of the child.

The ongoing process of synthesising current and new information requires the practitioner to be critically reflective of their work with the family and their own role in the process. Consultation with others and professional supervision is crucial to this process. Good supervision enables practitioners to think clearly and critically about their practice and to challenge their view of the family.

Assessment Framework

Good analysis is supported by the use of an assessment framework that assists practitioners to integrate all the available information about the family. The *Best interests case practice model: Summary guide* (Miller 2012) provides a useful assessment framework and goal planning tool for practitioners. It is available at <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/best-interests-case-practice-model-summary-guide>

In order to inform a thorough risk assessment, analysis of the available information must consider:

- Context: the current and historical circumstances of the family and their parenting. For example: Why has the family been referred to the service? Has anything changed in the family's circumstance that has added to their problems? What has been the role and impact of other services working with the family? What has been happening when things were going well for the family? What is needed to get them back on a stable footing?
- Circularity: the patterns of behaviour and problems that repeat for this family over time, including trans-generational patterns. For example: What is the level of alcohol use in the family? How might a pattern of violence impact on parenting patterns and the level of trauma experienced? How safe are other family members for the child when these dysfunctional patterns are entrenched within families?
- Constraints: the barriers that get in the way of or prevent good outcomes. For example: Are the parents able to learn new parenting strategies? Can they learn and develop new skills in the time required to ensure the safety of the child? Is the impact of past unresolved trauma a barrier to them connecting emotionally to their child? Is the parent's level and pattern of drug use affecting their ability to prioritise the child?
- Connectedness: the number, strength and types of relationships that provide protection for the child and the family. For example: What is the quality of the parent-child interactions? Are there other family members who are available to the child, either physically or emotionally, when the parent is struggling to respond? What support is available from family and community and are the parents open to that support? Is it adequate to support the child? Have the parents had a positive relationship with professionals and/or services that can help motivate engagement and facilitate change?

In forming a view of the level of risk to the child, the practitioner must decide on the level of significance to be allocated to the information gathered. An assessment of risk needs to consider:

- What harm has occurred and/or is occurring to the (unborn) child?
- What is the pattern and severity of the harm to the (unborn) child?
- How vulnerable is the child to the harm based on the age and stage of development, medical issues, genetic problems, developmental problems?
- What strength and protective factors are apparent in the family and are they adequate to reduce the problems that are causing the harm or to balance the effects of the harm on the (unborn) child?
- What is the likelihood of future harm occurring, based on patterns of behaviour in the family, capacity of the parents, motivation and potential for change?
- What are the actual consequences for the child of the harm - both past, current and future?

- What is the potential of the parents for change, including their level of engagement with services and the change process?
- What is the timeliness of the change required? Can the child's development wait for changes to occur in the parents and/or their parenting? It is important here to keep in mind the critical nature of infant development and the importance of the attachment relationship in the first years of a child's life. Sustainable change is difficult and a practitioner needs to consider the reality of relapses in patterns of behaviour (e.g. around drug use).

Case study 1 (continued)

After about eight weeks, when Andrew was about 30 weeks gestation, Sarah disclosed to Alison that her mother was Aboriginal and had been one of the Stolen Generation. She had had Sarah when she was in her early 40s and she had really been unable to cope with motherhood. Alison talked with Sarah about her understanding of culture and what it meant to her and wondered if she wanted help to become more connected to her culture. Sarah was non-committal initially but, two weeks later, said that she did want to know more about her culture and sought Alison's assistance in doing this. Alison was very careful to telephone the local Aboriginal community organisation whilst she was still with Sarah. The worker at the organization ended up speaking to Sarah directly and Sarah was invited to visit the organization and start to learn about her culture and community.

Alison became aware that Sarah was still taking amphetamines when Sarah presented at a meeting one day with red rimmed eyes and jittery behavior. Alison talked to Sarah about the effects of amphetamines on the baby, and how these could be lifelong. She talked with Sarah about how babies who are born drug dependent can find it very difficult to soothe themselves and that they would have to go through a withdrawal process, just like an adult would. Sarah had tried to stop taking amphetamines in the past and knew how hard it was to stop but she was upset at the thought that her baby would have to experience this suffering as well. She asked Alison to help her stop taking the drugs. Alison said she would help her as much as she could but that she would also like to consult with a specialist drug and alcohol clinician. Sarah agreed to this occurring. The drug and alcohol clinician joined the care team and worked with Sarah through Alison. Sarah stopped taking amphetamines but found it very difficult to also stop taking Xanax. Alison liaised closely with the drug and alcohol clinician but it soon became clear that Sarah would benefit from direct, specialist treatment. Sarah agreed to this.

Planning

Planning is the phase where a practitioner makes decisions about what actions to take to support the infant and their family. As with every phase of the Cradle to Kinder service provision, working in partnership with the family is the key to successfully engaging them in the process and bringing about lasting change. Involving family members in discussions that bring together information and considering the family's perspective in the analysis phase helps them to understand the rationale for action. It is not always possible to come to a shared view of the situation. Even if, however, the parent has a different perception of the problem to that

of the practitioner, the practitioner must continue to work openly and honestly with the parent, engage in reflective conversations with them and challenge behaviour that is not helpful or is harmful to the child.

At every stage, practitioners need to work with parents and the family to explore new information and perspectives, clarifying the situation and forming a shared view of the family's strengths and challenges. Regular meetings with the family and the care team provide opportunities to acknowledge parenting strengths, review progress and creatively explore how to solve problems. Taking a shared approach to support the developing infant can help the family find new ways of thinking and prevent them feeling overwhelmed and alone in their parenting role.

The *Child and family snapshot - Practitioner field tool and genograms* (Department of Human Services 2012) is a helpful resource designed for use with families. It assists practitioners in their analysis of information and in formulating action plans. It is available from <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-and-family-snapshot-practitioner-field-tool-and-genograms>

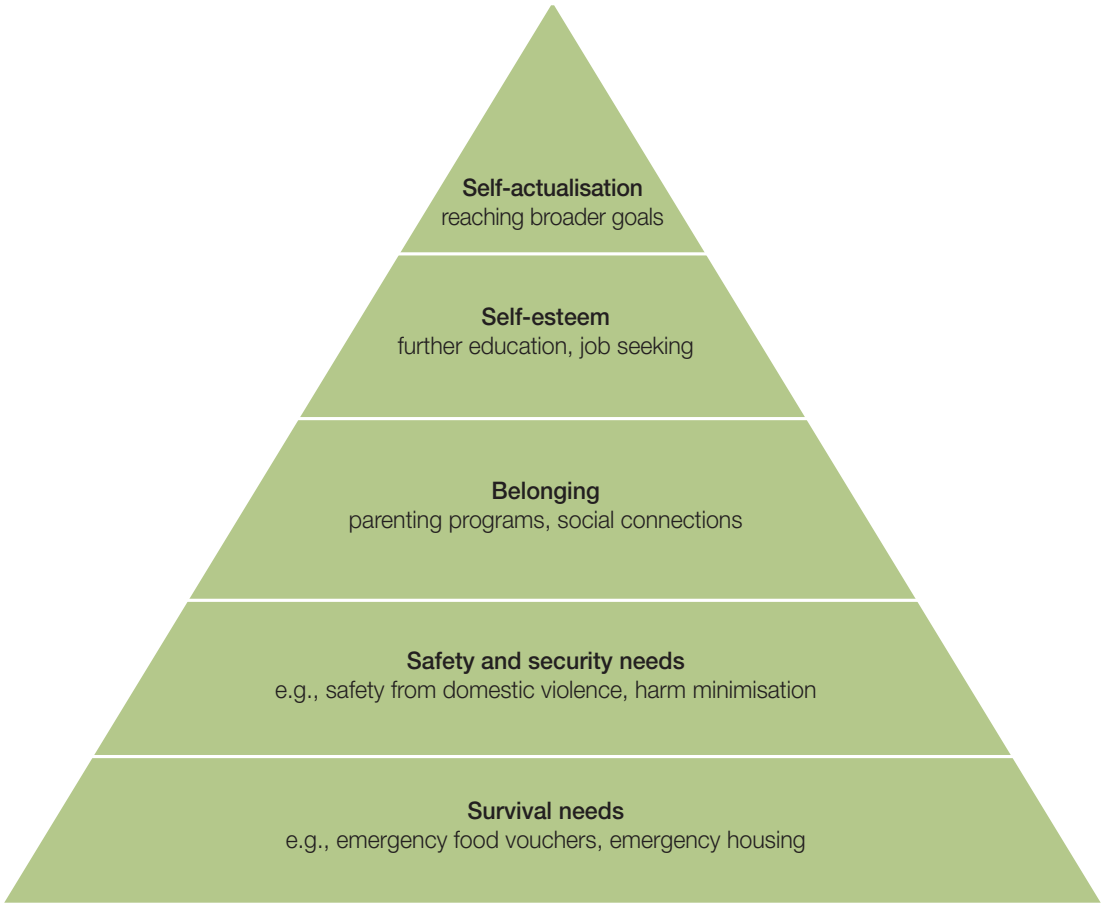
In planning for families who are struggling under the demands of multiple problems, practitioners face the challenge of prioritising the type and timing of support to be offered to the family. Identifying a myriad of problems and formulating plans to meet all the family's needs simultaneously can be hugely overwhelming for families and lead to disengagement with the program. Given the extended time that Cradle to Kinder is able to remain involved with families, the intervention can be carefully planned and staggered over time, with priority given to the safety, stability and wellbeing of the child. At all stages of the intervention, the time taken for parents to resolve problems that might be creating a barrier to them providing adequate parenting, must be balanced against the needs of the child.

Current research is inconclusive regarding the need for practitioners to prioritise addressing specific risk factors associated with parental behaviours (e.g. problematic alcohol and drug use, mental health issues and family violence) above a focus on improving parenting. For example, a practitioner might support a parent who is misusing drugs to access an AOD treatment service, *prior to* addressing parenting issues. But how does the practitioner keep in mind the ever changing developmental needs of the infant, balancing these against the reality that a parent with AOD issues may (repeatedly) relapse as part of their recovery process?

A report on the impact of parental mental illness cited a study which found that "*the best intervention for children of mentally ill parents is to ensure high-quality treatment and rehabilitation services for their mothers*" (Leverton, 2003, p.399). In a report on parents with substance abuse problems, Jeffreys and colleagues (2009) highlighted the need for practitioners to consider how the child's needs are met and argued that services should focus on parenting interventions, rather than focusing on mental health (as noted by Leverton, 2003) or alcohol and other drugs (as noted by ACMD, 2003). In contrast, a study by Eckenrode and colleagues (2000) found that, as family violence had a limiting effect on the effectiveness of a home visiting program aimed to reduce child abuse and neglect, there was a need to address issues of family violence simultaneously with those related to parenting. Engstrom and colleagues (2008) argue it is important to have integrated, multi-dimensional and multi-modal services. This reinforces the efficacy of the Cradle to Kinder service model as one based on an integrated, multidisciplinary, case management approach that is delivered in both individual and group settings.

Practitioners must keep in mind the impact of broader systemic issues, such as poverty and social disadvantage, on parenting. Parents can struggle to benefit from counselling or parenting education if they are unable to provide their children with appropriate clothing, fix the car or pay the rent. A mother may struggle to provide adequate parenting if she is concerned about lack of money to provide food and pay the heating bills or feels unsafe in the neighbourhood. Bromfield and colleagues (2012) offer an adaptation of 'Maslow's Hierarchy of Needs' to help service providers identify and think about how family needs may be prioritised and met in this situation. Its focus is on the parent's needs, on the understanding that if these needs are met, this will assist in meeting the child's needs. However, it is important to consider these as separate, yet interconnected, needs. This can be a helpful framework for practitioners to use in thinking about their intervention with families and in analysing where things might have become 'stuck' or why small improvements and progress is not sustained over time.

Figure 1. Maslow's Hierachy of Needs (McAdams, 2006)



Action Plans

A key requirement of the Cradle to Kinder service includes the development of a child and family action plan that reflects the needs and choices of the family. The action plan is developed with the family and can involve extended family, friends and other professionals. Outcomes from case conferences and family meetings feed directly into the action planning process. The action plan should be expressed in clear and plain language that is easily understood by the family. Goals should be SMART:

- Specific
- Measurable
- Achievable
- Related to the concerns
- Time limited and timely

The plan should also describe what actions will be implemented to assist the family in achieving the goal. For each action, a particular person is given responsibility for undertaking that action within an agreed timeframe. The action plan should not be a task checklist for practitioners but a truly shared document that shows the activities of all who are working together to support the infant and their family (including the parents and other family/ community members). The action plan is a live document and should be regularly reviewed with the family in order to track progress. The Cradle to Kinder practitioner, with the permission of the family, should ensure that the action plan and all relevant information is shared with those involved in supporting the family to achieve the goals specified in the plan. All family members should be given a copy of the action plan.

Using creative approaches to writing action plans with families helps them to engage with the plan, including:-

- Bringing some butchers paper, booklets or bright pens to planning meetings, so as to encourage families to write their own plan.
- Using pictures for parents who have low literacy
- Having plans translated for families who do not read English
- Using coloured stickers to help track their progress towards goal attainment
- Providing families with a personal diary so that they can record their progress towards achieving their goals

5.2.3.3 Action

The action phase of the model involves implementation of the plan and responding to unexpected situations that might arise over time. There is still much to learn about what interventions work best, especially when supporting parents with multiple and complex needs. Research suggests that the best outcomes are achieved if interventions are made up of multiple and interacting components. Programs should provide support and development for both the parent and the child, using a variety of materials and delivery methods to support learning and facilitate change (Katz, Spooner et al. 2006).

It is important that families participating in the Cradle to Kinder program receive interventions that are based on what we know works best. In a review of randomised trials that have shown best effects, Olds, Sandler and Kitzman (2007) identify the two most crucial components of successful programs as those that pay attention to engaging parents in the program and those that specify ways to bring about changes in parenting.

Frequency of contact

Evidence indicates that frequent contact is required early in the intervention in order to engage the parent with the service. As an approximate indication, initial contact with the family might be through twice weekly home visits and regular phone contact in between visits. The action plan should include an agreed plan for the type of contact and the frequency with which it will occur. Frequency of contact will vary throughout the period of a family's involvement with the Cradle to Kinder program and should be based on a consideration of issues that might arise for the child, their family and/or their community at different points in time.

Additional program support is likely to be required when the family is experiencing a crisis or a period of significant upheaval. There are known developmental periods in the early years when parents face increased challenges that can disrupt the whole family. Emotional, behavioural, motor and language development progresses in a dynamic and unique way for each child. Just before a surge in development in any one area, the child often experiences a temporary regression in the same or another area of development. If provided with information and support at these times of regression, parents have an opportunity to better understand their child's unique ways of managing developmental challenges (Brazelton and Sparrow 2006). For example, a period of frequent contact might be indicated during the time when a child starts eating solid food or begins to move independently. Less frequent contact might occur if the child is engaged in childcare and the parent is re-engaged in school or employment.

The intensity of contact with families is likely to reduce over the four-year period as parenting capacity and skills increase and other services are engaged as part of the child and family action plan. In order to ensure continued engagement with the Cradle to Kinder program, it is important that practitioners maintain regular contact with families throughout the extended intervention period of the program, particularly during periods of less frequent contact. At all times, service providers should rigorously review the frequency of contact with families, check levels of engagement with other services and monitor progress of the child. The level of contact must be adequate to ensure that the family are progressing satisfactorily and that the parenting being provided is adequate to support the safety, stability and development of the child.

Practitioners must ensure that a reduced level of program activity does not lead to premature case closure. Early closure may preclude the opportunity for the family to benefit from the longer term nature of Cradle to Kinder. It is important to remember that, as parents are building their self efficacy and reducing reliance on the parenting support provided by Cradle to Kinder, they may feel more able to engage in therapeutic interventions to address some of their personal problems. This phase might also provide an opportunity for further strengthening the parent's community links, particularly linking and supporting them into education, training and employment pathways.

Home visiting

Home visiting is not an intervention in itself but an effective way to deliver services to families who are less likely to engage in group or centre based activities. Home visiting also enables the practitioner to understand the family and community context for the family, individualise interventions based on family need and more readily engage partners and other family members in the intervention. There is evidence that home visiting is particularly important for parents who have learning difficulties, as it enables skills to be learned and applied where they will be used. Home visiting and other methods of assertively reaching out to connect with families assists in keeping families engaged in services so that they can benefit from planned interventions. Practitioners need to be sensitive to situations where families may not be comfortable with being visited in their home and offer alternative ways of delivering services to the family.

Group Programs

Most group programs that are reviewed and reported in the literature are parent training programs aimed at changing the behaviour, perspectives and attitudes of parents. Groups can be a powerful and effective way to deliver interventions. Practitioners need to be mindful of ensuring the group is accessible and engaging for parents. When working with families with multiple and complex needs, managing interpersonal relationships, behaviours and conflicts can be challenging. Challenging behaviours that are acted out in group sessions can act as a barrier to the continued engagement of parents with much to gain from the program. Parents can be fearful of being caught up in conflict situations and complex relationships. Parents who are working hard to stay on track and make positive changes in their life can be resentful of involvement with other parents who are still engaged in problematic behaviours, such as using illicit drugs.

Strategies for engagement need to focus both on explaining the group to parents and on how the group itself is conducted. Practitioners should clearly explain the group and its purpose and prepare parents for what to expect in the group. Being encouraging and open and removing any fears that parents may have about coming to the group is an important first step. The group itself needs to be conducted in a manner that privileges empathy, respect, honesty and a non-judgemental approach.

Some of the factors to consider when designing and delivering group based interventions are:

- Parents who lack confidence and self efficacy can be reluctant to engage in groups where their lack of knowledge might be highlighted and compared to that of other parents.
- Transport problems are one of the most common reasons parents give for non attendance at group- and centre-based parenting programs. This is especially relevant for newly arrived and refugee families who might lack confidence in knowing their way around and in using public transport with small children.
- The warmth and communication skills of the facilitator.
- The relevance of the content to participants is crucial to both recruiting and retaining parents in group programs. This is particularly relevant to engaging fathers. Facilitators need to be flexible in responding to individual learning needs within the group.
- The group can provide participants with the opportunity to connect with peers and form a social network. Evidence shows that participating in discussions with other parents helps parents gain knowledge, confidence and increased social support networks.

Group programs for parents and their infants provide an opportunity to work with the dyad and to model positive interactions that are led by the child.

A successful example of parent and child play groups for vulnerable families is Berry Street's Early Learning is Fun Parent Child Learning Groups (Boch 2012). Key elements of the groups include:

- Ensuring the group itself is fun. Playing and learning with infants and small children is the same thing. Playing and learning is enjoyable and rewarding for both parents and children.
- Strengthening attachment and attunement through play.
- Placing emphasis on the parent's role as teacher, thereby increasing parents' confidence in their role as the first teachers of their child.
- Facilitating child-directed learning.
- Building on strengths.
- Intentionally modelling and talking about play and learning approaches that emphasise the importance and value of attachment, attunement, self regulation, resilience and empathy, as well as encouraging playfulness.
- Encouraging empathy, self regulation and resilience.
- Modelling activities that encourage parents to be in the moment with their child, working alongside the child at his/her pace and taking his/her lead, offering a space that is calming, soothing, safe and comforting and checking in with the child about how they are feeling.
- Modelling a calming, non-reactive approach with both children and parents that aims to encourage feelings of safety and self regulation.
- Providing a calm and non-judgemental approach that allows both children and parents to explore new ideas and activities, make mistakes and try again. For example, practitioners convey the message that parenting is developmental, that we do not always get it right the first time and that we can keep trying.

The diverse and individual needs of women may make it hard for them to focus on their child's needs. Part of the role of the practitioners is to be able to identify what those needs and difficulties are and to address these and/or link with services within the local community that can respond to them. Women may come to the group primarily to meet their own needs. Practitioners need to understand and respond to parents' needs, as well as focus on the parent-child relationship and the learning, emotional and developmental needs of the children, understanding that children are sensitive and attuned to what is happening around them.

Key messages for practice identified in Berry Street's Early Learning is Fun Parent Child Learning Groups (Boch 2012) include:

- Providing a clear, regular and predictable structure for the group. This type of structure provides predictability, reliability and safety for participants.
- Allowing flexibility. Joining the group late is allowed and acknowledges the struggles parents may have in prioritising attendance.
- Being flexible with the number of participants, whilst acknowledging the possible difficulties that might arise in facilitating groups of more than ten or twelve families.
- Having a particular activity for each group (e.g. using photographs to capture and record images that can be used as reflective conversation prompts).

- Building a reflective aspect into the group process by offering dedicated time for joint reflection between practitioners and parents and by having a 'take home message' for each session.
- Using photography to convey play and learning in action, to track the journey of families over time, to assist in observation and to reflect on and celebrate achievements.
- Following up with parents who drop out.
- Checking in with parents is important to ensuring that their needs and expectations are being met.
- Taking time with ending the group and actively working to engage parents with universal services.

Evidence-based intervention strategies

When developing action plans with families, Cradle to Kinder practitioners should focus their efforts to bring about change in parenting in the following areas:

- Improving the quality of the infant-parent interaction and increasing the parent's capacity to understand the infant
- Helping parents to provide a consistent and stable care environment for their child
- Increasing the safety of the home environment
- Improving the home learning environment, particularly in relation to language acquisition

Infant-parent relationship building

Infant development takes place in the context of the infant's relationship with significant adults who are emotionally invested in them and who provide them with day-to-day care and attention. It is beyond the scope of this practice guide to discuss infant development in detail. A comprehensive understanding of child development is a core competency required of Cradle to Kinder practitioners so that they can support families to provide an environment that enables the child to reach their full potential. It is essential that practitioners link families to and consult with maternal and child health services, GPs and other child development specialists throughout the Cradle to Kinder program. This ensures that the child's development is monitored and any additional support that may be required can be provided as soon as concerns are identified.

Development takes place across a number of domains during early childhood and is influenced by physical, emotional, social, spiritual and cultural factors. The child's opportunity to develop a warm, intimate, reciprocal and continuous relationship with a primary caregiver who he/she trusts will consistently meet his needs is the blueprint for learning about self, for understanding and trusting others and for making sense of the world. A parent needs to be both physically and emotionally available in order to respond promptly to their child's needs. When difficulties arise in the parent-infant relationship, all aspects of development can be impacted but particularly the infant's social and emotional development.

From its inception, both the parent and the child mutually contribute to their relationship but, in the early stages of development, the characteristics of the parent have a greater influence on the quality of the relationship than the characteristics of the child. Bowlby (1969) described this as the attachment figure being stronger and wiser than the attached person. It is important for interventions in the early childhood period to pay attention to building positive infant-parent relationships and to influencing the development of attachment security for the infant.

Attachment security is closely linked to indicators of positive mental health for infants and children: increased levels of empathy, higher levels of self esteem, the ability to relate positively to parents and peers, improved readiness for school and learning and the capacity to regulate emotions.

Characteristics of the parent

For secure attachments to develop, parents must accurately interpret the infant's emotional signals, respond to them sensitively, display warmth and affection, understand and accept their infant's behaviour and feelings and be physically and psychologically available in response to the child's distress. Daniel Hughes (2009) describes the characteristics of the parent's attitude that are crucial to the facilitation of attachment security, a positive parent-child relationship, rich and beneficial experiences for both the parent and their child and the overall development of the child. Hughes summarises the qualities that parents need to develop under the acronym PLACE:

- ***Playful:*** interactions are characterised by rhythms, movement, laughter, exaggerated facial tones and variations in voice tones and inflection ("a sing-song voice"). There is energy in the interaction that brings both the infant and the parent to life.
- ***Loving:*** the underlying attitude of the parent is one of unconditional love and wanting the best for the child. Love is conveyed in non-verbal ways through facial expression, gaze, body language, touch and a desire for closeness. Love is communicated verbally in voice tone and intonation. Words are also used to express love and affection.
- ***Accepting:*** the parent accepts and loves the child for who she is. There is no need to judge her and try to change her. Her behaviours are accepted even when they pose challenges for the parent. Safety for the child is enhanced when her inner self is not at risk of rejection, ridicule and disappointment in the way that her parents relate to her.
- ***Curiosity:*** before birth, parents are curious about who their infant is and, after birth, observe the baby's appearance, movements, body rhythms and gaze. The parent is curious about new developments and notices the infant's special qualities and abilities. The parent discovers and comes to know the infant, positively impacting on the infant's discovery and understanding of self. For example, when a parent is excited and animated in response to the child, the parent communicates to the child that she is interesting and lovable and the child comes to know that she has those attributes.
- ***Empathy:*** the parent is able to understand and reflect the emotional states of the child and is able to feel the emotion with her. The parent shares and expands on positive feelings and acknowledges and provides support in response to negative experiences. The parent uses clear facial expressions, body movements and voice tone and inflection to communicate that she understands the child's emotional experience. It is through this playing back of the child's experience that the child learns to understand her emotions and regulate her own behaviour. The parent does not need to be able to fix the problem for the child, but is present to help the child manage the problem.

Characteristics of the child

From birth, babies communicate their needs and feelings with body language and vocalisation. These are referred to as 'cues'. The child contributes to the reciprocal relationship with his/her parent by giving clear cues about what he/she needs and then provides cues to convey back to the parent the success or otherwise of their efforts to meet those needs. When babies are

responded to promptly and sensitively, the child learns that they can successfully communicate their needs, can rely on and trust their parent to meet their needs and feel loved and cared for. The child's cues are enhanced and reinforced by the parent. When babies respond positively to their parents' responsive care giving, the parent gains confidence that they are able to care for their baby competently.

Just as not all parents find it easy to identify, understand and respond sensitively to their baby's cues, some babies do not provide clear cues to their parent or their cues are hard to read. Babies who are born with complexities such as prematurity, medical or genetic problems, exposure to alcohol and other drugs in pregnancy and/or developmental delay can have difficulty giving clear cues to the parent. These babies are more likely to have low birthweight, difficulty with feeding, excessive sleepiness, irritability and difficulty in being soothed. This can make reading their cues and knowing how to respond to them much more challenging for parents. Sometimes the baby needs to remain in hospital for prolonged periods after birth and might be cared for in an incubator. Vulnerable parents can find this situation frightening and overwhelming. Transport difficulties can preclude them from visiting the baby as much as they might wish. Fear of the baby's condition and lack of confidence in handling and caring for an unwell or fragile baby can play a role in their emotional and physical availability, therefore impacting on the attachment relationship. Cradle to Kinder practitioners can play a critical role in advocating for the parent and helping them understand what is happening at this time. It is important that the parent is given every opportunity to understand and learn how to manage the care needs of the baby following discharge from hospital.

Babies are born with individual personality traits or temperament that influences their perceptions of the world, their responses to those perceptions, their sensitivity, their responses to new situations, their activity level, their predictability, their adaptability and their ability to persist (Kurcinka 2000). A child's temperament is also a major factor in how easy or difficult the child is to care for. When children have a difficult temperament, even the most competent and confident parent can be challenged. The "fit" between the parent's own temperament and the child's and the parent's ability to understand and adapt their parenting accordingly is what helps.

Practitioners need to think carefully and analyse the individual elements of the parent-child interactions as they work with families. The NCAST Parent-Child Interaction (PCI) scales provide a framework for understanding the contributions from both the adult and the child. The scoring of the scale helps the practitioner to identify the areas of strength and weakness for both the parent and the child and provides a guide for where to focus the intervention (NCAST Programs 2012). See section 5.2.3.4 for more detail regarding implementing the NCAST scale.

Symptoms of infant-parent relationship difficulties often present as common child behavioural problems, such as feeding, sleeping and settling problems for infants and toddler behavioural problems. After careful exploration and elimination of other possible causes, the practitioner should work sensitively and respectfully with the parent in order to shift the focus of the intervention away from the perceived 'problem' behaviour in the child towards the underlying attitude and understanding of the parent.

There are a variety of interventions underpinned by attachment theory that have demonstrated effectiveness in improving the quality of the infant-parent relationship. The following are core components of these programs (Cohen, Lojkasek et al. 2006):

- Providing a context for physical and emotional interaction between the parent and the child
- Focusing on the emotional signals from the infant and building the parent's sensitivity and capacity to respond to these signals
- Providing a context for playful interaction where the infant can lead and explore the relationship with the non-intrusive parent
- Recognising that the relationship between the therapist and the parent forms a secure base from which to work through the relationship difficulties, acting as a model for the developing infant-parent relationship

Video interventions

The use of video in reviewing parent-child interactions has become increasingly prevalent in interventions with families who have young children (Miron, Lewis et al. 2009). There are several different methods to guide video interventions.

Interaction guidance (McDonough 2000) was initially designed to engage families otherwise considered 'hard to reach'. It has been shown to be an effective intervention in helping parents understand and process their infant's communication (Mares, Newman et al. 2005). The observed interactions between the infant and their caregiver are understood as a reflection of their relationship more broadly. The relationship becomes the entry point for intervention.

The goals of interaction guidance are (McDonough 2000):

- To increase caregivers understanding of their child's behaviour and developmental capability
- To encourage and build the caregivers confidence in their role of parent to the child
- To increase the enjoyment of the caregiver and the child in their interactions

Interaction guidance uses a videotaped, short free-play interaction between the infant and their caregiver or a family interaction. The videotape is then viewed and reviewed with the family to highlight, acknowledge and build on strengths as well as to identify the more challenging aspects of the interaction. The therapy designed by McDonough (2000) was delivered in weekly, one hour sessions with six minutes of the play interaction recorded at each session.

The use of the NCAST PCI Teaching Scale as an outcomes measure in the Cradle to Kinder program provides an opportunity for using the videotaped interaction to guide the development of positive parent-child interactions, in addition to scoring the quality of the interaction. The NCAST PCI scales are designed for scoring the interactions between one caregiver and the child so that the elements of the interactions can be analysed and dealt with on an individual basis. The use of more broadly recorded footage to support reflective conversations and learning with parents is an important core element of effectively delivering the Cradle to Kinder program to families.

Some families and practitioners can be hesitant about taping family interactions. The following strategies may be helpful for practitioners:-

- Start by using videotaping capacity on smart phones or handing the camera to the parent so they can capture some footage
- Be playful and creative in order to build confidence
- Make an assessment about how parents might respond to the idea of being taped and go slowly until confidence and trust is developed, especially if either the infant or caregiver is feeling overwhelmed by the situation

Most practitioners find that, once the parents have trust in the process of having their interactions recorded, they find it a very helpful tool that enables them to sit back from the interaction and understand and learn about their child and their parenting behaviours.

It is possible to record and explore interactions that involve more than one caregiver. This might be very useful to help explore and discuss perceived differences in how infants respond to individuals. For example, a young parent who is struggling to establish a relationship with their infant can feel undermined when they see their infant responding positively to a grandparent or practitioner. Playing back a videotaped interaction can be used to highlight moments when the infant responds positively to the young parent and used to explore what others might do to elicit a response from the infant. This helps parents to understand their infant's capacity for interaction and also offers the opportunity for the young mother to try out this behaviour for themselves.

It is useful to record the interaction in a context that is as close as possible to what is usually happening for the family, as this enables the worker to assist in addressing any concerns related to the individual situation for the family. For example, older siblings can demand a lot of attention that makes it difficult for caregivers to provide one-to-one attention for the infant. Using recorded episodes can help bring this to the attention of parents, help them identify and build on positive behaviours and make plans for balancing the demands of multiple children.

After sitting with the family to view the tape, it is helpful to get the parents to provide their perception of the interaction. It is useful to use questions to get an overall impression of the interaction, such as: In what way was this interaction the same to how it normally is? What was different about it? How did you feel about this play time? What did you notice most about it? How do you think it was for your child?

It is essential to highlight and explore the positive aspects of the interaction first, starting with those noticed by the parent if possible. The practitioner might then replay the tape, noticing particular aspects of the interaction, exploring what was happening for both the parent and child and how the parent may have been feeling at that moment. It is important to explore what the parent thinks the child was doing and feeling at this time. After spending time noticing and highlighting positive aspects of the interaction, the practitioner should follow the lead of parents with respect to less helpful aspects of the interaction.

Watching a taped interaction enables parents to themselves see, identify and raise the more challenging aspects of the interaction. This reduces the tendency for defensiveness if raised by the practitioner. If the parent does not raise any areas for development, the practitioner can use strategies such as asking about anything the parent would like to see change about the interaction or stopping at a point where the practitioner has noticed an area for development (e.g. the parent not being sensitive to an infant cue) and exploring the parent's perception of what occurred. The aim is not for the practitioner to use their authority and offer instructions but rather to use their experience and knowledge to sensitively explore the parents' perceptions of the interaction. The aim is also to encourage the parent to think about what is happening for their baby and the impact of their parenting behaviour on him/her, whilst offering possible alternatives that they can try in the future.

An important aspect of interaction guidance is to observe changes in the interaction over time. By capturing positive changes in the way infants and caregivers interact, the practitioners can highlight and acknowledge positive change. Most importantly, the caregiver can see these

changes for themselves. The scores across the different subsets of the NCAST PCI Teaching Scales enable the changes in the quality of the parent-child interaction to be measured. It is also valuable to give parents edited copies of the interactions, so they can observe changes over time. The recordings also act as a reminder of the positive aspects of their relationship with their child.

At times, the exploration of thoughts and feelings as part of reviewing a video tape can bring up traumatic issues from the past for parents. It is these representations of past relationships and traumatic events that can impact dramatically on how caregivers see and relate to their child. Interaction guidance and exploration of videotaped interactions can help to identify issues and assist parents to engage in therapy to heal from past trauma. Referral to an infant mental health professional can provide an opportunity for relational and direct therapeutic work with infants.

Case Study 3

Amanda and Brenda had been working with Cradle to Kinder since Brenda was seven months pregnant. By the time Amanda was 14 months of age, the family's situation was reasonably stable although they had experienced significant difficulties in the past. Amanda's father was very violent towards Brenda. The violence started when Brenda became pregnant and only stopped when Child Protection indicated that they would need to place Amanda in care if the violence continued. Brenda had a history of initially engaging with family violence services before then disengaging and returning to the violent relationship. The Cradle to Kinder practitioner had worked closely with Brenda in supporting her to attend the family violence program but there had been only intermittent success.

When Amanda was 12 months of age, she started walking. Around the same time she started to say 'no' to her mother and assert her independence. Brenda found this very difficult to manage and complained to the Cradle to Kinder practitioner that she was being 'oppositional'. The practitioner explained to Brenda the developmental processes occurring at 12 months, in relation to separation and asserting independence. Some interaction guidance occurred with Brenda and Amanda, where they were asked to play as they would at home and were filmed for five minutes. During the play session, Amanda was playing with blocks and banged them together loudly. Brenda had two blocks and banged them too, and then started to build them into a tower. Amanda copied Brenda but had difficulty getting her blocks to balance. Brenda tried to help Amanda but Amanda became frustrated and pushed the blocks away. Brenda scolded her and Amanda started to cry. Amanda looked away from her mother. Brenda said, 'Oh, I'm sorry. Come here' and pulled her to her lap for a cuddle. This sequence was replayed and Brenda was struck by how crushed Amanda looked when she scolded her, but also by how disappointed Brenda herself looked when Amanda refused her help. These feelings were discussed and Brenda revealed how important it was to her sense of being a good mother that Amanda accept her help. At the same time, also she could also see how much Amanda wanted to build the tower herself. Brenda could also see from the video how much Amanda needed her help when she was upset.

The following are examples of other evidence based programs that use video-assisted reflection with parents.

Watch Wait and Wonder is an empirically proven method that has been refined over many years and implemented in response to a range of child relational, behavioural, regulatory and developmental difficulties. It is a child-led, psychotherapeutic approach aimed at enhancing caregiver sensitivity and responsiveness, at building the parent-child attachment relationship and at increasing the child's sense of self, self-regulation and self-efficacy. The context for the therapeutic intervention is a free play session where the parent takes the lead from the child and is helped by the therapist to be reflective about the child's feelings and capacities. The intervention helps the parent to understand the infant as a separate individual, as well as her/his own parenting responses to the child. Watch Wait and Wonder is recommended for children over the age of 4-6 months when they are capable of independent movement. More information is available from <http://watchwaitandwonder.com>

Circle of Security is an evidence-based, early intervention program designed and evaluated by Marvin Cooper, Hoffman and Powell (2002) for child and caregiver dyads in the Early Head Start initiative in the US. The program was developed to prevent insecure attachment and mental health disorders and has been trialled with high risk populations. The program engages parents and uses visually based materials (i.e. graphic illustrations and videotaped examples of parent-child interactions) to help parents understand the needs of their child. The Circle of Security intervention is 3-4 months in duration and comprises a group learning component, alongside home visits for exploration of individual assessments, setting individualised treatment plans and reviewing taped interactions. More information is available from <http://circleofsecurity.net>

Promoting First Relationships is an intervention based on attachment theory that uses a strength-based and reflective process to promote self-growth and change for parents (Kelly, Zuckerman et al. 2008). The program is designed to equip service providers with effective strategies, practical tools and in-depth, evidence-based information to help them build the capacity of parents to develop secure and healthy relationships with their infants and toddlers. The program integrates elements of NCAST, Circle of Security and interaction guidance and provides the practitioner with helpful reflective practice prompts. More information is available from <http://pfrprogram.org>

Practical parenting skills building

Establishing consistent daily routines

Children's healthy development is influenced by values and cultural practices that create difference in how parents and families emphasise aspects of development or developmental tasks for their child. How parents support exploration, place limits on behaviour and value independence differs greatly. In some cultures, greater importance is placed on gaining independence, whereas in other cultures there is greater importance placed on encouraging the child to be more reliant on the adult care-givers. Whatever the cultural and family context, however, the emotional relationship with parents and the provision of a consistent, predictable and safe care environment provide the stable and secure base from which the child can safely explore their environment, learn new skills and take on new challenges without fear as they progress towards autonomy.

Establishing daily patterns and routines for babies and toddlers is an important way that parents assist children to regulate their behaviour. Regular daily patterns help to reinforce a predictable world and create safety and stability for young children. Knowing what will happen each day, with whom and where, is comforting for children and can also help them heal from stressful and traumatic experiences. As children develop, knowing about their daily routines helps them to take on more responsibility, increase their capacity to manage their feelings and make autonomous decisions.

Having a daily routine does not mean that families have to conform to a rigid and inflexible schedule, rather it enables the development of consistent daily patterns that helps the child understand his or her world. Establishing consistent daily patterns is quite challenging for some families whose lives are characterised by chaos. It is important to remain flexible and sensitive to the individual needs of the family, whilst also helping them to understand the role that establishing consistent daily patterns provides in creating a predictable and secure base for their child's development.

Many parents experience difficulties around creating routines around feeding, sleeping and settling behaviours. These are the most common problems that lead parents to seek support from child and family and early parenting services. Unsettled behaviour in infants can be a complex problem and requires careful attention to detailed information gathering and observation, in partnership with families. Practitioners need to be alert to the possible health causes of unsettled behaviour, as well as understanding the dynamic of the parent-child relationship. Children exposed to substances during pregnancy or who are born with low birth weight or prematurely can all struggle with behaviour regulation after birth and have a greater need for co-regulation support (Lillas and Turnball 2009). This is further exacerbated when parents also have regulation difficulties of their own, as a result of mental health problems, problematic alcohol and drug use, family violence and/or past trauma. These vulnerable parents have fewer resources to co-regulate their child and to learn how to support their child's disrupted rhythms.

'Controlled comforting' or 'controlled crying' are terms used to describe the strategy that has been found to be helpful in teaching young children how to sleep and self-settle. Whilst evidence has not found any harmful effects from implementing controlled comforting, care must be taken by Cradle to Kinder practitioners to choose a strategy that is a good fit for families. Teaching a child new sleep behaviours must be part of a broader approach that looks at other aspects of what is happening for the child throughout the day. Learning new skills takes time and persistence for both the parent and the child. The problem will usually worsen before it improves, whilst crying will often escalate in the interim. Parents who are overwhelmed, experience high levels of stress and have poor impulse control are less likely to be able to implement these strategies. Escalation of the crying can act as a trigger for an angry outburst that places the child at risk of physical harm. Parents who have not developed a strong relationship and commitment to their child may avoid interactions with their child by keeping them in the cot for long periods under the guise of implementing sleep routines.

Maternal and child health nurses and early parenting services provide up-to-date information and support for families regarding age appropriate daily routines for infants and toddlers, as well as providing support to parents in understanding the dynamic of their relationship with their infant. Early parenting services provide a range of parenting education and support services, including residential and outreach programs, that can provide the additional and

intensive assistance that vulnerable families may require to implement consistent routines around sleeping and meal times. Early parenting services can provide consultancy and professional development opportunities for Cradle to Kinder practitioners around strategies to respond to sleep, settling and other behavioural problems.

The Cradle to Kinder practitioner needs to be alert to the infant who is described and presents as a "good baby". Babies who are quiet, who do not demand much attention from the parent and who sleep for long periods can be a cause for concern and a sign that the child has given up on getting a response from the caregiver. Perry (2001) describes this as the "dissociative continuum". Infants use a range of cues to get attention from their caregiver and when the caregiver responds with comfort and nurture, the infant learns that the signals they have used are successful. When children do not receive a response that meets their needs or the response is not timed in relationship to (contingent with) their signals, the infant experiences these signals as unsuccessful and stops using them. Interpreting the behaviour of infants and responding in a way that meets their needs is difficult for most new parents but, for vulnerable parents who lack the support of family and community, who struggle with their learning and who are juggling other complex challenges, it can be highly complex and require careful support and education.

Responding to behaviour

The period of early childhood is when young children are learning to regulate their emotions and behaviour. The early care environment has a major influence on emotional and behavioural development, particularly the social and emotional relationship between the infant and the parent. There are many characteristics of the child that parents do not have control over but that may influence child behaviour, such as temperament, intelligence and personality. The aim of any parenting intervention is to help parents to accept the child for who they are, to understand their child's individuality and to adapt their parenting to better "fit" with the child. Studies have highlighted problem solving capacity and accurate perception of the child's capability as the key elements of adaptive parenting (Watson, White et al. 2005).

Supporting parents to prevent behavioural difficulties in their young children commences at birth. As well as strengthening the parent-child relationship, increasing parents' understanding and empathy for their child and providing a consistent, predictable and nurturing care environment, practitioners can assist parents to implement a range of strategies to encourage positive behaviour. These strategies include:

- Creating opportunities for positive interactions by keeping children interested and stimulated. Parents can be assisted in understanding age appropriate activities, how to make low cost toys and how to access free activities. Keeping the child busy with age appropriate activities they can do with parents and alone, reduces the need for children to escalate behaviour to get attention. Providing safe activities also allows children the opportunity to explore and lessens the need for the parent to repeatedly say 'no' or 'don't'.
- Reinforcing positive behaviour by noticing and rewarding it with praise, reward charts and special activities. This can be challenging for busy and overwhelmed parents, where the tendency is to leave the child alone when they are being well behaved and provide attention only when the child escalates their behaviour to a point where the parent feels forced to react. Teaching parents from birth how to respond to the child's engagement cues, whilst engaged in a playful activity that teaches the child skills and supports development, is reinforced with the use of the NCAST teaching tool.

- Helping parents to learn gentle ways of teaching children what they can and cannot do. Parents can be supported in understanding what their young child is capable of at different ages. Unrealistic expectations can also be gently challenged. Parents can also be provided with new parenting strategies, such as distracting infant's attention onto a positive activity, getting down to the toddler's level and/or giving simple and calm explanations of what is expected of them. Using short periods of time out can assist with managing challenging behaviour in older children but encouraging parents to be involved with their children or using "time-in" is usually advisable for parents who are less likely to give their child positive attention and stimulation.
- Planning for managing situations where difficult behaviour is more likely to occur, such as in supermarkets or appointment waiting areas. Practitioners can accompany parents on such outings, thereby creating an opportunity to learn and practice strategies to prevent escalating behaviour in these settings.

Behavioural concerns

Both the caregiver environment and parenting practices have a direct influence on infant and toddler pathways to behavioural problems (Barlow and Parsons 2003). The parent-child relationship and attachment security is the most important predictor of emotional and behavioural outcomes for children. There are, however, a broad range of parent, child, family, social and economic factors that place children at risk of behavioural disorders (Centre for Community Child Health 2006).

Tremblay and colleagues examined the precursors to aggressive child behaviour and found that most children initiate the use of physical aggression in infancy. The changes and challenges children face during the early years of development elicit some strong feelings that are often expressed physically, prior to the development of verbal skills. Aggressive behaviour usually peaks between the ages of two and three years, when children are able to express their will and parents begin to set rules and limits for behaviour. Whilst physically aggressive behaviour is innate, most children learn to regulate their use of physical aggression and develop alternative methods in the pre-school years, mediated by the care-giving environment. In fact, children are likely to be 'socialised out' of being physically aggressive, rather than acquiring physically aggressive behaviour during their childhood. Tremblay uses this research to argue strongly for targeted parenting interventions, focused on behaviour management, in the early childhood period.

Expressions of aggression, such as tantrums, biting, kicking and hitting, are part of normal development in young children. It is important to discuss children's behaviour with parents and help them to promote positive behaviours, to develop realistic expectations and to set appropriate limits. When aggressive behaviour is extreme, prolonged and potentially harmful or dangerous, more intensive behaviour interventions are indicated. Problem behaviours are often reinforced and a dysfunctional and coercive pattern of parent-child interactions emerges. Parents are often inattentive, give in to wilful behaviour and/or only respond when the child's demanding behaviour escalates. Over time, therefore, the problem behaviour is reinforced, escalations increase and parents respond with punitive and harsh discipline, in an attempt to manage the behaviour.

There is evidence that parenting programs, aimed at teaching parents behaviour modification techniques, have been successful in preventing and reducing a range of problem behaviours and aggression in children. The implementation of behaviour modification programmes with

families whose children are at risk of developing behaviour disorders is important, as problem behaviours in the early years are very common, can persist for a long period of time and usually worsen over time. These programs are built on social learning theory, a theory informed by an understanding that children's behaviour influences and is influenced by their parents' behaviour.

Effective interventions for preventing and managing behavioural concerns in early childhood

Both the Triple P and Incredible Years programs have evolved over 20 years and have developed parenting interventions that are considered empirically proven treatments for children who are at risk of or are developing a behavioural disorder (Watson, White et al. 2005; Centre for Community Child Health 2006).

Triple P is a behaviourally based family intervention, that is derived from social learning principles and that has been widely implemented across a range of family circumstances and in response to a range of child behavioural problems, both in Australia and overseas. Triple P was designed and developed in Australia and is therefore consistent with the Australian context. It is a multi-level intervention, aimed at preventing severe emotional, behavioural and social problems in children by enhancing the knowledge, skills and confidence of parents (Sanders, Cann and Markie-Dadds 2002). Triple P incorporates five levels of intervention on a continuum of increasing intensity based on varying levels of dysfunction and behavioural disturbance in parents and children. The program has also been developed to target five developmental stages, including three periods relevant to children involved in the Cradle to Kinder program: infants, toddlers and pre-schoolers. The program incorporates five principles of positive parenting:

- Ensuring a safe and engaging environment
- Creating a positive learning environment
- Using assertive discipline
- Having realistic expectations
- Taking care of oneself as a parent

Further information is available from <http://www10.triplep.net>

The Incredible Years are a series of research based parenting programs that have been proven to reduce children's aggression and behaviour problems, whilst increasing their social competence. The programs were designed to prevent and treat behaviour problems when they first appear in the toddler and pre-school years through to middle childhood. The program is based on cognitive, social learning, self efficacy and relationship building theories and uses video modelling in a group setting as the primary mode of intervention. The Incredible Years has developed an extensive library of taped parent-child interactions that show both effective and ineffective parenting interactions. The taped vignettes are used in facilitated group discussions, in practice sessions, as part of collaborative learning, for peer support, to encourage self reflection and to facilitate the development of problem solving skills. The Incredible Years program was designed and developed in the USA but has been successfully adapted for European, New Zealand and Australian contexts. The program targets four phases of development relevant to children in the Cradle to Kinder program, including infancy (6 weeks to 1 year), toddlers (1-2 ½ years) and preschool (3-5 years).

Other resources:

Raising Children Network: The Australian parenting website at <http://raisingchildren.net.au/> *Centre for Child Community Health: Practice resources*. The Centre for Child Community Health has developed eleven practice resources that aim to broadly translate the research evidence on a number of important parenting issues (e.g. breastfeeding, eating behaviour) into easily understood practical information that can be readily used by a range of professionals, assisting their daily work with young children and their families. The practice resources are available at <http://www.rch.org.au/ccch/profdev/Practice_Resources/>
Tuning in to Kids is six-session group parenting program that helps children learn to understand and regulate their emotions. Further information is available at <http://www.tuningintokids.org.au>

Providing a safe environment

Safe sleeping strategies

The implementation of safe sleeping strategies has been shown to have a major impact on reducing the risk of Sudden Infant Death Syndrome (SIDS). Despite a major public health prevention strategy, the risk of SIDS remains high in some groups, particularly families involved in Child Protection interventions (Department of Human Services 2012). An essential activity for Cradle to Kinder practitioners is to provide direct support to parents to ensure they understand the importance of implementing strategies to reduce the risk of SIDS for their child. Practitioners should sight infant sleep arrangements and, where required, provide clear information regarding safe sleeping strategies, ensure adequate understanding of the information and, where necessary for implementing the strategies, provide material support. Information should be recorded in case records that describes the actions practitioners have taken to support parents to reduce the risk of SIDS, as well as the response of parents to their intervention. The children's sleep arrangements and the SIDS risk assessment should be reviewed frequently during the first two years of the child's life. Flexible support funding might be needed to assist families to purchase a cot that meets approved safety standards. Up-to-date and evidence-based information and resources in different languages are available on the SIDS and Kids website (<http://www.sidsandkids.org>)

Parents and others providing care for the infant need to know and understand how to reduce the risk of SIDS. The following should be considered (SIDS and Kids):

- Make sure that, from birth, the baby always sleeps on their back, not on their side or tummy.
- Sleep the baby with head and face uncovered
- Avoid exposing the baby to cigarette smoke both before and after birth
- At any time when the baby sleeps, night or day, provide a safe place to sleep. The safest sleep environment is a cot, portable cot or bassinette that meets Australian safety standards with a firm and well-fitted mattress. The baby should be placed with their toes at the foot of the bed and bed clothes tucked in at chest level. There should not be other things in the cot, such as any loose toys, pillows, bumpers, extra padding and other objects that can clutter the cot and cover the babies face.
- Babies should not be left unsupervised to sleep in strollers or bouncinettes.

For many families, including Aboriginal families, whose cultural child rearing practices include the baby co-sleeping with adult caregivers, discussing and supporting care-givers to adopt a safe sleeping environment for their baby requires sensitive and skilled communication.

Most parents have their baby in their bed at some time. Current evidence has shown that it is the circumstances in which bed sharing occurs, rather than the bed sharing itself, that constitutes a risk of SIDS or of a sleeping accident occurring. SIDS and Kids recommends that, for the first 6-12 months of an infant's life, that they sleep in a cot placed next to the parents' bed so that parents can respond promptly to their child. This has been shown to reduce the risk of SIDS (SIDS and Kids).

It is **not safe** for parents to share a sleep surface with their baby:

- If either parent smokes
- If either parent is under the influence of drugs, alcohol or sedation or in any situation where a parent might be excessively tired.

If, after careful discussion and consideration of the risks, parents do choose to share a sleep surface with their baby, it is important that they still adopt safe sleeping strategies to reduce the risks of SIDS or a sleeping accident from occurring, including:

- Sleeping the baby on their back from birth.
- Placing the baby alongside one parent, not in the middle of the bed between parents.
- Not wrapping the baby, as this restricts arm and leg movement. A baby sleeping bag is a better option.
- Ensuring the mattress is firm and keeping bedclothes away from the baby's head and face.
- Ensuring the baby cannot fall off the bed or get trapped beside the mattress and the wall. Placing the mattress on the floor and keeping it away from the wall might help.
- Not leaving babies to sleep unsupervised on an adult bed.

Preventing Shaken Baby Syndrome

Shaken baby syndrome is not an uncommon cause of death and injury in infancy and is a severe and preventable form of physical child abuse. Shaken baby syndrome has catastrophic consequences, ranging from death, severe developmental delay, cerebral palsy, blindness to seizures. Shaken baby syndrome has been adopted as the basis of a primary prevention campaign in Victoria, with all new parents provided with information about shaken baby syndrome in birthing hospitals and as part of well-baby visits by Maternal and Child Health Services.

Children are most at risk of being shaken in the first 12 months of life but the period of greatest risk is between two to four months, when crying peaks. The most common perpetrators are parents and their partners and the trigger is usually inconsolable crying. Inconsolable crying is part of normal infant behaviour. The problem is how the caregiver responds to the crying. Cradle to Kinder practitioners play a key role in educating parents about the dangers of shaking babies, as well as in supporting parents with strategies to respond to infant distress and to develop safe ways of managing their own stress. Male parents and partners are more likely to shake babies, therefore engaging fathers and male partners is paramount. The presence of a new adult partner in the home is a period of increased risk of abuse for the child.

Strategies to prevent shaken baby syndrome include:

- Discussing with parents normal patterns of development and crying for infants and reassuring parents that most parents find this difficult. Babies can appear to be in pain and crying bouts can be intermittent but usually increase in the evening. Bouts of inconsolable crying usually peak between two and four months of age and start to improve from 5-6 months.
- Reinforcing how to respond to crying by first checking for a parent's understanding of the most common reasons why babies cry, such as tiredness, hunger and wet/dirty nappies.
- Helping parents to implement regular sleep and feed routines.
- Teaching parents how to know when their child is unwell, who to call and where to go for medical advice and treatment.
- Discussing with and helping parents to make a plan for how to manage situations when they feel frustrated and cannot stop their baby from crying.
- Encouraging parents to seek therapeutic treatment to address poor impulse control and anger management issues.

Safety in the home

Children are particularly vulnerable to different types of injury, depending on their stage of growth and development. This vulnerability is dependent on a combination of factors - the child's developmental stage, exposure to environmental risk factors and the presence of protective factors (Towner and Dowswell 2002). Most injuries to young children occur in the home as that is where young children spend most of their time. The majority (i.e. 54%) of children injured at home and requiring hospital treatment are aged 0-4 years (Royal Children's Hospital 2009).

In a recent study exploring maltreated children identified in health data sets, Schnitzer, Slusher, Kruse and Tarleton (2011) found that burns, poisonings and drowning-related injures to children under four years of age were frequently preventable and occurred in the absence of appropriate protective factors, particularly supervision by parents.

There are many aspects for parents to consider in providing a safe environment for their baby and toddler. Safety needs change rapidly as the infant grows and develops his/her capacity to explore and move independently in their environment. Close adult supervision is an important aspect of reducing the risk of injury to young children. Vulnerable families often, however, face additional challenges in supervising their children due to their lack of access to resources and safety products and the distraction of stresses and anxiety due to the concerns of everyday living (Scott, Higgins and Franklin 2012). Using home check-lists to raise parents' awareness of safety, assisting parents to install practical safety aids and modelling child safe parenting practices are key activities of the Cradle to Kinder program.

The most common causes of injuries to young children are:

- Poisoning
- Burns
- Finger jams
- Dog bites
- Falls
- Near drowning

There are excellent resources available to guide practitioners in supporting families to implement strategies to increase safety and reduce the risk of preventable injuries for their children. Using a safety checklist to help parents identify potential hazards in their home and community environment is a helpful way to raise awareness, identify issues and plan to address safety needs.

Practice resources, including a safety checklist and parenting tip sheets based on current best evidence, are freely available on a number of websites including:

- Royal Children's Hospital, Melbourne <http://www.rch.org.au>
- Raising Children Network <http://www.raisingchildren.net.au>
- The child accident prevention foundation of Australia: Kidsafe <http://www.Kidsafe.com.au>

The existence of factors such as family violence, alcohol and other drug misuse and mental health issues frequently co-exist and are common in families involved in Child Protection interventions. These factors have considerable impact on the safety of children and are discussed in section 5.4.5 below.

Safety around other adults

Helping parents think about and plan for how to keep their child safe from others is an important aspect of reducing the risks of abuse to children. Parents who are confident in their caring role may be more able to assert themselves with others and protect their child from harm. It is important for practitioners to raise and discuss with parents their role in keeping their child safe from others. Although this is often a difficult topic to discuss, practitioners' ability to talk openly with parents acts as a model for how they can have these conversations with their children as they grow. Raising parents' awareness and equipping them with knowledge and information helps them to feel more confident and assertive in keeping their child safe. It is important to explore the thoughts and perceptions of the parent regarding their role in protecting their child from abuse.

A parent's own experience of sexual abuse can impact on their response to keeping their own child safe. Some parents might not have talked to others about their own experiences and carry the shame of what happened to them. Some might feel helpless and anxious about their capacity to protect their child when they were not protected themselves.

Helping build parent's confidence and capacity to protect their child begins in the early years and includes:

- Encouraging parents to think about the safety of other people who have access to their child and developing a safe network for their child. Do they have any concerns about other family members and friends? Are there members of the family or social connections who have a history of criminal or sexual offending? Parents can be very concerned about the consequences of speaking out against family members so it is important to help them identify people who they consider safe to leave their child with.
- Coaching parents to carefully watch the behaviour of other people when they are around their child (e.g. watching for behaviours such as inappropriate handling and touching). It is helpful to encourage parents to trust their feelings and, if they feel uncomfortable about something, think about why they feel uncomfortable and talk to someone they trust to deal with the problem.

- Providing parents with information about possible indicators of abuse, such as unexplained bruising and lacerations, redness and bruising around the genital area, preoccupation with and increased displays of sexualised behaviour, increase in distress and/or unusually withdrawn behaviour.
- Teaching parents that close supervision of their child is the most important thing they can do to keep them safe from harm. Parents who use alcohol and drugs need to think about how their substance use might impact on their ability to closely supervise their child and how it may expose their child to others who might pose a risk.

Even in the pre-school years, parents can start to equip their child with the skills to help keep themselves safe from sexual abuse by:

- Using proper names for body parts and using these terms in conversation with the child. Evidence shows that children who know the correct names of body parts are less likely to be tricked into sexual games and more able to raise concerns with a trusted adult.
- Maintaining boundaries around privacy in the home, such as providing privacy for the child when toileting and bathing.
- Teaching the child about 'right' and 'wrong' touch. Although young children do explore their bodies as a normal part of their development (e.g. holding their genitals and occasional masturbation), this behaviour should occur in the context of a safe, playful relationship with peers of the same age and intellectual functioning.
- Teaching the child that their body is their own and respecting the child's right to be assertive and say 'no' if they do not want to be hugged, kissed and held by someone. Sex offenders are less likely to offend against a child who is assertive and says 'no' to inappropriate touch.

Resources

<http://www.childwise.net/images/stories/documents/online_publications/WiseUp_to_Sexual_Abuse_Booklet.pdf>

<http://www.childwise.net/images/stories/documents/online_publications/Yarning_Up_Booklet.pdf>

<http://www.childsafetyaustralia.com.au/community/childabuse/keepchildrensafe.htm>

Developing a home environment that supports learning and development

Promoting development through play

Children start learning from the moment they are born and the learning that takes place in the first three years is possibly greater than at any other stage in the child's life. This learning is not formal and does not necessarily require access to specialist products or materials. It takes place within an environment where a child feels loved, feels secure and is safely able to observe, explore and experience life around them (Raising Children's Network, <http://www.raisingchildren.net.au>). Play is the way that children learn, enabling them to explore, experiment with and understand how they can impact on their world. Children need the support and security of a trusted adult who can provide and ensure a safe environment to explore and extend their learning by teaching them new skills. Play has been described as 'child's work', yet play should not be directed and does not need to have a planned and purposeful outcome (as the term "work" implies). It is, however, through the process of play that children achieve success and acquire new skills. Play is considered so important to children that it is enshrined in Article 31 of the United Nations Convention on the Rights of the Child.

Parents are their child's first teacher and helping them to understand their role in their child's development and learning is critically important. This can also be daunting to parents who have difficulty with their own learning, have experienced a sense of failure in schooling and/or have not had the benefit of positive parenting experiences in their own childhood. Some vulnerable parents feel particularly concerned about their capacity to play as they might feel they have never experienced this in their early years. Parents should be reassured that they come well equipped to be a capable teacher to their child and, whilst their involvement is critical, other family members and professionals will also play an important role in supporting their child's learning.

In the first few months of life, the baby is most interested and entertained by social play. All that is needed is for the parent to position themselves face-to-face with their child and play with their children by looking, smiling, touching and vocalising. Parents will often naturally use a high pitched voice and vary their intonation as they interact with their baby. Repetition and exaggerated intonation help to hold the baby's attention and can then be extended into rhymes, songs and lap games. As the child develops, play starts to become more physical and to involve the use of the body and physical movement, such as tummy time, playing with balls and being gently bounced on their parent's knee. When the child starts to reach out for toys, they can be offered items for manipulative play that helps to build fine motor skills and coordination. Parents should provide items that are not too small or that pose a choking hazard for children.

Toddlers enjoy using their imagination in play and usually start to imitate their parent as they begin 'pretend play'. At this stage, parents can be helped to include and involve the child in the activities of the day in order to provide a rich and stimulating learning for the child (e.g. pretending to cook using pots and pans, pretending to talk on the telephone and using a doll to imitate baby care activities). Looking at books and talking about the images with their caregivers is also a way that children learn about their world and their place in it.

In order to learn, children need to have a safe environment in which to explore, play and extend their learning experiences with the support and supervision of a concerned and responsible adult. They also need to be involved in activities that provide stimulation and a reason for their participation. One of the most important aspects of how parents provide support for their child's learning and reinforce their active participation in activities is by giving praise and encouragement to their child. The NCAST Teaching scale provides Cradle to Kinder practitioners with a framework for guiding parents to provide age appropriate learning activities that support early learning.

Play promotes young children's development in many ways but it is also important in providing an opportunity for children and parents to spend time together and have fun. The focus should be on the interaction between the parent and child, or 'how' they play, rather than what the play activity is, unless that activity is unsafe for the child. Sometimes parents have a fixed expectation that the child should play with objects in a certain and "correct" way and must be helped to understand that children should be encouraged to approach and play with objects in their own way.

When working with parents who are struggling to respond to the care and learning needs of their child, practitioners might have to observe interactions closely to find an opportunity to provide positive feedback and give encouragement to the parent. Capturing images on video is very helpful in allowing parents to see the behaviour for themselves.

A positive play interaction should include:

- Allowing the child to take the lead. Play should enable children to explore their world and experiment with how they can impact on their world. It should not be directed by an adult. Taking the child's lead occurs when the parent identifies that the child wants to play, is in the right mood to play (i.e not grumpy and tired) and is giving engagement cues, or when the parent offers an invitation to the child to play and the child responds positively with engagement cues.
- Allowing repetition so the child can demonstrate competence, then expanding the play to help extend skills whilst providing support if the child becomes frustrated by unsuccessful efforts.
- Being 'present' for the child by being interested in the play, giving positive encouragement and feedback to the child and showing joy in the play interaction.

Supporting children's play does not rely on parents providing expensive toys. Most children find play that involves an adult and requires very few props the most entertaining of all. There are many low cost toys that can be made from items readily available to most parents. As the child grows older, play can involve more physical play and body movements. Then, as the child learns to walk, outdoor play enables the child to explore the natural world.

Practitioners can help parents to explore low cost play activities in the local community and accompany them on outings to support them in guiding play interactions and learning in different contexts. Maternal and Child Health Services can also provide information about age appropriate play activities. Parent groups and supported playgroups can provide an opportunity for children and parents to socialise and play with other children. Group facilitators also provide modelling and ideas for parents about play ideas for their child. Connecting children with childcare can provide them important access to play-based learning when parents are struggling to provide a home environment that supports the child's positive learning experiences.

Play also provides children with a way of expressing their feelings. When children have experienced stressful and traumatic events or situations, they will often re-play events using their toys as they try to make sense of their experience. Play based therapy is used to assist young children in their recover from trauma.

Acquiring language and early literacy

The period from birth to school entry is a time of incredible growth in language development and capacity. In all cultures, language is one of the most powerful ways that children learn to understand and interpret human behaviour (Shonkoff and Meisels 2000). One of the most precious gifts we pass on to children is language (Clarke, 2009) and the way in which children learn and acquire language is remarkably similar across cultures (Shonkoff and Meisels 2000). Most children learn verbal language skills naturally by hearing others speak and observing the communication process between others. Children's language development has been found to be associated with their being exposed to a high verbal environment. The converse is true, where a child exposed to a low verbal environment will have fewer words in their vocabulary (Hart & Risley, 1995; Huttenlocher et al 1999). The maintenance of the first or home language for children is important and there is now recognition that a sound foundation in the family's language of origin has social, personal and cognitive benefits including increased self-esteem and confidence (Clarke 2009). In her discussion paper on young children learning English as

a second language, Clarke (2009) states that children who are learning English as a second language do not usually have any trouble learning and acquiring English whilst maintaining their home language. She highlights the need for early childhood professionals to be careful to distinguish the difference in the progress of children learning English as a second language from language delays or disorders.

It is the process of acquiring literacy – the ability to read and write - that is more complex and has a greater bearing on overall success in the ability to learn and life outcomes for the child (Centre for Community Health 2008). Acquiring literacy is a process that takes place from birth and is influenced by the quality of the early learning environment before a child attends school. Language acquisition also depends on hearing, the ability to distinguish sounds and the ability to link meaning to specific words. Other skills that emerge with the social and emotional development of the child include the ability to focus on, pay attention to and engage in social relationships (Zero to Three 2009).

Children who start school with a poor foundation for literacy often struggle to keep up with the rate at which other children learn to read and write, thereby finding it difficult to engage with the school's learning and social environment. Poor reading and writing skills are associated with lower self esteem, poorer educational, social and health outcomes, higher rates of unemployment, welfare dependence and teenage pregnancy. Children from low socioeconomic backgrounds are more likely to have difficulty with reading and those children who experience difficulties in learning to read are unlikely to catch up. All of these factors contribute to a continuation of the poverty cycle (Centre for Community Health 2008).

Literacy is attainable for most children, even those from disadvantaged families, and is an important focus of parenting skills development throughout the Cradle to Kinder service provision.

Strategies for encouraging and supporting the development of literacy skills are freely available to all parents and include:

- Talking to children more. Immersing children in language leads to an increase in vocabulary. Some parents feel embarrassed about talking to babies and very young children so helping them to understand the importance of language development and their role as teacher to their child is crucial. It is important to encourage parents to narrate a 'story' to the child as they are undertaking day-to-day activities, such as changing a nappy, bathing, feeding and going for a walk. Making use of objects from every day and natural environments assists can support children to acquire language skills. As children grow, providing more sophisticated language to describe things helps to extend their vocabulary.
- Encouraging the singing of songs and rhymes can be a way to provide enjoyable interactive time with infants whilst building language skills. The sharing of songs and rhymes can also be a good way to connect children to their culture.
- Sharing books. Spending more time reading together and exploring words and pictures in a book can be an enjoyable time for both parent and child. Parents with low literacy levels might feel unsure about reading with their child so it is important for practitioners to encourage parents to explore pictures and provide their own words if they are unable to read. Parents might like to make a book for their child that includes information and stories about their own childhood, family and culture. Parents can access age appropriate books free of charge through local library services. Many libraries have a range of books suitable for families from different cultural backgrounds and language groups. Libraries also provide free activities to support early literacy, such as story-telling sessions. Maternal and child health services, playgroups and childcare settings also provide materials to support early literacy.

- Supporting the development of early numeracy is also important to future learning. It is important to encourage parents to take advantage of every day interactions to introduce number concepts to children, such as counting fingers and toes or choosing simple books, songs and rhymes that introduce numbers.

Practice Resources

The Raising Children website has an extensive range of tips and resources for parents to use from birth to support early learning and literacy <http://www.raisingchildren.net.au>. Libraries provide free access to the internet.

Additional resources from Berry Street's "Early Learning is Fun" program are available: <http://www.childhoodinstitute.org.au/Resources>

Connecting families to universal services

Universal services are inclusive and less stigmatising for families and are, therefore, ideally placed to provide the most appropriate support for families over the longer term. In general, however, vulnerable families are less likely to access and engage with universal services, with the Cradle to Kinder priority groups being under-represented amongst users of universal services. Research indicates that groups who are less likely to access universal services include families with low incomes, young parent families, sole parent families, Indigenous families, families from certain culturally and linguistically diverse communities, families experiencing unstable housing or homelessness, families experiencing family violence, families with a parent who has a disability, substance misuse issue or mental health issue and families who have been in contact with Child Protection services (Brotherhood of St Lawrence 2004). In most cases, it appears 'retention' rather than initial 'access' is the key issue particularly within Maternal and Child Health services and kindergarten. Most parents make contact with services, but some then cease attendance, attend infrequently, or do not become fully involved in the service's activities.

Cradle to Kinder practitioners and service providers are in a position to maximise the potential for families to connect to the universal service platform. As part of this role, providing advocacy for the family and increasing the capacity of universal services to respond to the needs of vulnerable families are key activities.

Antenatal Services

Connecting pregnant women with antenatal service providers, including hospital- and community-based clinics and GPs, and promoting consistent attendance, is an essential activity for Cradle to Kinder practitioners. Women in the target and priority groups are known to have low levels of attendance and to present to services later in pregnancy. Engagement in antenatal care at the earliest possible stage in pregnancy enables engagement in screening and treatment measures that promote healthy outcomes for both mother and the child (e.g. healthy eating, smoking, alcohol and drug use, breast feeding, sexual health and family planning).

The Koori Maternity Services (KMS) program, developed in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) provides culturally appropriate maternity care and support for Aboriginal women at eleven VACCHO sites across Victoria. The principle focus of the program is on increasing access to antenatal care and postnatal support to improve the health and well-being outcomes for Aboriginal women and their

babies. All sites employ an Aboriginal health worker and undertake health promotion, provide support to pregnant Aboriginal women and identify pathways for clients into other services. The services also provide antenatal and postnatal care and support relationships with the birth hospital. VACCHO provides statewide support and coordination to the services as well as advising the department about service planning and development. For more information about the KMS program refer to the website <http://www.health.vic.gov.au/aboriginalhealth/programs/koori_maternity.htm>

Maternal and Child Health Services

The Maternal and Child Health Service plays an essential role in supporting families in the Cradle to Kinder program. The service offers all families ten free health and development consultations (referred to as Key Ages and Stages consultations) from a qualified maternal and child health nurse in the first three and a half years of a child's life. Additional contact can be arranged as required, especially for vulnerable children and families. The maternal and child health service can also provide Cradle to Kinder practitioners with consultancy support related to child and family health and development issues.

The Enhanced Maternal and Child Health Service provides more intensive and extended outreach support to families with multiple risk factors, including short-term case management in some circumstances. Many of the families participating in the Cradle to Kinder program will be engaged with the Enhanced Maternal and Child Health Service in the early period after the birth of the baby. With the support of the Cradle to Kinder practitioner, the aim is to then transition families to the universal, centre based service.

The Maternal and Child health Service also provides a free 24 hour telephone advice line.

For further information about Maternal and Child Health Services refer to the website <http://www.education.vic.gov.au/childhood/professionals/health/Pages/maternalchildhealth.aspx>

Early childhood care and education

In order to support healthy brain development, children need to be actively engaged in play and communication from an early age, which is why access to childcare and early education services can be so important to vulnerable families who might struggle to provide the level of stimulation and interaction required on a consistent basis. The Cradle to Kinder practitioner can play a major role in promoting the protective aspects of engaging the child in high quality early learning and care services and in assisting parents to negotiate timely access to services.

Whilst antenatal and maternal and child health services are widely available, this is not always the case for childcare and early education services. In some rural areas, services can be sparse whilst in high growth areas, service capacity might struggle to keep abreast of demand. In these situations, families need to place their child on a waiting list for access to services from an early age and service capacity can be quickly consumed by children who are accepted on a 'first come, first served' basis within an allocation system that may not give priority to children and/or families with additional vulnerabilities or needs. Transient families, young parents, parents with low literacy and parents from non-English speaking backgrounds appear to be the most impacted (Brotherhood of St Lawrence 2004).

Costs for childcare and early education programs can also be prohibitive for vulnerable parents. A 'Special Child Care Benefit' is offered by the Australian Government's Department of Human Services It provides financial support for families whose children are at risk of serious abuse or neglect and/or where the family are experiencing hardship that requires additional hours of childcare. More information and the documentation required to access this benefit can be found at <http://www.humanservices.gov.au/spw/customer/forms/resources/fa023-1207en.pdf>

The Victorian Government's Department of Education and Early Childhood provides the Early Start Kindergarten grant directly to service providers so that any three year old Aboriginal child and any non-Aboriginal child known to statutory Child Protection services can access two years of quality education and care before beginning school. This grant applies to any family referred to Child FIRST by Child Protection. More information is available at <http://www.dhs.vic.gov.au/for-individuals/financial-support/concessions/education/early-start-kindergarten>

Parent groups

A wide variety of parent support groups are available within local communities. These groups can either be universal (for example, first time mothers' groups in Maternal and Child Health services) or targeted (for example, young mothers' groups). The most common type of parent groups are playgroups. Playgroups provide social contact and support for parents and stimulation and socialisation opportunities for their children. Supported playgroups have been initiated in many areas in response to low levels of engagement in universal and parent-initiated groups. Supported playgroups are targeted at particular groups of parents and are usually facilitated by early childhood workers or peer group leaders. Supported playgroups allow parents to build connections with each other, with universal services and with more specialised supports that may be available in their community. For more information refer to Playgroup Victoria's web site at <http://www.playgroup.org.au>.

5.2.3.4 Reviewing and measuring outcomes

A constant and cyclical process of regular review is essential throughout the delivery of the Cradle to Kinder program in order to consider assessments and plans in light of new and emerging information, to critically reflect on and appraise the impacts of the practitioner's actions and to prove service effectiveness. Outcome measures are specified in the Cradle to Kinder program framework and practice prompts for reviewing outcomes are included in section 5.2.4 below.

A primary focus of reviewing outcomes is the development, health and wellbeing of the infant. Early childhood development is a critical period and sometimes cannot wait for parents to recover from trauma, unstable mental illness or alcohol or drug dependence. Practitioners must remain alert and constantly reflect on whether the infant is meeting developmental milestones and if the parenting provided by the family is adequate to support the child's development in a timely way. For instance, are there other family members available to provide the parenting support required for healthy infant development? Would engagement in childcare or early educations services provide sufficient additional stability and stimulation to support development? All children should be engaged with universal maternal and child health services or other services such as a GP, where their development can be regularly screened and monitored.

Developmental screening is essential to identifying children with additional needs as early as possible. Diagnosis of developmental delay or other special needs is a complex area and early detection is balanced against the negative consequences of labelling children with a diagnosis too early in their life. Parents who experience difficulty in their relationship with their child can also tend to label their child's behaviour or development as deficient rather than accepting responsibility for addressing some of their parenting difficulties. This area needs very sensitive communication with families. It is important to discuss with families how they feel their child is developing and if they have any concerns for their child whilst openly, honestly and respectfully challenging parents who might be blaming of the child.

Parents need to be given time to improve and change their situation. The process of review needs to take into consideration whether the intervention has provided parents with the best possible chance to learn and make changes. For instance, is the service delivery culturally appropriate? Has the practitioner sought cultural consultation? Has the practitioner's education methods matched the learning needs of families? Is the practitioner's information and instructions provided in a form that parents can easily understand?

It is important that the desire to maintain engagement over the sustained period of the Cradle to Kinder intervention does not cloud the view of what is happening for the infant in the family. If parents are not fully engaged in the process of change and the practitioner believes that they have been given every chance to do so, then it may be necessary for Child Protection involvement after consultation with the Senior Child Protection Practitioner (Community Based).

Outcome measures

The Family Outcomes Star

The Family Outcomes Star is both an outcomes tool that enables organisations to measure and summarise change for families and a case management tool that can support parents in making changes by providing them with an understanding of the steps they need to take to be more effective parents. The Family Star forms part of the broader outcomes measurement framework for the Cradle to Kinder and Aboriginal Cradle to Kinder programs (refer to the Program Framework in section 4.1 above)

Using the Family Star and Recording Outcomes

A copy of the Family Outcomes Star, along with the User Guide (for parents) and the Organisation Guide (for practitioners), can be downloaded at <http://www.outcomesstar.org.uk/>. Registration is required in order to access these documents, although the registration process is free of charge. Access to the online version of the Star requires payment of a licence fee.

All service providers are expected to provide the department with the (anonymised) Star readings for families accessing the Cradle to Kinder and Aboriginal Cradle to Kinder programs. This should be submitted to their local area engagement officer at the Department of Human Services on a quarterly basis as part of the outcomes measurement template that has been developed. This enables the information to be summarised and analysed at a statewide level.

Frequency of Usage

The Family Outcomes Star should be used for the first time with a parent before their child reaches eight weeks of age. The Star should then be used, at a minimum, on a quarterly basis with parents. It may be useful for this to align with the timeframe for the regular review of the

family's case plan or action plan. This does not, of course, preclude individual agencies from utilising the Star at more frequent intervals with parents or in response to particular life events that may significantly impact upon parenting capacity.

Integration with the Best Interests Case Practice Model (BICPM)

The overarching case practice model that guides and informs practice within the Cradle to Kinder and Aboriginal Cradle to Kinder programs is the BICPM. The Family Outcomes Star does not replace a risk assessment for children and is not a substitute for the BICPM. As such, it is not necessary for agencies to complete the Star Support Plan that is attached to the Family Star.

The case management approach that underpins the Family Star does, however, align with a number of the key elements of the BICPM, including:-

- A strengths-based approach that acknowledges the positive aspects of what parents and children do well, what parents do despite problems and how they have tried to overcome these problems.
- An outcomes-focused approach that encourages a culture of reflective practice
- Proactive engagement with families that relies on a process of relationship building with parents that shapes shared goals and can promote change
- A practice culture that is empowering of families through respecting their rights, noticing their strengths and working towards these becoming sustained over time

The fit between the Family Star and the BICPM is summarised in the table below:-

Family Star Outcomes	**BICPM - Key Domains (refer to pages 20-8 of the *BICPM Summary Guide 2012*)**	**BICPM – Examples of Relevant Key Considerations (refer to pages 20-8 of the *BICPM Summary Guide 2012*)**
Promoting good health	Child or young person's health and development	Health and physical development Emotional and behavioural development
Meeting emotional needs	Child or young person's health and development	Child well-being Emotional and behavioural development
	Parenting/carer capacity	Parent or carer capacity for meeting the child's needs – emotional warmth and responsiveness
	Child's stability	Connection to primary caregiver Connection to culture
Keeping your child safe	Child or young person's safety	Protection from harm Consistency of protection Basic care provided Level of primary carer's/mother's safety
	Parents' offending history	Patterns of criminal behaviour
	Parenting/carer capacity	Parent or carer capacity for meeting the child's needs – ensuring safety

Family Star Outcomes	BICPM - Key Domains (refer to pages 20-8 of the *BICPM Summary Guide 2012*)	BICPM – Examples of Relevant Key Considerations (refer to pages 20-8 of the *BICPM Summary Guide 2012*)
Social networks	Child's stability	Connection to school, childcare, friends Connection to community Child's ability to make key connections Connection to culture
Supporting learning	Child or young person's health and development	Opportunities for play, learning and education
	Parent/carer capacity	Parent or carer capacity for meeting the child's needs – stimulating learning, development and well-being
Setting boundaries	Parent/carer capacity	Parent or carer capacity for meeting the child's needs – guidance and boundaries
Keeping family routine	Parent/carer capacity	Parent or carer capacity for meeting the child's needs –consistency and reliability
Providing home and money	Social and economic environment	Housing, employment patterns, income, informal community networks and cultural connectedness

The Family Star does not specifically incorporate considerations related to the 'current family composition and dynamics' and the 'family history' key domains of the BICPM, although aspects of these domains (e.g. transgenerational patterns, family cultural connections and the role of gender and power in family dynamics) directly impact upon both parenting capacity and parents' self-perception. As such, they are relevant to many of the Family Star outcomes.

As a case management tool, the Family Star's usage can also be mapped across to the four stages of practice that underpin the BICPM – information gathering, analysis and planning, action and reviewing outcomes. Like the BICPM, the Family Star emphasises the interconnectedness of the different stages of professional practice, operating through a practice lens that is child focussed and family sensitive.

NCAST Parent Child Interaction Teaching Scale

The NCAST Teaching Scale offers a thorough assessment of a parent-caregiver interaction, assessing both caregiver and child behaviours in the context of a teaching episode. Teaching tasks are prescribed and use standardised toys and equipment. The teaching manual provides a guide for a range of age appropriate activities from which parents can choose. Observing and assessing parent/caregiver interactions regularly over time provides indications of the relationship and interaction patterns between the caregiver and infant. The NCAST scales are ideal in that they provide an indication of both strengths and potential difficulties in the ways in which the parent and child interact. The scales are reliable indicators of successes or potential barriers to a child's future development (NCAST 2012) and are sensitive enough to measure changes in interaction as a result of intervention in relatively short periods of time. Some of these episodes may be captured on video to enable the parents to reflect on features of the interaction experience. Taking the time to view the videotaped interaction and to reflect on the interaction with parents provides a basis for the joint formulation of an intervention plan.

The interaction is scored on six sub-scales (i.e. parent's sensitivity to cues, response to child's distress, social-emotional growth fostering, cognitive growth fostering, child's clarity of cues and responsiveness to parent), parent contingency, total parent and child scores and total overall score. Scores are compared with means and standard deviations derived from a comprehensive research database of two thousand and one hundred families. The NCAST research program found insignificant differences in scores between ethnic groups but significant differences in scores depending on caregivers' education level. Results guide the focus for intervention with the family.

Frequency of use

The PCI Teaching scale is to be administered by Cradle to Kinder staff when the child is 6 weeks, 12 weeks, 6 months and then at 6 monthly intervals until the child turns 3 years of age.

Administering the scale

Making Arrangements

- The practitioner should ensure familiarity with the types of activities, age groupings and materials needed for the caregiver to teach the child a particular activity (the manual provides a reference copy).
- The practitioner should consider where the child is developmentally – this will enable the practitioner to determine whether the activity chosen by the caregiver is appropriate for the child's capabilities.
- In general, caregivers should choose an activity no more than two months in advance of a very young child (1-8months) and no more than six months in advance of an older child (8 months+).
- If the caregiver's choice of activity is outside these guidelines, the practitioner may need to provide some guidance and ask them to select another activity more appropriate to the age of their child. Review the list with them, and perhaps suggest a range of items that they might consider.
- If the child can do the task immediately, the practitioner should suggest another task at a higher age level and use the second task for scoring.

The Setting

- The practitioner should consider where it would be comfortable for the parent and their child to conduct the interaction. The observation may be conducted anywhere in the home or in another setting.
- If the practitioner is working in the home, he/she should encourage the caregiver to select a location/position where they might normally engage in play. This helps to keep it natural.
- The practitioner should explain that they may need to move or reposition themselves during the session to get a better view of the face and eyes of both the parent and the child, as these are important elements in any interaction.
- Being captured on video is often challenging for parents and the first few minutes of any observation can appear stilted – participants can be nervous or easily distracted. This usually wanes quickly and in a matter of minutes things return to their natural pace and style.
- It is important to keep the context, place and process similar to make comparisons at different time points.

The Observation

- During discussion with the caregiver, the practitioner should emphasise that they are interested in observing an interaction that is as close to normal and natural as possible. The practitioner should let the caregiver know that, in order to avoid interrupting the interaction, they will not be speaking and that the caregiver should ignore them and carry on as if the practitioner were not there.
- The practitioner should try to position themselves (and the camera) so that they can see both the caregiver and child continuously. The practitioner should inform the caregiver that they may need to change positions to maintain the best view but that they will try to keep distractions/disruption to a minimum.
- The practitioner should remind the caregiver to let them know when the teaching is complete.

Introducing the teaching scales to parents

- It is important that the practitioner ask the caregiver for permission to proceed with capturing the interaction on video and to taking some notes to share in discussion with them afterwards.
- Examples of how the practitioner might introduce the scale to a caregiver are:-
  - "So that I can learn more about how you and your child learn together I would like to watch you teaching X a new activity or skill. What I am interested in is how you interact – it is not important whether X manages to do the task him/herself"
  - "Here is a list of activities children ranging in age from birth through to four years can do. Please read through the list. Let me know the first activity that you feel your child cannot do". (N.B. the practitioner should be cautious about saying what they 'should be able to do' at a particular age)
  - "See if you can teach X to do Y (describe the activity they have chosen e.g. turn the page of a book). Take as long as you like. Please let me know when you are done".

5.2.3.5 Closure

The long-term relationship with a consistent and trusted worker and service enables the parents to make positive life changes, build skills and establish social connections that will lead to independence.

Whilst the intention of the Cradle to Kinder program is that families will be supported up until the child turns four years of age, there may be circumstances where case closure occurs before this time. Decisions regarding case closure should be related to the achievement of outcomes rather than strict adherence to a specified period of service involvement. The aim is to help the family to independently manage the care of their infant with support from their family, social and professional networks. There is a need for care plan reviews at regular three monthly intervals to assess the family's progress towards self management and to agree goals for the next phase of the intervention. It is essential that parents are aware of their progress towards self-reliance (as the ultimate goal of the program) and of the notion of future program closure once this goal is achieved. Planned closure must be preceded by a transition and exit planning phase, undertaken with the family to ensure that they are actively engaged with the range of early childhood, health and community services that are appropriate to meeting their needs.

Possible reasons for closure include:

- Planned closure at the child's fourth birthday with goals met, informal supports in place and engagement by the family with universal services.
- Planned closure at the child's fourth birthday with some goals not achieved and requiring assistance from other services to achieve these remaining goals.
- Planned closure earlier than the child's fourth birthday when the family and the service agree that there is no need for continuing involvement due to goals being met, informal supports being in place and engagement by the family with universal services. This does not preclude the family being referred back to the Cradle to Kinder program in the future, should life circumstances change significantly for the family.
- Planned closure when the family move to an area where Cradle to Kinder is not operating, prior to successful goal attainment. In these circumstances, the family should be referred to Child FIRST in the new catchment area.
- Unplanned closure due to the family withdrawing from the service.
- Unplanned closure due to Child Protection involvement leading to removal of the child from the parent/s' care.

Strategies to prevent premature closure

It is important that parents are retained in the program so they can benefit from the longer term intervention that Cradle to Kinder can provide. The target families are those who are highly likely to experience parenting challenges as their child grows and develops and it is therefore crucial that closure of the program does not take place prematurely during a period of perceived stability. These stable periods provide an opportunity for parents to test their ability to manage the next challenging phase as a parent (with the support of the program in the background) so that they can incrementally increase their independence and build their sense of self efficacy throughout their involvement with the program. It may be that, during a period of stability, the parent is able to engage with therapeutic interventions to address some of their own underlying emotional or psychological issues, thereby increasing the likelihood that change will be sustainable over a long period of time.

It can be important for families to know and appreciate that their allocated keyworker is part of a broader team and that it is the team as a whole that is helping the family. In particular, if the keyworker leaves the service or is on leave, the concept of a team can help the family not feel abandoned and may avoid a crisis ensuing for the family. This can include making sure that other professionals are introduced into the practitioner-parent relationship on a regular basis. This could include co-workers as well as other service providers. When a practitioner leaves the service, it is important that a careful and thoughtful transfer to another practitioner takes places. Exploring with the family what this ending of a relationship means for them is also important to the service maintaining ongoing engagement with the family.

Unplanned early closure of the intervention needs careful reflection and exploration. It is often from the feedback of families that disengage from services that practitioners have the most to learn. Why did the service not live up to expectations? Was there anything further that could have been done to reduce or avoid the level of risk to the child? What can the service do to make it better for others?

Housing instability is likely to be one of the most common causes of early program closure so practitioners should attempt to establish strong links to services in other areas when parents move into those areas. Where closure is due to factors other than the achievement of agreed goals, practitioners need to be particularly mindful of their own reactions and make use of reflective supervision to explore these in greater depth.

Managing planned closure

Closure of the program might create anxiety for families and requires thought and discussion throughout the intervention. Being clear about closure from the beginning of the intervention is important as this early focus can help later conversations. Whilst building strong relationships with families is a major element of program success, this can also create difficulties for both families and staff when managing the ending of the relationship. It is important to conceptualise closure as a phase or a period rather than as a distinct event. It is helpful to focus on closure for the last six months to twelve months of the intervention. This allows the Cradle to Kinder practitioner to 'step back' whilst still remaining connected with the family. It is critical to work through with the family (both parents and children) what the ending means, both in terms of the positive aspects (for example, pride, satisfaction and a sense of accomplishment), as well as the more difficult aspects, such as possible sadness and a sense of loss.

Closure can also be difficult for practitioners. Given the practitioners relationship with the family over several years it is likely that significant transference might evolve. For example, workers may find it hard to 'let go' of the parents and the children. These feelings may need to be addressed through the supervision process. A focus on how individuals remember people and how they internalise what others have given them is a helpful area for reflection and supervision. It is helpful for practitioners to be aware of the possibility that both parents and practitioners may identify new problems or that problems may escalate at the last minute as a means of justifying the ongoing involvement of the family with the program.

5.2.4 Practice considerations and prompts

This table is aimed at providing support for Cradle to Kinder practitioners as they progress through the phases of their intervention with families. Practitioners need to keep in mind that the intervention process is cyclical and that, at different times throughout the program's delivery, using the 'reviewing outcomes' column in the table might identify the need to gather further information or to consider a different action to improve progress towards achieving positive outcomes. The table is based on the key domains outlined in the BICPM Summary Guide 2012 (Miller 2012). The program objectives, casework activities and family outcomes, as defined in the Cradle to Kinder Program Framework (refer to section 4.1 above), and elements of the Family Star case management tool are also integrated into the table.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Safety	Basic care	Is the parent aware of and thinking about the safety needs of the baby? Do the parents think about what they might need to care for the baby: equipment, knowledge, support? Are they able to think about changes the house might need or any changes in their behaviour or social circle? What is the observed capacity of the parent to provide safe basic care including preparation of formula, bathing, handling the baby, nappy change? How will the child be transported? Does the car seat meet safety standards? Is the baby's sleep environment safe? Do the family need flexible funding support for safe and approved baby equipment? Are parents aware of SIDS safe sleeping strategies? Is the home environment safe for the age and stage of development of the child? Can the parents adapt their parenting to the changing care needs of the child? Does the parent have any difficulties in meeting their own self-care needs? Who else may be a source of protection or risk?	Does the parent have the skills to respond to the immediate care needs of the infant? How vulnerable is the infant? How vulnerable is the parent? If the child has additional needs, how are the parents able to manage these extra pressures and care demands? What additional support do they need and how realistically can that level of support be provided by family, community and/or services at the time and place when it might be needed? Are there other people in the child's life who can be involved in meeting the child's basic care needs when needed?	Partner with the family to discuss concerns and work out solutions. Use flexible funding to provide immediate practical assistance and purchase equipment where required. Use teaching methods that are matched to the parents' learning needs to help them acquire basic parenting skills. Involve others in the family's social network in noticing and responding to the child's needs.	How is the child presenting? Does she look well nourished and thriving? Is she clean and does she appear well cared for? Are the family attending MCH visits? How is the child's growth tracking against percentile charts? Has the child been well? Are safe sleeping arrangements adhered to? Are there other people in the child's life who are protective?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Parents understanding of the needs of an infant and the developing child and ability to prioritise for these needs	Is the mother aware of and prioritising the needs of the foetus for a healthy intrauterine environment? Is the family thinking about and preparing for the birth of the baby? Has the mother thought about breast feeding her baby and had the opportunity to explore the feelings this might bring up from her own past? (After birth) does the parent respond promptly to the infant's distress and hunger cues even when wanting to do something for him/herself? Is the parent able to adjust to the changing needs of the child as he/she grows older, such as becoming mobile, acquiring language, extending and stimulating through play and providing opportunities for social interaction?	Based on past patterns of behaviour, family history and current situation, how do you think the parents will respond to the baby? Do the parents have some constraints that will pose a problem in their ability to prioritise and respond to the child such as mental illness, alcohol and other drug misuse, family violence? Are they open to your attempts to engage and provide support?	Link with and promote attendance at antenatal care services. Explore issues related to the emotional preparation for becoming a parent. Provide information about the developmental capacities of the child and provide parents with the opportunity to build appropriate parenting skills in response to these changing capacities. Highlight the special role of the father and make sure he is included in service delivery.	Has the parent attended antenatal appointments? Is the parent acting in a way that shows she is prioritising the needs of the baby over herself and/or her partner? Are the parents keen to learn and understand more about the child or do the personal concerns of the parents dominate? How do the parents work together to ensure that the child's needs are responded to?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Parent-child relationship to support attachment	Do the parents focus attention on the baby most of the time or get distracted and caught up in other things? Do the parents have a balanced view of the child or is there a sense that there is a script that the baby needs to adhere to? Do the parents show joy in interacting with the baby? Do the parents watch carefully when others are around the baby, especially those not known to them? Are they eager to hand the baby over to others or keep the baby close to them? Do they leave the child with strangers or people they do not know well?	Does the parent have any underlying issues that might increase their difficulty in forming a close relationship with their child such as mental illness, drug and alcohol misuse, family violence and/or a learning difficulty? Was the parent protected as a child? How might any past abuse trauma impact on the parent's capacity to develop a protective bond with the child?	Use the video to play back interactions and engage the parents in reflective conversations to build their understanding of their child and how to respond to their cues and/or needs. Explore and discuss the ways that parents can protect their child from harm. Provide information about the indicators of trauma and abuse. Use a genogram, ecomap and/or social network map to explore and discuss ways to build a safe network for the child. Use the Family Star to reflect and record progress with the parents in the area of "Keeping your child safe".	Is the quality of the parent-child interactions improving over time? Do the parents have insight into their actions? Have they been able to make changes? What is the parent's response to reflecting on their interactions with the child? Have there been any consultations with Child Protection? What was the outcome of these? Has the child been subject to a report to Child Protection? Has there been Child Protection involvement with the family and for how long?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Opportunities for harm	Is the pregnant woman smoking, using drugs and/or alcohol? Is the father smoking in the presence of the pregnant woman? How does the woman refer to the foetus? How do parents respond to the child's distress? Do they respond calmly and with patience and understanding or show irritation or handle roughly? Does the parent or family member closely supervise the infant and not leave the baby unattended or in the care of unsuitable carers? Is the young parent involved in risk taking behaviour? How is this impacting on the child? Is the home environment safe for the age and stage of development of the child, including safe sleeping practices and car safety? Are the pets in the house supervised and safe for the child? Is the parent aware of and do they understand the information relating to preventing shaken baby syndrome?	What does the current situation suggest for the health and development needs of the child (e.g. drug withdrawal post-birth)? What has been the previous history of risk taking behaviour and how likely is this to continue now that the young person is a parent? How do the parents respond to the raising of concerns? Are they receptive to support and advice? Is the level of cooperation and engagement likely to support the changes needed?	Join with the parents around a desire to be the best parent they can be for their child. Involve the parents in identifying concerns and finding solutions. Build on their strengths by using actual examples of observed behaviour and parenting practices. Provide information in a way that the parent can understand and clarify their level of understanding. Remain respectful and hopeful of the capacity for change.	How are the parents progressing in making the changes that are required to address concerns? Record and highlight examples of the parents making decisions which keep the best interests of their child in mind. Is the time taken to make the required changes happening in a timeframe that will meet the child's needs? Have there been any accidental injuries to the child? Have there been any incidents of family violence? Has the parent demonstrated risk taking behaviours?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Health and safety of the mother	Is the woman attending antenatal services? What is the health of the mother and how might this impact on the child before and after birth? What is the mother's understanding of how her health and self-care is impacting on the unborn child? Is the mother consuming alcohol? At what level? Is she using other drugs? Is there any history of mental illness? If so, is the woman seeing support from a medical practitioner or a mental health worker? Is she taking prescribed medication according to her doctor's advice? Are you able to establish that the mother is safe before and after the birth and is she able to protect her child? Does the family feel safe in the local community? Is there any family violence, past or current? Is there a change of partner or new people coming into the home? Is the mother associating with people who may pose a risk to her or her child, such as drug dealers? Is the family residing in an area with high levels of crime?	What are the past patterns associated with the mother's mental health, alcohol and other drug use and engagement with treatment services? Are there further assessments and professional supports required? What is known about past relationship patterns? What is the impact of the mother's new partner or associates on her and her child's level of safety? What supports are needed to ensure the safety of the family?	Clearly explain your role/ mandate and partner with the parents to act in the best interests of the child. Engage the mother in health services before and after birth. Use the screening questions from the CRAF. Engage with the father and include in the program if safe for the mother and child. Support engagement with men's behaviour change programs. Observe and compare interactions with different caregivers. Provide information about the impacts of stress on brain development. Look for any signs of distress or trauma in the child. Where needed, engage the child in infant mental health therapeutic assessment and support services. Provide information and support to access legal rights such as intervention orders and/ or parenting orders. Consult with Child Protection as required.	Record and review visits to antenatal and postnatal health services. Is the mother's mental health stable? Is she taking her prescribed medication regularly? Has the program engaged with the father and explored issues of concern with him? Reflect on the demands placed on the mother that might be related to the behaviour and actions of her violent partner. Review the perceived level of safety with the family. Explore changed circumstances and agree what else might be required to increase the level of safety for the child and the mother.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Signs of adequate and safe care	Does the woman understand how her self-care and health during pregnancy impacts on the health and later development of the foetus? Does she understand the signs of the onset of labour and when it is important to seek medical advice, such as bleeding, rupture of membranes and/or swelling of the face, hands and feet? Does the father or mother's partner understand the importance of the mother being safe and well? Do the other family or community members understand the importance of the mother being safe and well? Is the infant's weight being monitored and increasing as expected? Does the infant appear clean? Are there signs of possible inadequate care of the infant, such as severe nappy rash? Is there any unexplained bruising?	Build a trusting relationship with the woman and her family to support positive parenting. Engage other service providers, including antenatal services, in the care team and keep updated regarding the progress of the pregnancy. Engage the broader family and community who have an interest in supporting this child. Clearly articulate the indicators that demonstrate that the child is adequately and safely cared for.	Partner with the parents to develop a family action plan and agree the shared goals. Clearly identify the goals and ensure they are SMART (specific, measurable, achievable, related and timely) to the identified concerns. Ensure that information and support is provided in a way that provides the parents with opportunities for change.	Will achievement of goals mean that practitioners can be confident that parental care is adequate to support the safety, stability and development of the child? If not, what additional goals need to be developed and/or added? Is progress against the plan as expected and timely enough to meet the imperative of infant developmental needs and early brain development?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Stability	The developing attachment to primary caregivers and family	What are the underlying issues for these parents and how might this impact on their ability to develop a strong emotional connection with their child? What is the parents' understanding of their role in developing a sense of security and stability for the child? Who is the caregiver for the infant who has the most skin-to-skin contact? Who are all the significant people involved in providing care for the infant? Is there someone taking the lead in keeping the baby's needs in mind and ensuring care-giving responses are timely and nurturing? How does the family share responsibility for care? How does the involvement of family in the care of the baby impact on the confidence and involvement of the young parent? How does the child respond to the different people providing care? Does the child seek the parent when distressed or frightened? Does the child explore more when the parent is present? How can the NCAST scale assist in identifying the strengths and opportunities for change in the interactions? Are there siblings in the family? Is there any difference in how the siblings are parented? Do the other children appear to be attached to the parent/s?	Observe the parenting behaviours of all caregivers and responses of the child so as to identify the current source and quality of the emotional bonds and level of affection for the child. Does the child use the parent or someone else as a safe haven or secure base? Analyse the results of the NCAST Teaching scale and identify areas for intervention to strengthen the primary relationship for the child.	Provide information to parents about the importance of secure attachment and their role in their child's development. Engage the parent in reflective conversations as you review video footage, highlighting positive aspects of the interaction and exploring areas of difficulty. Support the parent to reflect coherently on their own childhood experience. Explore the impacts of siblings on parent availability and experience of parenting.	Review the quality of parent-child interactions using the NCAST teaching scale. Compare changes in scores across time. Correlate the NCAST results with the broader observations of parenting behaviour and child responses over time. Reflect with the parents and locate/record the parent's capacity to meet the child's emotional needs within the Family Star.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Connection to community	How is the family connected to the community in terms of their Aboriginal community, their cultural community, their geographical community and other communities? Is the parent new to the community or do they have well-established connections? Does the community provide comfort, support and positive challenges to the parent? What are the strengths of the parents' connections to friends, school, workplace/s and local agencies? Have any harmful experiences occurred within a community context, such as gang involvement, a spate of suicides, natural disasters?	What are the connections that are most likely to be supportive of the parents and their parenting role? Are there any connections that pose potential risk? What other connections do the family consider they might need?	Involve community members as agreed by the family. Use your professional knowledge and networks to provide information and facilitate access to appropriate community agencies and activities. Promote access to the universal service platform. Join with the parent and other supports to plan for opportunities for the young parent/s to stay connected with friends and their school.	Review and record the number and strength of community connections, as well as the parent's sense of connectedness to support networks. Use the Family Star (social networks outcome), the ecomap and the social network map to explore progress in building connections. Record number of referrals and engagement with community services. Has the young parent used the support of their connections to solve problems independently of the Cradle to Kinder program?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Connection to culture	Does the child appear to be developing at the appropriate rate across all areas of development? Are the family aware of the child's capability, especially for social interaction, and understand their role in supporting their child's development? Is the care-giving environment providing adequate support for child development? What are the results of the NCAST scale? How is life for this child and any other children in the family? Is the parent-child relationship characterised by warmth and nurture or are the parents preoccupied with other things? Does the child get stimulation and attention? Have the parents provided consistent daily routines? How are they implementing positive strategies to prevent behavioural concerns in relation to the child? How is the child's language developing? Is the parent providing enough exposure to words and language to support early literacy?	What is the likely impact of past patterns of behaviour, family history, pregnancy and birth on the future development of the child? What additional supports might be required by the child and the family?	Partner with the parents, engage them in reflective conversations and involve them in being curious about what their child is capable of. Build a collaborative partnership with the family to promote trust and reduce defensiveness. Explore with the family their perspective on how their child is progressing. Provide information on healthy foetal development, early brain development and child development milestones in a form that the parents can understand. Highlight for parents the crucial role they play in their child's development. Help parents to provide explorative play experiences and stimulate learning appropriate to the child's age and stage of development. Provide information and support to establish daily patterns, set limits and implement positive parenting strategies. Assist the family to identify developmental concerns and follow up on seeking specialist assistance where this is required.	How is the child progressing against developmental milestones? What are the particular strengths of the child and parents and how can these be used to build parenting capacity and development in other areas? How open are the parents to information and support and are they able to consistently implement parenting strategies? Have the views and perspectives of others been actively engaged in considering the child's progress? Record and review MCH and GP visits to monitor key ages and stages of development. Does the parenting provide adequate support for learning and development? Is there opportunity for social interaction, such as through attending playgroups and other early childhood services?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Parents' offending history	Patterns of criminal behaviour	Have you been provided with information related to a parent's past criminal offences, especially violent offences and child sexual offenses? If there is a new partner in the home, have they previously engaged in criminal behaviour? Is there a history of police attending the home? If there is a history of illicit drug use, does it involve criminal activity? Is the parent involved in criminal activity that exposes the child to additional risks? If a parent has a criminal history is he/she willing to discuss the circumstances? Are youth justice, corrections or other related services involved in supporting the parent to avoid future criminal activity?	What are the implications for the safety of the mother and the child? How might these patterns impact on the parents' capacity to provide for the child's safety, stability and development? What are the implications for staff safety?	Work in an open, honest and respectful way to clarify information and gather new information as it comes to light. Clearly explain your mandate in relation to the protection of the child. Engage with the father and promote access to behaviour change programs. Provide information to parents about the impact of stress and violence on the child's developing brain. Consult with Child Protection if required.	What are the relationship patterns within the family? Are there changes in the behaviour patterns and/or financial status of the family that cannot be explained? Are there any indicators of family violence? Have the police been called to the home and under what circumstances?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Parenting capacity	Capacity to meet child's needs	What is the parent's overall capacity to provide adequate care for the infant in a way that meets the child's needs across all areas of development? Are there any issues related to mental illness, drug and alcohol misuse, family violence or parental learning disability that is impacting on parenting capacity? If parenting capacity is reduced during times of intoxication, unwellness or fear, does the parent have a strategy to manage this? Does the parent have the capacity to adapt their parenting to the changing developmental needs of the child? Are there any developmental problems or delays for the young parent and how might these impact on the child? How does the NCAST scale compare with your general observations of the parenting responses? Does the parent have any difficulty with learning? What is the parent's perception of their own strengths and challenges and does this correlate with your perspective and that of other family members and professionals? Does the family seem open to support and information in order to increase their parenting knowledge and skills?	What will be needed to overcome impediments to parenting capacity? Will the time needed to stabilise the parent fit with child's needs? What professional and non-professional supports are required? Does the young parent have adequate support to ensure their own developmental needs are met? What support do the parents perceive they need in order to be able to parent the child safely? Are you able to reach agreement regarding the goals in the action plan and the way to achieve them? What is the parents' capacity to solve problems?	Provide information, educate in new skills and provide opportunities to practice skills. Clarify understanding at every step in the process. Use the NCAST score and video review to reflect on the individual strengths of the child and the parent. Use the Family Star as a way to engage the parent in reflective conversations and to motivate change in relation to outcomes, such as meeting emotional needs, keeping your child safe, supporting learning, setting boundaries and keeping family routines. Be open and honest in discussing challenges and build a collaborative approach to finding solutions and tracking progress.	Partner with the family to review progress using the Family Star. Engage in professional supervision to critically reflect on your work with the family and progress to date. Consider the views and perspectives of the family, community members and the care team to provide a balanced view of how things are going. Plan for how you will work with the family and the care team to improve outcomes. Are we being overly pessimistic or optimistic about how the service might be able to help this family?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Parents' attitude to the child	How does the parent see the child? Ask questions such as "How would you describe your child?", "How would you describe the way your baby behaves?", "What do you enjoy most about being a mother/father to your child?", "What do you find most challenging?", "What have you tried that works?", "What does a typical day look like for you and your child?", "Are there times that are more stressful and what works best?", "What do you like doing together with your baby?" and "What are your hopes and dreams for your baby?" The parent might not necessarily know answers to these questions but it is important that they are engaged in thinking or trying to work out what is happening for the baby. (Before birth) what is the parents' sense of how it will be to parent the baby?	What factors are influencing the parent's perceptions of and attitude to their child? What do they think they need to so in order to achieve their hopes and dreams for their child? What do they require to support them during the stressful times? What is their understanding of their role in their child's development?	Partner with the parents in reflecting on interactions captured on video. Explore their thoughts, feelings and perceptions. Use reflective questioning to build their understanding of the unique characteristics and capacities of their child. Acknowledge and highlight the positive aspects of their relationship with their child. Reinforce the child's responsiveness to the parent. Make a family video to remind them of the good things about their relationship with their child.	Track changes in parental attitudes by reviewing the Family Star outcomes with the family (i.e. 'meeting emotional needs'). Compare the NCAST scores across the parent and child subsets, discuss progress and use examples from the video to mark changes. Make a family film to highlight the positive moments for the parent and provide a model for future interactions.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Parents' history of being parented and family relationships	Explore the parents own experiences of childhood and being parented, both trauma/adverse experiences as well as positive experiences. Ask questions such as "In what way would you want to be like your mother/father?", "What things would you want to do differently?" and "Who in the family does the child remind you of?" What is the parents' connection to their families? Do they view this connection as supportive or difficult? What involvement does the parent want their child to have with extended family? What is the parents' ability to express their thoughts and feelings about their past experiences as children?	Partner with the parents to reflect on the genogram and plan for how they want their family involved in supporting them. Arrange a family meeting to gather together all the people with an interest in supporting the safety, stability and development of the child. Explore issues of identity and cultural connections for the young parent. Provide an opportunity to connect with cultural groups and activities.	Identify people in the family and cultural community who can provide support to the parents and the child. Collaborate to develop an inclusive plan for who can do what, when and how. Make sure the young parent has an opportunity to have time out but in such a way that her/his parenting role is not undermined by other family members. Assist the parents to repair relationships with family members and discuss the importance of repair in building a secure base for their child.	Review with the parents any changes in connections with their family. Bring all family members together to gather perspectives from others in how the support plan is going and if the child's needs are being adequately met. Is the parent able to coherently think and feel about their past experiences without reliving them?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Factors that impact on day-to-day or ongoing parental functioning	Does the family have any physical and/or mental health issues or a disability that might cause difficulties in their capacity to parent? What is the level of and circumstances surrounding any alcohol and drug use? Is family violence present within the family? What is the observed impact of these issues on the parent's capacity to respond sensitively to their infant? What does the parent find stressful? How does the parent react to stress? What does the parent find calming and comforting? Is the parent connected to any treatment and support services? What has been helpful for the parent in the past? Does the parent have insight into the potential challenges and impact on their parenting role? What is the parent's capacity to meet the child's needs on a 'good' day? What is the parent's capacity to meet the child's needs on a 'bad' day? What makes it a 'bad' day?	Partner with the parents to explore issues and support engagement with treatment to address mental health issues, drug and alcohol misuse, family violence, and/or past experiences of abuse. Apply theory of change and be realistic, open and plan for the possibility of relapses. Consult with Child Protection as indicated.	Identify professional supports, utilise care team, seek secondary consultation and promote access to services. Observe the actual day-to-day functioning of the parent across different contexts and over time. Use actual examples of parenting behaviour to highlight strengths and progress. Explore challenges and motivate change.	Stand back and reflect critically on your work with the family. Arrange a professionals meeting to bring together all the relevant information, outcome measures, assessments and broader perspectives to inform and assess progress against the action plan. What has constrained progress and impacted on program success? How are constraints overcome?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Sources of support	Who provides support for the parent in their role? Do the parents have more informal or formal supports in their life? Who could they call on for help, especially in an emergency and after hours? How helpful is the "help" the parents receive from others? Are there any additional supports they require to care for their baby? Does the family have the physical and financial resources to provide adequate care for the baby (e.g. formula, nappies, clothing and blankets)?	Is there adequate support available to this family to ensure the child is safe? Explore with the family what supports they need and help to engage professional and non professional supports around a common interest in the child.	Provide information and help parents develop an emergency plan so they know who to call on for help. Work with the parents to build their capacity to solve problems and access resources independently, such as financial planning and engaging with social groups (e.g. playgroups).	Review progress using the Family Star and the eco map with the family. Have the parents engaged with other forms of support in readiness for ceasing involvement with Cradle to Kinder? How has the family engaged their support systems to help solve problems? Record use of flexible funding support.
Current family composition and dynamics	Who forms 'family' and community for the child?	Who forms 'family' for this child, including parent figures, siblings and the other key relationships within the family, both now and previously. Who forms 'family' for the parent? Are there former carers who are part of the parent's 'family'? What are the strengths and challenges embedded within the family relationship dynamic? Are there family members that the parent wants to reconnect with? Does the family want to connect or reconnect with members of their cultural community? What are the patterns of behaviour and how has the family dynamics played out over time?	Review the ecomap and genogram to explore with the parents the connections that provide support and are protective for the child. Recognise that family membership may change as the child grows older. Explore the influence that the absent parent or family member has on the current situation.	Work in partnership with parents to identify who they want to be involved in supporting the child. Arrange a meeting as soon as possible to gather together the perspectives and resources available to the parents. Include family and community members in the action planning process. Help parents to allocate roles and responsibilities and manage any difficulties.	Review family composition and dynamics to ensure the parents and child's needs are being met. Has the program done all that can be done to help parents connect with and gain support from family and community?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Family history	Trans generational patterns	What are the transgenerational patterns of behaviour and parenting in the family? How are these issues understood and described by the parent? Are there stories of resilience, courage and strengths in the family history? How are they likely to impact on the parenting of this child? For Aboriginal families, how has the history of trauma, racism and disadvantage been experienced and how does it impact on the current situation?	Explore and discuss issues of cultural and family history with the parents. Partner with them and provide support in reflecting on what they need to safely parent the child. Seek cultural consultation. Think about organisational issues that might create a barrier to engagement and service effectiveness for parents who have experienced child removal in the past.	Use the genogram as a way to explore strengths and positive aspects of family. Ask what patterns of behaviour and parenting the parents hope to bring into their own family and what things do they not want to repeat. Work collaboratively with the family and services to provide support to help parents achieve the goals they identify. Support the parents to identify a safe network for their child.	What positive examples of change are evident? Have you acknowledged effort and highlighted positive examples? Have the negative aspects of repeated patterns been identified and what can the program do to provide additional support?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Social and economic environment	Financial security	What are the family's sources of income? Are they sufficient to meet the additional demands of infant care? What sources of additional financial support are available in times of crisis (both informal and formal)? Are there adequate finances to purchase a safe cot, nappies, clothing and formula? Does the family need some assistance with financial planning to ensure provision of basic care items? Are they impulsive or are they able to follow through on decisions they make about finances? Does either parent have problems with gambling or drug use?	Explore the pattern and history of the parent's ability to prioritise spending and manage finances independently. Support the family to engage in financial counselling, where appropriate.	Partner with the parents to develop a plan to prioritise expenditure for care of the child and the basic survival needs of the family. Work with the parents and the care team to identify and access community resources and promote financial independence. Use the Family Star outcome, 'providing home and money', to support reflective conversations and to motivate change.	Is the child always provided with adequate food and clothing? To what degree is poverty impacting on the parent's ability to meet the child's needs? How many times have flexible support funds been needed to buy basic items and what does this mean for the ability to self manage? What else can the program do to build sustainability?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Housing	How often do the family move and what are the reasons for this? Is the current housing stable and suitable for raising a young child? What is the current status and stability of the family's housing? Where is the young parent residing? Is it appropriate for a new baby? Has this young parent lived independently and what skills might be needed to manage this? What is the family history of housing stability? Are the family connected to a housing agency who will be included as part of the care team? How familiar is the family with their current neighbourhood and do they have community and social supports available to them? How will the housing situation impact on the parents' ability to parent?	Based on historic patterns and current circumstances, explore the stability of the living situation for the family. Reflect on how this might impact on their engagement with the service and retention in the program.	Work collaboratively with the parents to promote the importance of establishing stable and secure housing for the family. Provide information and engage the family in financial management strategies to increase housing stability. Provide information, skills training and support in how to live independently. Support the family to connect with housing support agencies. Include the housing worker in the care team.	How many times has the parent had difficulty in paying rent? Acknowledge efforts to stabilise accommodation and reinforce the importance of this to the child. Record any moves and follow up to retain the parent in the program. Record when the young parent leaves care.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Education	Has the young parent continued to connect with their school? What plans do they have to continue with their education after the birth of the baby? What was their experience of school in the past? Who has provided support to them at school during the pregnancy and what support can this person provide after birth? Does the young parent place any value on the importance of continuing education?	Explore the support available to enable the young person to continue their education. Partner with the parent to think about what would help maintain engagement in school or reconnect with an education pathway.	Explore and discuss the role that education and training for the parent has in supporting the future outcomes for the child. Actively support the parent to engage in school by including this in the action plan. Extend your knowledge of what programs are available for young parents and make links with services.	How is the parent progressing with their plans to return to education? What else can the program do to support this goal? What is getting in the way of success in this area? How can progress and achievement with parenting help build confidence and capacity to engage in formal education?

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
	Employment	What is the employment history for the family? Are the parent's connected to an employment support agency? What are the plans for future training and employment for the mother and/or father? What supports and information might be needed to connect the parents to future opportunities for skills training and employment? How would employment impact on the parenting and the child?	Reflect on the factors that impede or could facilitate the parents gaining employment. Be aware of Maslow's hierarchy of needs and the likely timing of when this is a feasible goal for the parent.	Stand back and think carefully about what the priorities are for the parent and the child at this time. Focus on building the self-confidence and capacity that will be a platform for engaging in employment. Assist the parent to explore and identify appropriate and safe childcare options. Increase your knowledge and partnerships with organisations who provide training and employment programs for young and vulnerable people.	What has been done to connect the young parent to training and employment pathways? As other priorities have been met, has the program done all that it can to promote sustainability and independence for this family. What relationships and partnerships does the Cradle to Kinder service provider need to facilitate this outcome for parents? Record when parents are successfully linked to education/training and employment pathways.

Key Domains	Key considerations	Information gathering	Analysis and Planning	Action	Reviewing outcomes
Community partnerships, resources and social networks	Social networks and connections	Complete a genogram and ecomap or social network map to explore the available family, culture and community resources for the family.	Use your professional knowledge and relationships to identify the resources available and provide information to parents about what other networks and connections might be able to help the family. Think about how to facilitate engagement with services by working collaboratively with parents and sector partners.	Actively promote engagement with community services and opportunities to build informal support networks (e.g. playgroups, parent support groups). Keep in mind the role of the universal service platform in providing sustained support for families and discuss this with parents. Help parents to work out ways of navigating the services and solving problems of access in order to build self-confidence.	Review community connections with the Family Star to assist the family in building on progress. Partner with the family to identify and challenge the strength of engagement with and access to other services. How dependent is the family on your advocacy when accessing supports? Do the family have the type of support they need to manage independently?
	Services involved	What other support services are the family involved with? What do they use them for? How helpful are they. What other services are required? Who might have been connected with the family previously who can provide information and support engagement in Cradle to Kinder?			
	Connection to universal services	What is the connection to universal antenatal and early years services? Is the family aware of the automatic referral to maternal and child health services at birth? Has the family connected with the maternal and child health service? Does the family know how to access child care? Would early connection to childcare and access to the childcare benefit assist the parents and the infant? Are there contra-indicators for child care, such as the child's experience of disrupted attachment? Are there playgroups the parent/s can attend with the child?			

5.3 Responding to families

5.3.1 Use of flexible support packages

Flexible support funds (service brokerage) are available to families participating in the Cradle to Kinder program. Flexible support funds of up to $3,000 per family enable the Cradle to Kinder service to provide additional supports that have been identified in the child and family action plan. Flexible support funds can assist in providing immediate practical help for families and has been found to positively impact on engagement in the early phases of program involvement. It is important that, before accessing flexible support funds, staff work with families to promote financial independence and explore other sources of funding available to the family in the local community. Cradle to Kinder service providers are responsible for monitoring, accounting and reporting on expended funds.

Flexible support funds may be used for:

- flexible childcare or respite
- purchasing a specific service capacity to overcome service gaps or access specific interventions, such as specialist assessments for children or specialist interventions
- dental treatment
- medical interventions for the child and family
- one-off payments to address immediate safety issues within the client's home (e.g. a safety standard approved cot)
- purchasing baby clothes, nursery and play equipment
- payment of utilities bills
- emergency assistance with rental payments
- educational assessments, tutors, training or educational costs.

It is important to note that, whilst the use of flexible support funds to provide practical assistance is helpful in engaging parents, providing practical help is only one aspect of the intervention. If the underlying issues leading to the requirement for funding and practical support are not addressed, then small changes brought about will be unsustainable and unlikely to make a lasting difference. Staff can also become disappointed and lose hope when they see that the impacts of their efforts are not sustained over time.

5.3.2 Connecting parents with education and training

Education and learning are critical to an individual's life chances and education is a pathway out of poverty and intergenerational disadvantage. The unemployment of parents can have an impact on children's development with children who come from economically disadvantaged backgrounds experiencing poorer outcomes in health and education (DEECD 2010). Both national and state governments have adopted strategies to increase levels of educational attainment and improve connections to employment opportunities. The Cradle to Kinder program priority groups are more likely to experience barriers to education and employment. Connecting parents to education, training and employment pathways is therefore an important goal for the Cradle to Kinder program in order to promote self reliance and reduce welfare dependence.

Reviews of the effects of early intervention programs in improving the economic situation and self-efficacy for parents show mixed results (Watson, White et al. 2005; Watson and Tully 2008). The exception to this is in two of the three trial sites for Old's Nurse Family Partnership program (Olds et al. 1998, 2004, 2010) where, in working with young unmarried mothers, there was a reduction in the use of welfare, an increase in employment and longer spacing between pregnancies.

Factors associated with unemployment and the poverty cycle are extremely complex. Family, community and neighbourhood factors are all relevant, as are individual factors such as experiences of neglect and abuse trauma, disability and single parenthood. Half of all children in one parent families live in a household where no adult is employed (COAG 2012). Aboriginal families are greatly impacted with Aboriginal parents more likely to have lower education levels, higher unemployment and underemployment levels and be unemployed for longer than their non-Aboriginal peers (DEECD 2010).

Young people in care and after leaving care do not do as well as the general population in education attainment and employment. Cashmore and Paxman (2007) found that young people who had been in care were much less likely than their 20-24 year old peers in the general population to have completed Year 12 (42% of care leavers compared with 80% of young people their age).

Capacity for self-efficacy and independence are major factors in an individual's ability to perform many of the tasks involved in employment. Young people who have experienced trauma often struggle to develop self-efficacy or a sense of competence if they have little or a distorted sense of control or personal power (Jackson, Waters et al. 2013). The impact of trauma and grief on Aboriginal people's self-efficacy was noted in the HREOC (1997) Bringing Them Home report. The absence of self-efficacy or confidence in one's ability to cope with difficulties can lead to increased hopelessness (Schmied and Tully, 2009).

Over the period of Cradle to program involvement, service providers can work with education and training providers, Centrelink and parents to develop strategies to support access to education, training and employment opportunities that will assist them to make positive changes in their lives and improve the family's capacity to be self supporting. Strategies to build relationships and links with the education, training and employment sector can be implemented across different levels of the organisation and include participation in local area education, training and employment networks, the engagement of service providers in local Cradle to Kinder advisory groups and the forging of relationships directly with providers that arise from individual case work with parents.

Whilst there is little clear evidence regarding what works best in increasing access to education and employment opportunities, some strategies that are likely to assist include:

- Working collaboratively with parents to increase their confidence and sense of competence in their parenting role, which can then be used as a platform for increasing their sense of competence more broadly.
- Promoting to parents the positive impact of education and training on their employability and the subsequent improvements in outcomes for their children's health and education that are likely to result from their being employed

- Supporting young parents to reconnect with education within six months of the baby's birth
- Supporting parents to engage in therapeutic services to assist them to address issues that may impede their ability to access education or employment, including those related to past trauma, alcohol and other drug misuse, mental health concerns and managing poor impulse control.
- Helping parents to access financial support and brokerage funds to fund education and training programs.
- Assisting parents to access quality childcare and the Special Child Care Benefit.

Resources available to support young people in reconnecting with education and employment opportunities include the following:

- "Springboard" is a program that provides intensive, individualised education and employment support for young people leaving care who are disengaged from education, training or employment. Brokerage funding is available and managed by the Springboard service provider to enable flexible, creative responses to meet young people's individual education, training or employment support needs and to overcome barriers to their participation. More information is available at <http://www.dhs.vic.gov.au/about-thedepartment/plans,-programs-and-projects/ programs/youth-specific/springboardintensiveeducation-and-employment>
- Zero tuition fees for accredited training is a DEECD initiative that provides free tuition for accredited training courses from Certificate 1 to Diploma level for young Victorians who are currently subject to custody or guardianship orders and living in out-of home care.
- Transition Brokerage is available for young people over 16 years of age on custody or guardianship orders to purchase services or materials that would benefit their individual, personal or vocational development (e.g. education resources, life-skills
- education, recreation and hobbies).
- Post-care Brokerage may be used for any purpose that will assist the young person to achieve and/or maintain their independence. Brokerage may contribute to accommodation costs, health and dental care that cannot be covered by Medicare, education, training and employment, access to health and community services, life-skills education and connections to community. More information is available at <http://www.dhs.vic.gov.au/ about-the-department/documentsandresources/reports-publications/leavingcare-guidelines-for-brokerage <http:// www.dhs.vic.gov.au/about-thedepartment/>
- CREATE Foundation's Create Your Future scheme awards grants of $300 to $3,000 to applicants aged 15 to 25 years who have had a statutory experience. Grants are categorised under the following areas:- accommodation/living, education/training, driving lessons subsidy, health and wellbeing, laptops for education/training, travel/conferences and other items (e.g. clothing, uniforms for employment, computer equipment/software). Refer to <http://www.create.org.au>

5.3.3 Working with culturally and linguistically diverse families, including refugee families

Cradle to Kinder program requirements state that, in working with culturally and linguistically diverse families, service providers will:

- Have policies, processes and/or practice guidelines in place to promote the competence of management, staff and carers in working with culturally and linguistically diverse communities.
- Collect information on the cultural identity of clients, including country of birth, preferred language and if an interpreter is required.
- Have protocols in place to establish mutually respectful and collaborative partnerships between culturally and linguistically diverse and mainstream services.

Parents from recently arrived and refugee communities experience the additional stress of adjusting to a new culture and way of life. They may have been exposed to traumatic events, violence, sexual abuse and forced to flee from oppression. In seeking asylum, many have spent lengthy periods of time in refugee camps prior to arriving in Australia. In addition to their traumatic experiences, parents are often isolated from their families and community which further impacts on their parenting (Miller 2012).

It is important that workers do not treat families from a particular cultural group or country as homogenous but rather understand and identify their individual experiences and needs. One of the most important skills to have as a practitioner working with people from many different backgrounds is the ability to explore the meaning of differences in perceptions, values, traditions and belief systems. Understanding some of the cultural, religious, political and economic situations that families have experienced prior to settling in Australia can assist practitioners in developing a deeper understanding of why parents see and do things in certain ways. Nothing replaces the need to identify and clarify with individual families what they perceive as their needs and how practitioners can best assist them but exploring some of the cultural differences in how things are done can be helpful in identifying potential areas of difficulty.

This section does not attempt to provide a comprehensive guide in how to work with all families from CALD backgrounds but raises some of the shared experiences for families who often face additional parenting challenges due to language, cultural and structural barriers.

Some of the issues that may make adjustment to life and parenting in Australia more challenging are:

- Roles of men, women and children within the family differ. Men in particular can experience a loss of status. Changes in cultural expectations can lead to increased tensions in families.
- Parents are isolated from the support of extended family and community that they would have expected to play a major role in helping to raise their children.
- Families often live alone as a nuclear family in Australia, in contrast to the cultural practice of living in larger extended family groups.
- In refugee communities the experiences of torture and trauma, grief and loss can be extreme and impact on relationships with partners and children. Family members are often separated and have died as a result of war, including the loss of children. Parents can be overwhelmed with feelings of grief and loss, leading to increased levels of depression and anxiety. Trauma can emanate not only from experiences from their home country but also from their journey to Australia and their experiences when they arrive.

- There is an increase in the number of women parenting alone in refugee communities.
- Lack of traditional role models to support parenting, such as elders in the community. Parenting concerns are usually dealt with in the family and community, not shared with unknown professionals. Placing the child in childcare can be very unfamiliar and a daunting experience for families from cultures where allowing people from outside the family and community to care for children is unheard of.
- Language and literacy barriers, as well as unfamiliar concepts and expectations of parenting, make it difficult to access help with parenting concerns

Strategies to work in partnership with CALD families include:

- Be open to different ways of defining family and explore each family's notion of who makes up the family and community for their child.
- Get to know and include all significant carers for the child.
- Help families connect with their community (e.g. through playgroups) so that they can meet and get to know other families in their local area.
- Keep in mind that there may be ethnic differences within refugee groups that mean that some families do not want to connect with other families from a particular CALD background.
- Build relationships with community groups to access support, information, guidance and networking links. Strong relationships help build the communities understanding of the service and can increase access and participation for other community members.
- Collaborate with other agencies who are involved with the family and link with specialist agencies to ensure effective support. Specialist agencies can partner with Cradle to Kinder service providers to deliver staff training and networking activities.
- Carefully explain the service to the family, how it operates, the professional skills and qualifications of staff and how it might benefit the family.
- Take time to explore and become familiar with the cultural child rearing practices and routines of families. Acknowledge and respect the cultural practices that have successfully raised healthy children over many generations, often through incredibly difficult situations. Offer information and new possibilities, such as appropriate foods for a young baby, starting with what is familiar and then expanding to include new, unfamiliar and available foods.
- Allow flexibility with appointment schedules as many families will have been accustomed to presenting to a service and waiting, rather than having a scheduled appointment time. Explain why your work is arranged in this way to help parents understand the reasons for this and so as to reduce the likelihood of them dropping out of the service. Providing a calendar to enter appointment times and offering reminder calls or text messages have been shown to help.
- Respect the family's culture and first language by using culturally appropriate play resources and encourage the use of traditional songs, rhymes and language resources in the home language.
- Be aware that many parents have low literacy levels in their own language and that there can be many different language groups for people coming from the one country. Check understanding and present information in verbal, written and pictorial format.

- Open up for discussion the areas where cultural differences are most likely to occur such as sleeping routines, home safety and behaviour management. Provide explanations for what, how and why we recommend certain strategies. Respect and explore the ways that children have been cared for and kept safe in their culture.
- Work with peer leaders or workers from the family's cultural group where possible but be aware that in small communities the worker might be known to the family and this can impact on confidentiality and service provision.

Communication is a key factor in providing the Cradle to Kinder service and workers must ensure access to language services for families unable to communicate in English. The use of accurate interpreter and translation services improves both access to services and service effectiveness. Effective communication is an essential feature of creating safety within a helping relationship for people who have experienced trauma (VFST 2009).

Access to professional interpreters for some language groups in newly arrived or small and remote communities can pose a challenge for practitioners and may require forward planning and scheduling. The Department of Immigration and Citizenship (DIAC) provides the TIS National interpreting service. TIS National is available 24 hours a day, seven days a week over the telephone for any person or organisation in Australia requiring interpreting services.

The ability to effectively and competently work with interpreters is essential to effective cross-cultural practice. Clearly, poor skills at working with interpreters will hinder the ability to make accurate assessments, formulate plans for effective interventions and develop positive relationships with clients.

Strategies for working with interpreters include:

- Work with professionally accredited interpreters or bi-lingual workers only. Do not use untrained people, children or family members as interpreters.
- Determine if the parent wants a female or male interpreter.
- Be aware that in small communities the interpreter might be known to the family. This can impede confidentiality.
- Face and speak directly to the family, not to the interpreter.
- Seek clarification and check understanding to make sure the family understand what you have said.
- Check in on how the interpreter met the expectations and needs of the family. If suitable, try to book the same interpreter at each visit in order to promote trust and ensure consistency.

Practice Resources

- The Department of Human Services *Cultural Diversity Guide* (2006) aims to assist agencies by identifying a range of available strategies to improve cultural responsiveness and levers to effect cultural change. It is available at <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0004/594877/cultural_diveristy_guide_2006.pdf>
- The Department of Human Services *Language Services Policy* (2005) outlines the requirements necessary to enable people who cannot speak English, or who speak limited English, to access professional interpreting and translating services when making significant life decisions and where essential information is being communicated. The policy is available at <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/language-services-policy>

- The Victorian Multicultural Commission provides independent advice to the Victorian Government to inform the development of legislative and policy frameworks, as well as the delivery of services to culturally, linguistically and religiously diverse communities. Further information is available at <http://www.multicultural.vic.gov.au>
- The Australian Multicultural Foundation initiates projects and programs that promote an awareness of the diversity of cultures within Australia and the contribution of people from all cultures to the development of Australia. Further information is available at <http://amf.net.au>
- The Raising Children Network is an extensive resource for parents and professionals. It has many up to date, evidence based information guides and helpful resources, including a tip sheet on working with interpreters. <http://raisingchildren.net.au/working_with_parents/working_with_parents_landing.html>
- The Australian Childhood Foundation has some resources for parents translated into several different languages available at: <http://www.kidscount.com.au/website/default.asp>
- The Victorian Foundation for Survivors of Torture Inc (Foundation House) provides a range of services to people from refugee backgrounds who have survived torture or war related trauma. It provides direct services to clients in the form of counselling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. Direct services to clients are coupled with referral, training and education roles aimed at developing and strengthening the resources of various communities and service providers. Further information is available at <http://www.foundationhouse.org.au/about/index.htm>
- The Translation and Interpreting Service (National) is available 24 hours a day, seven days a week over the telephone for any person or organisation in Australia requiring interpreting services The contact number to access an interpreter over the phone is 131 450.
- Migrant Resource Centres are located in different locations across Australia and provide a range of services aimed at helping to settle and integrate recently arrived people into the community. For details about the services funded in your local area go to <http://www.dhs.vic.gov.au/funded-agency-channel/management-toolkit/diversity/cultural-diversity/migrant-resource-centres-metropolitan-victoria>
- Adult Migrant Education Service (AMES) provides English language classes, employment, training and settlement services to new and recently arrived refugees and migrants. Refer to <http://www.ames.net.au> for details of your local service.

5.4 Working with families from the target group

5.4.1 Working with young parents

Adolescence is the developmental stage bridging childhood and adulthood when significant physical, cognitive and emotional change takes place. Developmental progress cannot always be predicted by age and is strongly influenced by the individual's cultural, family and personal experiences. In some cultures, parenting in adolescence is viewed as socially 'normal' whilst, in Western cultures, teenage pregnancy is seen as a major social concern, with governments investing in social, economic and educational programs in order to reduce its prevalence.

In a recent longitudinal study of adolescent mothers and their children (Whitman 2011), adolescent parents were more likely to have children with disorganised attachments and attachment styles that are less stable over time, although this was not always the case.

Parenting at less than 16 years appears to increase the level of concern but it is the social and interpersonal difficulties leading to reduced emotional readiness and capacity for parenting that are more important considerations than age itself.

Not all teenage pregnancy should be presumed problematic but the developmental process of adolescence can conflict with the tasks involved in becoming a parent (Easterbrook, Chaudhuri and Gestsdottir 2005) and lead to poorer outcomes for both parent and child. Becoming a parent during adolescence disrupts the normal developmental pathway and is particularly disruptive to education, often leading to a premature disconnection with school, reducing education attainment levels and impacting on later opportunities for employment and self reliance for young mothers. Some studies suggest that teenage pregnancy is more often a consequence of adverse childhood factors, low educational attainment and reduced school-related self-esteem (Coren, Barlow and Stewart-Brown 2003), leading to teenage mothers having reduced learning potential and cognitive readiness for parenting.

Other challenges experienced by pregnant and parenting young people include:

- The obvious body changes of pregnancy can further complicate adjustment to the changes in body image brought about by puberty. Some young mothers can resent what the foetus is doing to their body.
- Adolescence is a time of reflecting on and testing the relationship with parents. Pregnancy usually involves a process of the new mother identifying with her own mother, in contrast to the adolescent task of separating emotionally from parents. The birth of a new baby creates the need for additional support from the young mother's parents and can be in direct contrast to the adolescent's usual developmental task of negotiating independence from parents. Sometimes this conflict can result in a total abdication of parenting responsibilities to the grandparents or in a desire by the adolescent parent to be independent and to isolate themselves from parental support (Reder and Fitzpatrick 2003).
- Adolescence is usually associated with an egocentric nature of thinking and decision making and with experimenting with and exploring relationships and social experiences. This is in direct contrast to the requirements of parents to be focussed on and prioritise for the constant demands and needs of the dependent baby for attention and care. Even during pregnancy the adolescent mother has to acknowledge the needs of the baby as separate to her own and assume responsibility for care of the foetus as a developing being. Denial of the pregnancy is not uncommon and can lead to lack of engagement in antenatal care until the later stages of pregnancy.
- Emotional issues associated with adolescence, such as difficulty in containing emotions, acting on impulse with little regard for consequences and blaming others, can generate feelings of anger and resentment towards the infant.
- Adolescence is a time of risk taking, with more focus on seeking reward and instant gratification rather than on considering the costs or consequences of the risky behaviour. Risk taking in adolescence is explained by the neurobiological fact that the adolescent brain has not yet fully developed the adult capacity for self-regulation and decision-making (Steinberg 2005; Gardiner and Steinberg 2005).

Young mothers are more likely to (Coren, Barlow and Stewart-Brown 2003; Newman 2012):

- Come from a background of socioeconomic disadvantage and low educational attainment
- Have their own family history of abuse and neglect.
- Delay or avoid antenatal care.
- Smoke, use alcohol in harmful ways, use illicit drugs and have poor nutrition during pregnancy leading to pregnancy and birth complications (Shaw and Lawlor 2007; Molbourn 2007).
- Have a higher risk of pregnancy and birth complications, due to associated factors including poverty, poor education, low social support and inadequate antenatal care, rather than due to maternal age and physical immaturity
- Suffer depression (age <20) (Laws and Hilder 2008).
- Struggle to adjust to the realities of parenting and to placing the needs of the baby first.
- Be less verbal with their children, placing them at risk of delayed language and cognitive development.
- Be less knowledgeable about child development and have unrealistic expectations of their child's behaviour.
- Perceive their child as more difficult and provide restrictive and punitive parenting.
- Be less sensitive in their parenting interactions.
- Provide parenting that is less stimulating.
- Have children with disorganised attachment (Loundes et al. 2005).

Many of the factors associated with young mothers are applicable to young fathers but much less is known about adolescent fathers. Just like young mothers, young fathers are usually from disadvantaged backgrounds and have low education and employment prospects. Young parenthood has also been shown to increase the risk of psychosocial problems, antisocial behaviour and low self-esteem for young men (United Nations 2011). There is also an association between increased risk of crime and young fatherhood (United Nations 2011). Young fathers are less likely to have completed school, have higher unemployment rates and are therefore less likely to be able to contribute economically to the support of their child. Young fathers are also less likely to have knowledge of child development and child care activities, so require additional support and inclusion in program activities in order to provide them with the opportunity to acquire confidence and competence in their parenting role.

Strategies for working with young parents include:

- Engage the extended family in interventions with adolescent parents. Recent research shows that, contrary to previous beliefs, parental involvement dwindled during the teenage years but that parental involvement is crucial to provide support for adolescent development (Robinson, Power and Allan 2011). Whilst the involvement of the family is crucial, young parents need to be encouraged to increase their sense of competence and confidence in their new parenting role.
- Work to re engage the young person with schooling. Getting young parents back to school within six months of the birth is found to reduce the likelihood of repeat pregnancy and increase the likelihood that young parents continue their education. Assisting the family to engage with schools to support the young parent and building the capacity of schools to engage and retain young parents can be helpful activities for Cradle to Kinder service providers.

- Help in reducing the rate of subsequent pregnancy. Evidence shows that intensive psychosocial support after birth and engagement with school are the most successful ways to prevent early repeat pregnancy (Committee on Adolescence and Committee on Early Childhood, Adoption and Dependent Care 2001; Olds et al. 1997). Engaging the young woman in family planning and adolescent focussed women's health services is also an important factor.
- Engage fathers. Contact with fathers is associated with improved outcomes for children. Adolescent or adult fathers who maintain active participation with an adolescent mother in the prenatal, neonatal, and immediate post-partum processes have a greater likelihood of ongoing involvement with their children (United Nations 2011).
- Use innovative approaches to parent education and instruction. Engaging young parents with web based resources and support groups might appeal.

5.4.2 Working with parents who have experienced trauma and neglect as children

Being responsive and attentive to the day-to-day needs and demands of babies and young children is something that many parents find challenging and, at times, daunting. Although evidence shows that parents who have been abused and neglected in childhood are more likely than others to abuse and neglect their own children, this is by no means always the case (Egeland, Jacobvitz and Sroufe 1988). Selma Fraiberg and colleagues (1975), in their seminal article on 'ghosts in the nursery', ask why some families appear destined to re-enact the tragedies of the past whilst others seem galvanised by their past to ensure the same does not occur for their own children.

> *"History is not destiny, then, and whether parenthood becomes flooded with griefs and injuries, or whether parenthood becomes a time of renewal cannot be predicted from the narrative of the parental past. There must be other factors in the psychological experience of that past which determine repetition in the present."* (Fraiberg, Adelson and Shapiro 1975)

There are multiple factors that contribute to a person's resilience in the face of adversity, including intelligence, temperament and being successful at something (Egeland, Jacobvitz and Sroufe 1988; Newman 2012). Egeland and colleagues (1988) identified the availability of strong supportive and consistent relationships that provided an alternative model from the abusive relationship to be the most important factor. He identified three relationship variables most likely to protect parents against repeating the parenting patterns they had experienced. These were:

- The availability of an emotionally supportive relationship during the child's early childhood years, other than the abusive relationship,
- Undergoing therapy with a professional for at least a 12 month period at some time in the parent's life, and,
- The formation of a stable and satisfying relationship with a partner during adulthood.

Trauma is the overwhelming and uncontrollable feeling of intense fear, helplessness and loss of control in response to terrifying life events (Herman 1997). Exposure to multiple, chronic and prolonged trauma, including experiencing family violence, physical and sexual abuse and neglect, especially in early childhood, has pervasive and long-term effects Van der Kolk 2003).

If trauma has occurred in the context of supposedly trustful relationships early in life and in a continuous or frequent pattern, then it is understood as complex trauma (Herman 1997).

The parent's previous involvement in Child Protection and out-of-home care when he or she was a child is an obvious indicator of past abuse or neglect, but some adults may have experienced similar histories of child maltreatment without having come to the attention of Child Protection services. Whether or not they were involved with Child Protection services and/or out-of-home care, they may have been exposed to other types of trauma, as well as intrafamilial abuse. For those who were involved in the protection and care system, they may have experienced secondary traumas, such as medical examinations, court cases, separation from family and other adverse experiences. Secondary traumas can add to the weight of difficulties and thus the likelihood for longer-term harm.

There are different ways of understanding how trauma and neglect can be transmitted across generations and the opportunities that may exist to change or divert this pattern. As family systems theory reminds us, families exist not only in time but over generations. Trauma theory and attachment theory can also provide useful insights into understanding some of these processes. A commonly understood mechanism for the transmission of trauma from one generation to the next is through the impact of the originating childhood trauma on the parent then creating problems for their own child/ren. For example, a parent with serious difficulties with affect regulation, such as modulating his or her anger or fear, may create a traumatic environment for children and others in the household. Alternatively, the parent's fear of harming the child, due to difficulties with anger or avoidance and numbing symptoms, may lead the child to experience an absence of interaction (Auerhahn and Lamb 1998).

Experiences of children who have suffered early in life trauma and neglect are varied and are dependent on many factors, such as the types of abuse and neglect, the presence of other trauma, the age of the child when the negative experiences occurred, the positive developmental experiences that were missed, access to inter and extra-familial social supports and attachment relationships. Understanding these experiences for children can aid our understanding of what difficulties they may experience in adulthood and in parenthood. For example, studies have found different consequences associated with different types of maltreatment, including the following:

- Physical abuse has been found to be associated with developmental delays, problems with anger and violence, difficulties in forming and sustaining positive friendships, language problems, substance abuse problems, dissociation, mental health problems, such as PTSD, depression and borderline personality disorder, and major attachment problems (Briere 1992; Gibbons, Gallagher et al. 1995; Herman, Perry and van der Kolk 1989; Kaplan, Pelcovitz and Labruna 1999, Lynch and Roberts 1982; Schore 2001; Turner, Finkelhor and Ormrod 2006).
- Sexual abuse has been found to be associated with sleep problems, school problems, poor self-esteem, self-harming behaviours, substance abuse problems, dissociation, distorted sense of sexuality and mental health problems (Briere 1992; Browne and Finkelhor 1986; Finkelhor and Browne 1985; Herman, Perry and van der Kolk 1989; Sutherland 1996; van der Kolk, McFarlane and van der Hart 1996; Vivekanada 2000; Wolfe, Gentile and Wolfe 1991).

- Emotional abuse has been found to be associated with hyperactivity, problems with attachment, self-harming and suicidal behaviours, distorted sense of self, cognitive developmental problems, difficulties forming and sustaining friendships and some mental health problems (Briere 1992; Glaser 2002; Iwaniec 1997; Thompson and Kaplan 1995).
- Neglect has been found to be associated with developmental delays, neurological damage, anger and aggression, language problems and some mental health problems (Allen and Oliver 1982; Perry, Colwell and Schick 2002; Perry and Pollard 1997; Schore 2001; Turner, Finkelhor and Ormrod 2006).

A particularly concerning reality is that too many children have experienced multiple types of trauma. For example, in the Take Two population, over 90% have experienced more than one type of abuse and neglect (Frederico, Jackson and Black 2010). Researchers, such as Perry, have focused on the impact of developmental trauma on children, across the full range of traumatic and deprivation experiences. For example, exposure to abuse and neglect has been shown to disrupt the development of neural pathways, such as those involved in self-regulation, experience of reward and capacity to understand social cues and develop positive relationships (Perry 2009). As Perry states, "*Chaos, threat, traumatic stress, abuse, and neglect are bad for children*" (Perry 2006: 29). Of course, these experiences are also 'bad' for children when they become parents and wish to provide an alternative experience for their children.

It is not difficult to imagine the challenges in parenting that could be exacerbated when just some of these difficulties are present. The hope is that many children who experience such trauma and neglect will have subsequently experienced appropriate care and positive healing opportunities so that some, if not many of these difficulties, have been resolved or at least reduced before they become parents. Needless to say, however, such experiences of recovery are not as prevalent or as effective as we would hope and so many will reach parenthood with unresolved histories of trauma and neglect (Perry 2006).

Other mechanisms in which trauma experiences can be transmitted from parent to child and across generations include:

- A child may grow up feeling responsible for their parents' difficulties or may model their behaviours (Ancharoff, Munroe and Fisher 1998).
- Traumatic re-enactment is a common aspect of traumatisation and can lead to further traumatisation of the parent and of the child. For example, the parent may re-enact the role of the victim, such as through sexual exploitation or forming new relationships with violent partners, or they may re-enact the role of the perpetrator and involve others in the re-enactment, such as their partner or child (Ancharoff, Munroe and Fisher 1998). Transference can lead to memories of trauma being enacted in other aspects of daily life. The traumatised person may be unaware of why they react to situations in a certain way, knowing only that they are powerfully drawn to this kind of behaviour. When the originating trauma of the parents' own experience of child abuse or neglect remains unresolved, the inheritance that is passed to their children can be insidious. Parenthood may reactivate traumatic histories, so that new behaviours are enacted by the parent as the child reaches specific developmental stages. It is also likely that the prospect and realities associated with parenting may present with reminders and triggers for those with histories of trauma and neglect (Auerhahn and Laub 1998). The child's behaviours, or even just their presence, can trigger traumatic memories. Re-experiencing or re-enactment of the trauma and loss can

preoccupy the parent and make them unavailable to the child. The parent whose trauma is unresolved can also be frightening to their child because their responses and reactions are unpredictable or not contingent with the infant's behaviour. Parents whose traumatic memories are triggered by their infant's behaviour can be frightened by the child and dissociate. Women who have experienced past sexual abuse are at risk of re traumatisation during pregnancy and birth. The process of pregnancy, labour and birth can constitute a perceived loss of control for women and act as a potent reminder of the abuse. The invasion of her body by physical examinations and body changes from the pregnancy can also trigger traumatic memories and cause a barrier to engaging with antenatal services.

- Experience of trauma and neglect can impact on the parent's reflective capacity. The capacity to reflect enables the parent to consider the infant's emotional experience and interpret it in order to re-present it to the child in language that helps the child to understand the experience and related feelings. *'Oh you fell over when I was in the kitchen. You're crying. I am here now. Does your leg hurt? I know it feels yucky, but Mummy is here now. Let me kiss it better.'* It is through this process that the parent helps the young child to express emotions, manage them and understand them. A parent who understands and accepts her own emotions is more capable of helping her child to learn about and control emotions and behaviour (Kelly, Zuckerman et al 2008). The development of self-control has been found to be just as important in predicting future life outcomes for children as measures such as intelligence and social class (AIFS 2012). Parents can be helped to increase their child's capacity for self control by teaching them age-appropriate limits and expectations along with other parent education.
- Transmission of multigenerational trauma within the Aboriginal and Torres Strait Islander community has occurred through past government policies such as the Stolen Generations. This has lead to a range of consequences including disrupted child-rearing practices, barriers to passing on culture and lack of access to role models (Raphael, Swan and Martinek 1998). *"The whole impact of the processes of colonization, dispossession, discrimination, deprivation, and removal of children has affected indigenous family life in multiple ways and thus impacted broadly as well on successive generations."* (Raphael, Swan and Martinek 1998: 336)

These findings highlight the importance of gathering information with the parent about their own childhood experiences and exposure to other trauma, as well as the presence of any positive experiences. More recent research in the area of epigenetics will also increasingly inform our understanding of how some parent's experiences even before they conceived their child can change various characteristics they pass on to their children. Particular examples currently being researched include diet and stress. In other words, the environmental experiences in one generation can affect which genes are activated or expressed in subsequent generations.

Making sense of the impact of abuse and neglect requires a developmental perspective. Knowing the age of the child when he or she experienced trauma is a major guide for understanding its implications for the child (Perry 2006). Even in adulthood it is possible to have reparative experiences that work towards some degree of recovery from childhood experiences so this information is crucial in guiding this recovery work.

Another mechanism for transmission of trauma through generations is through attachment relationships. As seen from the research findings on the impact of abuse and neglect, children who are maltreated are at high risk of developing insecure or disorganised attachment with their parents. An important question is how this may impact on their subsequent capacity to parent and to support their children to have a secure attachment to them. For example, adults who had experienced secure attachment as children were found to be three or four times more likely to have securely attached children (Fonagy 1999).

> *"Early disruption of the attachment bond causes long lasting psychobiologic changes that not only reduce the capacity to cope with subsequent social disruption but also disturb parenting processes and create similar vulnerability into the next generation."* (Van der Kolk 1989:15)

Adult attachment styles are not in reference to the parents' response to their child, but refer to the ability to speak coherently about their own childhood experiences. Four adult attachment styles are (Main, Kaplan and Cassidy 1985):

(1) *Autonomous (secure) attachment style* = The adult is able to think openly and speak coherently about their past childhood attachment experiences.

(2) *Dismissive (detached) attachment style* = The adult is often unable to remember childhood attachment experiences or dismisses any difficulties and may idealise their parent or earlier experiences.

(3) *Preoccupied (entangled) attachment style* = The adult is caught up in childhood experiences and has a rambling way of speaking about the past as if it is still happening.

(4) *Unresolved (disorganised)* = The adult does not have a predictable way of thinking or feeling about past experiences and is highly chaotic and incoherent in attempts to relay the past.

Adult attachment styles are able to change with sufficient support, new relationships and/or therapy. For example, some adults who had childhood experiences of abuse and neglect may develop 'earned security'. They do not 'earn' this 'security' through willpower but through the positive support and influence of others (Roisman, Padron, Sroufe and Egeland 2002).

Adult attachment styles have been found to be predictive of the parents' availability and responsiveness to their children. For example, as seen in the table below, parents with an autonomous adult attachment style, even if they had a history of abuse and neglect, are more likely to have children with a secure attachment style (Van Iljendoorn 1995). Van IJzedorn's analysis of the different child and adult attachment styles found the following were strongly associated:-

Associated infant and parental attachment classifications (Van Ijzendoorn 1995)

Infant attachment styles	Adult attachment styles
Secure	Autonomous
Insecure-avoidant	Dismissing
Insecure-resistant or ambivalent	Preoccupied
Disorganised	Unresolved

In summary, research has shown that children's attachment style can be influenced by their parent's adult attachment style, distinct from the child's experience of previous abuse and neglect. Research has also shown that it is possible to influence a parent's adult attachment style. This therefore points to a clear target of intervention with parents who have an insecure or unresolved adult attachment style (Dozier, Stovall, Albus and Bates 2001). Namely, interventions should include a focus on helping parents to reflect and develop a coherent perspective of their past whilst simultaneously increasing their sensitivity to the child's cues (Belsky 1999; Dozier, Stovall, Albus and Bates 2001).

Becoming a parent is a significant developmental transition period. It is a time when people usually think a lot about their own experience of being parented and growing up in their family of origin. The transition process associated with parenting provides enormous opportunity for change, motivated by the fact that most parents want to do the best they can for their child. Working across the period from pregnancy and immediately after birth provides a window of opportunity for therapeutic intervention and healing to assist parents to understand and integrate their past experiences. Parents who have integrated and made sense of their past abuse are less likely to repeat the abuse in future generations (Egeland, Jacobvitz and Sroufe 1988). That is, parents who are able to remember, think about and understand their own childhood experiences and the potential impact it might have on their own parenting are less likely to re-enact the abuse (Newman 2012).

Mental health problems, such as those emanating from their experience of trauma, neglect and attachment problems, can make it difficult for parents to regulate their own behaviour and co-regulate with their infant. As mentioned in an earlier section in this practice guidance, co-regulation with the infant is essential in order to help the child develop his or her own self-regulation as he or she grows and develops. Parental psychosocial functioning has a significant impact on the capacity to sensitively attune to the infant and reflect on and empathise with the feelings of the child, the two most significant parenting factors contributing to attachment security (Barlow et al 2012).

An example of the impact of abuse can be seen in some women who have experienced childhood sexual abuse who struggle to establish a close and responsive relationship with their infant. Women report feelings of protectiveness, heightened awareness of children's safety and challenges associated with touch, attachment and breastfeeding as issues most likely to cause distress. The gender of health practitioners and the baby can heighten the impact, with males acting as a reminder of the perpetrator or being representative of the perpetrator in the mind of the woman.

Parents who have experienced abusive and neglectful parenting in their own childhood are more likely to repeat those parenting patterns when they have co-existing factors that include:

- Having current mental health issues, including depression and anxiety
- Being of a young age
- Living in chaotic, violent and unstable situations
- Misusing substances
- Experiencing current life adversities, such as poverty, housing insecurity and instability and/or lack of social support

Strategies for working with parents who have experienced trauma

The first principle in working towards recovery from trauma is to ensure the trauma is over and the person is safe (Herman 1997). Many of the behaviours of people who have experienced trauma are a result of their efforts to adapt and survive in an unsafe world (Hellett and Simmonds 2003). If they continue to be unsafe, they are unlikely to let go of survival strategies in favour of the vague promise of something better. For example, if a young woman is in a violent relationship or has recently left a violent relationship and is frightened of further violence and retribution, she is likely to continue to be hypervigilant and disregulated. Asking her to focus on learning new skills and co-regulating with her newborn child would require monumental effort and may, for her, feel unachievable. However, asking the same mother to focus on her baby once her own and her child's safety is assured will provide a better picture of what she is capable of achieving.

Another aspect of safety is developing a sense of security and confidence in others. This highlights the importance of engaging with the parents so that they can begin to see the practitioner as a source of reassurance and protection (Hellett and Simmonds 2003). Safety can be elusive and difficult to ensure for professionals involved with the family, as well as for the family. Team work is therefore crucial in these circumstances. The parents' experience of being abused or neglected by those who they should have been able to trust can add significant barriers to the process of engagement.

> *"The most basic principle in the treatment of early trauma is the establishment of a safe environment for the child and for the caregiving adults. This prerequisite can be challenging, particularly when the trauma involves interpersonal violence within the family, in the neighbourhood, or in the larger social context, and when the threat of violence is ongoing. The creation of safe external conditions is often beyond the scope of what the clinician can undertake to achieve"* (Lieberman and Van Horn 2004: 123).

Practitioners modelling empathy, persistence and their own capacity for self-regulation can demonstrate to parents an alternative to their past experience. If the parent was a client of the protection and care system, practitioners can have meaningful conversations with them that may help demonstrate the practitioner's understanding of their experience, in terms of both the positive and negative aspects. Some parents may look for points of difference between their own experience and their child's. Others may be comforted by similarities.

Stabilisation of symptoms or adaptations to trauma is another important step in the process of recovery from trauma (Herman 1998). There are various approaches to stabilising trauma-related symptoms. These include learning and practicing self-regulation and self-soothing strategies (e.g. breathing exercises, music and movement, therapeutic massage or yoga), cognitive behavioural approaches (e.g. self talk and challenging cognitive distortions or unhelpful thinking) and specific strategies for symptoms relating to alcohol and other drug usage.

Another step in recovery from trauma, once safety and stabilisation has occurred, is the re-telling and remembering the trauma in a way that helps the person make sense of their memories without reliving the trauma as if it is still happening (Herman 1997). This is a process where the harm can be exacerbated if the re-telling of the trauma is experienced by them

as re-enactment or triggering of the trauma. A key strategy is therefore to help parents with unresolved trauma access therapeutic treatment to aid their recovery. This can enable them to better meet the developmental needs of their child as well as facilitating their own experience of life enjoyment and a trauma-free existence.

Empathising with parents who are struggling to integrate their past experiences does not mean ignoring or excusing abusive or neglectful behaviour. Rather, understanding their past histories may better enable practitioners to determine the underlying causes of parental problems, to engage them and to assist them to seek help. Strategies that have been reported to help lessen the level of distress for women during pregnancy that may be triggered by their experience of trauma include (Stojadinovic 2003):

- Increased knowledge and understanding of the processes involved in pregnancy, birth and mothering.
- Awareness and exploration of how past experiences of abuse might impact during these processes.
- Increased sense of control in the choice of health practitioners, attendants and processes involved during pregnancy, birth and early parenting.

Whilst engaging parents in formal therapeutic interventions and counselling services is important, a systemic approach is also crucial in facilitating healing and recovery from trauma. The formulation of a care team is an effective way to provide a systemic response to trauma by ensuring that representatives of the significant aspects of a person's life are on the same page and can provide empathy, nurture and consistency. This is important for all the stages of recovery.

The final stage of trauma recovery is about reconnecting with others and discovering or re-discovering new goals (Herman 1997). Examples of this phase include building new skills (e.g. problem-solving strategies), planning and enacting positive activities and building and strengthening positive informal social connections and networks. Enabling the parent to reduce their reliance on formal social supports can be a major strategy to sustainable recovery.

5.4.3 Working with parents with learning difficulties

Cradle to Kinder Service providers are required to work in ways that are sensitive to the needs of children and parents with a disability including:

- seeking to understand the impact of the disability on the person and family
- providing a flexible service that recognises the strengths, wishes and desires of the person with a disability within their family context
- enabling parents with a disability to develop skills through modelling, practice and feedback to ensure generalisation (i.e. the ability to apply skills learned in one setting or situation to another) and maintenance of skills
- seeking secondary consultation from disability service providers, where required.

Children of parents with a learning difficulty can be at increased risk of neglect, resulting in health, development and behavior problems. Children can also be at higher risk of having an intellectual disability themselves due to genetic and/or environmental factors. Parents with a learning difficulty are over-represented in the Child Protection statistics and, in research across Australia, UK and US, have been shown to be 15 to 50 times more likely to have their children removed from their care (Bigby, Fyffe & Ozanne 2007). Unfortunately, this can often be

linked to the impacts of discrimination and social exclusion - such as poor living environments, prejudicial beliefs and expectations and gaps in support services - rather than resulting from the disability itself. Parents with a learning difficulty are more likely to experience poverty, lack of suitable housing, unemployment and low support from family and friends, all factors that make it more difficult to parent effectively. The incidence of parents with impaired learning capacity due to acquired brain injury is on the increase and can be associated with the impacts of problematic alcohol and drug use. It is important to keep in mind that parents may have significant differences in their cognitive skills, with some areas being relatively strong and other areas, such as memory and planning, being relatively weak. If practitioners have access to a cognitive assessment, it is more helpful to look at the specific information about the areas of strength and weakness, rather than just the IQ score. It is the understanding of the relative strengths of the parent that offers the best guidance in designing an approach to parent education that maximises the potential for the parent to learn.

Parents with a learning difficulty may face specific parenting challenges in the following areas:

- Flexibly applying parenting principles or skills, such as difficulty in adapting parenting skills to respond to the rapid changes in early childhood (e.g. parents may have difficulty adapting the amount of food a growing infant needs over time or adapting supervision required when the child starts to move independently)
- Recognising a child's cues and responding to the child
- Recognising issues of concern and solving problems
- Low literacy, such as being able to read only basic words
- Making judgements and decisions
- Long- and short-term memory
- Executive functioning
- Following complex instructions (Healthy Start 2012)

Clinical trials have demonstrated that parents with learning difficulties can and do learn, adapt and overcome parenting deficiencies when appropriate teaching methods and supports are put in place (Coren, Hutchfield et al 2010).

The best outcomes are achieved for parents with learning difficulties when support programs (Healthy Start 2012):

- Are suited to the parent's individual learning needs. Individual, rather than group-based programs, work best for skill development.
- Educate in the environment where that skill is needed. Parent education programs are most effective when they occur in the parents' own home.
- Use a structured approach (e.g. teach skills in small steps, model new tasks, provide accurate feedback and reinforcement and provide opportunities for practice and repetition).
- Are based on the needs identified by the family and involve parents in the planning and implementation of a program. The relationship between staff and parent should be a partnership, acknowledging that each person can be a resource to the other.

- Build parenting skills. Programs that aim to increase a parent's knowledge about parenting may be helpful, but teaching skills is required to help bring about change.
- Consider the different strengths, challenges and characteristics of the family and individual family members.

It is not unusual for parents with a learning difficulty to agree with your statements or just say 'yes' to questions regardless of the content. This may occur because:

- The parent does not understand the question
- The parent does not understand the type of answer that is required
- The parent may not be easily able to remember information that would help them answer the question
- The judgements the parent is being asked to make may be too difficult for them at this time
- The question may be poorly phrased, too long or too complex (Healthy Start 2012)

Checking parents' understanding of your conversations and the information you are giving them is of critical importance if parents are to get the most out of their participation in the program. Clarification is of utmost importance in the assessment phase so that you gain an accurate understanding of their needs and the supports they may require.

Tips for checking understanding:

- Use either/or questions instead of yes/no questions. An example of this is "Did that make you feel happy or sad?"
- Include an option of answering, "I don't know", to questions and make sure the parent knows that it is OK to say this
- Keep questions short and simple
- Use some open-ended questions e.g., "Tell me what you've been doing this week to practise the skills you've learnt in the program"
- Avoid statements or questions that have too much detail or are too complex
- Ask factual questions that require immediate and concrete answers
- Ask the parent to explain a comment you have just made or to tell you more about it e.g. "Tell me what it is going to feel like when your labour starts"
- Ask for examples to illustrate a comment
- Ask how the parent is going to do the task

Practitioners often feel challenged in knowing how to work effectively with parents with a learning difficulty. In a recent survey of staff, Frederico and colleagues (2012) identified that, whilst most staff applied best practice principles, they identified a gap in their access to specific and specialised information about how to work effectively with parents with a learning difficulty. It was to this end that, in 2005, the Healthy Start initiative was initiated (Healthy Start 2012). Healthy Start is a national strategy for researchers, policy makers, managers and practitioners to access and exchange knowledge, information, resources and expertise, with the specific aim of improving the health and wellbeing outcomes of children whose parent/s have a learning difficulty. The initiative provides a platform for collaboration and capacity building by facilitating and linking service providers with local hubs, facilitating forums and hosting a web based practitioner network. The Healthy Start website is a valuable resource for practitioners, providing access to relevant and up to date evidence summarised into comprehensive issues-based reviews, practice tip sheets and practical adapted resources suitable for use with parents with a learning difficulty.

Other helpful resources

The Brighter Futures Practice Resources website contains a series of practice resources that can be used by practitioners in their work with families (including in relation to working with parents who have an intellectual disability). They can be accessed at <http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/early_intervention_services/brighter_futures/brighter_futures_resources.html>

The Australian Institute of Family Studies website (at <http://www.aifs.gov.au/cfca/bibliographies/disabilityparent.php>) contains up-to-date research and information in relation to effective interventions with parents who have learning difficulties -

5.4.4 Working with families with multiple and complex needs

A review of Child Protection statistics reveals that many of the families who are referred to Child Protection services and whose children are at high risk of abuse and neglect, have multiple and complex problems. The co-existence and inter related complexity of problematic alcohol and other drug use, mental illness and family violence are particularly prevalent. These complexity factors rarely exist in isolation and are associated with broader complex issues of poverty and social exclusion (Bromfield, Sutherland and Parker 2012). Family violence, mental health problems and problematic alcohol and other drug use is closely related to experiences of physical and sexual abuse and neglect in childhood. Parents who have experienced abuse and neglect in their own childhood are highly likely to have problems with family violence, mental health issues and problematic alcohol and drug use in adulthood. The impacts of these problems on their parenting place their children at high risk of abuse and neglect, so perpetuating the cycle.

Wulczyn (2005) emphasised the importance of avoiding the use of a stereotypical approach when working with families with multiple and complex needs. He observed that not only do these families differ from other families experiencing fewer problems but they also differ from other families with multiple and complex problems. It is important that practitioners consider each family individually and tailor plans to respond to their individual needs. Being able to meet the family's specific needs and meeting their immediate need for practical help also appears to be crucial (Schorr 2003; Watson 2005). It is important to know and understand the problems that parents are experiencing so they can be supported appropriately. In terms of the impacts on the child, however, the parent's problem is less important than how that problem impacts on their parenting.

> *Assessing parent-child interactions, the quality of the home environment, the parent's perception of child behaviour, the parent's social support networks and his or her ability to solve problems is more important for determining whether a child is at risk of abuse and neglect than simply identifying or diagnosing parental problems such as substance abuse* (Mildon, Matthews, & Gavidia-Payne, 2003).

Family Violence

Family violence is more often perpetrated by men on women. It is a widespread community problem with an estimated 15-17% of women experiencing family violence at some stage over their lifetime (Braaf and Barrett Meyering 2011). Family violence is associated with poor outcomes for women, children and other family members. Violence is not always physical and perpetrators use varied ways to take control over the life of their victim, such as emotional abuse and controlling access to finances (Robinson and Maloney 2010).

Family violence has profound effects on children and varies with the age and vulnerability of the child. During pregnancy, the developing foetus may be directly impacted by the mother's physical and emotional distress (Jordan and Sketchley 2009). Direct assault of the mother may result in miscarriage, premature birth, physical injury or disability of the child (Bromfield, Sutherland and Parker 2012). Genetic changes in the foetus have been found to result from family violence. In infancy and early childhood, children can be harmed whilst being held in their mother's arms during an attack (Humphreys and Stanley 2006). In fact, at all ages, the presence of family violence places children at high risk of physical abuse, with rates of co-existence between family violence and physical abuse quoted as being between 45 and 70% (Holt, Buckley and Whelan 2008). Young infants who are exposed to violence even before birth may be impacted in a way that can have lifelong consequences, as the increased secretion of stress hormones may have a direct effect on the developing neural pathways and the subsequent architecture of the brain.

It is important that Cradle to Kinder practitioners are aware of the significance and likelihood of family violence in the target group as:

- Pregnancy and the immediate post-birth period is one of the periods when women are at the greatest risk of significant harm resulting from family violence
- Violence in pregnancy is thought to occur in up to 25% of pregnancies
- When violence occurs in pregnancy, it is highly likely to continue and escalate over time
- The early post-birth period has been shown to be the most dangerous time for moderate to serious violence to occur, when women and children are at their most vulnerable (Humphreys and Stanley 2006).

It is no longer appropriate to say that children 'witness' family violence because it is evident from the research that the child experiences the violence and can be directly and indirectly impacted. The toxic stress and complex trauma caused by living in a perpetual state of alert can damage the developing brain and have profound long-term psychological effects (Perry 2009). One common myth is that infants are less vulnerable to harm from family violence because they might be located away from the direct impacts (e.g. asleep in another room), but it is known that the infant brain is particularly vulnerable to the effects of elevated levels of stress hormones. The infant can be stressed by the fear created by the violence or from the absence of responsive and sensitive nurture by a mother who is under siege. A young child's capacity to form a secure attachment can be jeopardised by the ongoing presence of a frightening or frightened parent, both of which are likely when family violence occurs.

For women fleeing their violent partner, there is also a strong relationship between family violence, homelessness and housing instability (Bromfield, Sutherland and Parker 2012). Financial security is often cited by women as a reason why they feel they cannot leave the relationship (<http://www.austdvclearinghouse.unsw.edu.au>). There is also strong evidence of a link between family violence and drug misuse, especially alcohol abuse. Drug use and heavy drinking may increase the risk of violence towards an intimate partner and alcohol and other drugs can be used by the victim to relieve the physical and emotional pain of the abuse (Chan 2005). One of the most dangerous times for increased violence towards a woman in a family violence situation can be when she attempts to leave the violent relationship and so much caution is required regarding this process if it occurs.

The initial phase of working with families involves the identification of family violence and the assessment of the degree of risk posed by the violence. It is important that practitioners consult with family violence specialist services and refer to the family violence risk assessment framework (CRAF manual) available for free download at <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/718858/1_family_violence_risk-assessment_risk_management_framework_manual_010612.PDF>. The Specialist Practice resource, *Working with Families with Complex Needs*, also provides valuable information to guide practice. As with all other aspects of working with families, situations change and, as trust is established, families might reveal more about what is happening for them. It is critical that assessment and analysis of available information is ongoing throughout the intervention. The usage of screening and assessment tools at the beginning of the intervention should not make staff feel complacent about the future possibility of family violence being present. The sustained period of service involvement for families participating in the Cradle to kinder program also makes it highly likely that women will have new intimate partners over the course of the program.

Family violence within Aboriginal families

Family violence in the Aboriginal community is defined in a way that encompasses the broader nature of abuses that may occur in the Aboriginal community. The Aboriginal Family Violence Taskforce defined family violence as:

> *An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.* (DHS 2012:23)

Community violence is also an emerging concern in Victoria. This violence can take place between families and adds to the overall level of trauma experienced within the Aboriginal community.

Alcohol and other drug misuse

The impact on children of parent's alcohol and drug misuse is dynamic and complex. It is related to the nature, extent and severity of the use and the impact on the behaviour of the individual. The presence of protective factors in the child and family's life acts to mediate the negative impacts and might, at different times, be varied and variable.

Alcohol and other drugs change the functioning of the brain, either accelerating function or suppressing it, depending upon the substance being used. Withdrawal from drugs can also result in increased anxiety, anger, paranoia, sleeplessness and depression. There are increased serious health risks associated with long-term alcohol and drug use (e.g. cancer, liver failure and heart disease) that can also have significant impacts on parents even if they are no longer using substances.

Maintaining illicit drug use may mean that the parent is involved in drug dealing and other criminal activities (e.g. shoplifting, burglary and prostitution) that can expose the infant to additional risks. The need to allocate resources to acquiring drugs means that resources are not available to pay rent, buy food and pay for other basic care items.

The impact of intoxication and withdrawal on parents who misuse drugs and alcohol often results in inconsistent parenting behaviours. Responses can fluctuate between punitive, abusive responses and neglectful, absent parenting. Neglectful and absent parenting increases the likelihood of attachment difficulties, behavioural problems and injuries due to poor supervision. Parents can have difficulty in maintaining routines and even in providing basic practical care for their child. Infants are particularly vulnerable to the risk of significant harm if parents are unable to provide regular feeds, nappy changes and safe sleeping arrangements. Infants who are taken into bed by parents who are under the influence of drugs and alcohol are at high risk of dying from sudden unexpected death syndrome (SUDS).

Alcohol is toxic to the foetus and causes problems with neuronal growth and migration (Shonkoff and Meisels 2000). The actual amount of alcohol that is damaging and how it causes neural damage is unclear as outcomes for children - even in mothers with chronic alcoholism - are varied. Less is known about the direct impacts on foetal development of drug use. Cocaine use does, however, have specific known impacts on pregnancy, including a higher rate of spontaneous abortion, stillbirths and premature delivery.

Connecting parents to antenatal care providers as early as possible in the pregnancy is important in order to reduce the impact of substances on the foetus, to engage the parent in treatment and to prepare for additional care that may be required during and after birth. Specialist chemical dependency antenatal units are available at major metropolitan maternity hospitals. These units can attend to the specific needs of mothers and children impacted by alcohol and drug use in pregnancy and are also available for consultancy with generalist providers regarding how to manage the complex needs of this group.

Mental Health Problems

The term, ‘mental health problems’, is used as a broad description of issues that impact on an individual’s capacity to function in life, such as depression and anxiety, whilst ‘mental illness’ is used to describe more serious diagnosed conditions such as schizophrenia (Huntsman 2008). Individuals who have experienced abuse and neglect trauma during their childhood and been placed in out-of-home care experience rates of mental health problems at a significantly higher rate than their peers. The rate of mental health problems experienced by this group is considered so significant that the Victorian government has recently developed a guideline to prioritise their access to mental health services and to ensure that timely and appropriate assistance is provided or facilitated (Department of Health 2011). The guide also recognises that mental health assessments and interventions should recognise the need to support parents in their parenting role.

The most common mental health problems experienced by parents are mood disorders (i.e. depression and bi-polar disorder), personality disorders (i.e. borderline personality disorder and anti-social personality disorder) and schizophrenia. Mental health problems are on a continuum of severity and symptoms are often episodic in nature. Some mental health problems can be well controlled with medication and psychology support and/or counselling. At times when mental illness is severe and unstable, there may be immediate safety concerns for the baby, especially if the parent is psychotic.

Children of parents with uncontrolled mental illness face a high risk of physical and emotional neglect. Children can also be emotionally and physically abused if the symptoms of the parent's illness cause them to be violent, reactive and punitive (Cowling, 2004). Being able to identify problems when they occur, actively engaging parents in treatment, ensuring that the child is safely cared for and minimising the potential effect on the child's development are the keys to effective intervention. The range of mental illnesses and subsequent impacts on mood and behaviour are complex and require specialist support. Engaging with adult mental health services to provide direct support to parents and secondary consultation to Cradle to Kinder practitioners is required.

Perinatal mental illness

Perinatal mental illness covers a broad range of disturbances to mood and behaviour that women may experience during pregnancy and the postnatal period. Mental health problems in the perinatal period are common (i.e. 40%), with about 15% meeting the criteria for psychiatric diagnosis (American Psychiatric Association, 2000). Problems range from mild depression and difficulties adjusting to pregnancy through to post partum psychosis (PPP), which is a serious but rare disorder (Kendall, Chalmers and Platz, 1987). Many women who experience difficulties at this time have pre-existing illnesses or vulnerabilities, personality disorders and/or complex social difficulties. The onset of schizophrenia can occur after birth but most episodes of psychosis during the perinatal period are now considered episodes of bipolar illness (Mares, Newman and Warren, 2011).

The mother's perinatal mental health problems can mean that the child faces the risk of exposure to medications such as anti-depressants and anti-psychotics during pregnancy. Mental health problems in the mother also increase the exposure of the foetus to stress during pregnancy with subsequent increased risk to cognitive and emotional development (Cowling, 2004; Huntsman, 2008; Mares et al 2011).

Issues related to the safety of psychotropic (anti-psychotic) drug use in pregnancy and during breastfeeding is complex, with concerns for foetal abnormalities in the first trimester, toxicity and withdrawal symptoms after birth and longer term neurodevelopment delay (Mares et al 2011). The risk to the infant of medication in pregnancy and lactation has to be balanced against the risks of uncontrolled or inadequately treated mental illness for the mother. Issues can include suicidal behaviour, poor self-care and self-medication with drugs or alcohol. Current evidence regarding the safety of drugs is constantly updated and is available from the pharmacy department at the Royal Women's Hospital in Melbourne.

As discussed earlier in this guide, the infant's healthy development and attachment security is dependent on sensitive and responsive care giving from a parent who is emotionally and physically available. The greatest risk for children whose parent has a mental health problem is a disruption to the infant-parent interaction. Impacts vary according to the nature, severity and longevity of symptoms and how the negative effects are mediated by other care givers available to the child.

Case Study 1 continued

During this time Sarah remained living with her partner, who continued to be verbally abusive towards her. The family violence practitioner continued to come to the care team meetings and keep the Cradle to Kinder practitioner informed about what refuge services were available to her so that Alison could talk with Sarah whenever an opening arose. When she was at 38 weeks gestation, Sarah was physically assaulted again and this time went to the refuge where she stayed for a week before going into labour.

Child Protection practitioners attended the hospital after the birth. They were very clear with Sarah that she needed to protect Andrew from his father and, if she could not do this, then Andrew might be taken into care. Mother and baby were discharged to an Early Parenting Centre where Sarah was supported in developing her parenting skills. She bonded well with Andrew and seemed determined to protect him. The PASDS program had no concerns for Sarah and Andrew and they went home together and severed all contact with the Andrew's father.

Alison continued to see Sarah and Andrew. She increased her visits during the first three months, and paid particular attention to helping Andrew and Sarah learn to communicate with each other. Practical support was also provided in helping Sarah apply for the maternity payment. Sarah and Andrew attended a playgroup for vulnerable young mothers and learned to play together.

Sarah continued her drug and alcohol treatment and withdrew from Xanax. Andrew had not been born dependent on drugs but he was a fractious baby and difficult to soothe. Alison helped Sarah to understand this in terms of the possibility that the stress that Andrew had experienced during the pregnancy may have resulted in Andrew having a lower threshold for stress. They worked together to find ways to help Andrew calm down after becoming upset. The MCHN consultant to the team helped Alison and Sarah think of things for Andrew to do and together they discovered that Andrew liked swinging. They discovered this by trying to swing him in the baby capsule and seeing that he quietened quickly after this experience. They then purchased a baby hammock and set this up for Sarah and Andrew.

Sarah was encouraged to contact her family. She was able to reconnect with her sister. Their relationship progressed on an 'off and on' basis, with many conflicts resulting in periods of time when they refused to speak to one another. Sarah's sister had remained at home with their mother and, as a result, both girls had conflicting feelings. Sarah felt abandoned by her mother whilst her sister felt that Sarah had been rescued and had left her in the abusive home. Alison spent some time with both girls together and tried to help them work through their conflict. Neither of the sisters found this helpful and Sarah felt that Alison was taking her sister's side and, as a result, lost contact with Sarah for a week or two. Alison knew by now that this was Sarah's way of telling her that she had disappointed or upset her, and Alison talked this through with Sarah as soon as they reestablished contact.

When Andrew was a year old, Alison started to talk to Sarah about resuming her education or doing some training. Sarah said she wanted to be a child care worker and Alison arranged care for Andrew and helped Sarah enrol in a course.

Sarah needed a lot of support during this period because she had had a very poor and fragmented experience at school and was anxious about studying again. Initially, Alison drove Sarah to classes and picked her up again afterwards so she could hear about how things went for her that day.

Sarah met a new boyfriend at the training course and started seeing him socially. Alison insisted on meeting him so that she could help Sarah work out whether he would be safe around Andrew. Alison also needed to keep Child Protection and the care team informed. She talked to Sarah about this. Sarah was initially angry but she eventually understood that Child Protection had to follow through with their protection processes for Andrew.

One day when Andrew was about 14 months old, Andrew's father appeared at Sarah and Andrew's house. He said that he wanted to see Andrew and to resume his relationship with Sarah. An argument ensued and Sarah was assaulted whilst she was holding Andrew. As a result, Andrew fell over a balcony and landed on the ground. The balcony was at ground floor level so Andrew fell about 1.5 metres. He suffered two broken bones and was taken to hospital. Child Protection was informed and attended the hospital. Alison was on leave at the time.

When Alison came back from leave she found Sarah had fallen into a deep depression. Alison consulted with a mental health professional and Sarah went to see a psychiatrist. Her drug and alcohol clinician was involved again at this point because Sarah was reluctant to take medication for fear of becoming addicted again. The care team devised a plan where Alison would see Sarah three or four times a week and consult with an infant mental health clinician and an adult mental health clinician on a weekly basis. Sarah worked through feelings of helplessness that she had failed to protect Andrew from being hurt, and this brought up a lot of feelings from her past about times when she had not been protected either. Andrew was impacted by his traumatic experience and showed signs of Post Traumatic Stress Disorder. He again became difficult to soothe and swinging no longer worked. Going to the pool and swimming with his mum was helpful up to a point, with both mother and child feeling comforted by the warm water and the skin contact. His broken limbs were placed in plastic bags at these times and he enjoyed the freedom of movement that the water provided. Sarah dropped out of her course at this time too.

Sarah was able to resume her course a year later. She completed the course and started working part time as a child care worker when Andrew was 3 years of age. He then entered the kinder program at the child care centre where Sarah worked.

In the six months leading up to Andrew entering kinder, Sarah and Alison worked on ending the service. They talked a lot about what it would be like when Sarah no longer had contact with Alison and what other things she might do to seek help and to help herself. They also talked a lot about other losses and endings that Sarah had had in her life. Many of these brought up painful memories for her. During this period, she made a big effort to connect with her Aboriginal heritage and found some Aunties that she formed good relationships with. When Andrew entered four year old kinder Alison and Andrew and Sarah had a celebration and said goodbye.

5.5 Staffing Arrangements

5.5.1 Staffing levels/team structure

Service providers are expected to undertake an analysis of staffing levels to ensure the individual needs of children and families are met, with the service provider taking action to recruit staff when vacancies occur.

Service providers should have a staff recruitment strategy in place that:

- considers the individual and cultural needs of the client group (including the required cultural competence and understanding of people with disabilities) and seeks to increase the number of Aboriginal and culturally and linguistically diverse staff so as to be reflective of the service's local community
- enables the service provider to meet targets and their service agreement obligations
- highlights the roles and expectations of staff, the service provider and the Department of Human Services
- identifies the specific training requirements for staff in relation to working with the target group of the Cradle to Kinder program (e.g. competency in working with young people who have experienced trauma).

Service providers should ensure all applicants for staff positions are subject to pre-employment screening. Screening should include:

- direct contact (either face-to-face or telephone contact) with two referees to confirm the applicant's suitability, including contact with the most recent employer
- completion of a police records check and up-to-date Working with Children Check in compliance with the Department of Human Services policy and the Working with Children Act 2005. For applicants who have spent time overseas within the past five years, an international police check is conducted or, when this is not possible, two referee checks are arranged from the country where the applicant spent time.

The Cradle to Kinder Service is provided by a multi-disciplinary team that comprises highly qualified and experienced staff from a range of professional backgrounds, including early childhood development, psychology, infant mental health, social work and/or maternal and child health. The team must include at least one staff member with qualifications and skills in conducting therapeutic assessments and interventions for infants, children and/or young people.

All staff require well-developed knowledge and skills in how to care for and promote the development of infants and young children and work as part of a team, sharing knowledge and skills and working jointly with families to provide an integrated team approach. Promoting the development of relationships between the family and all team members helps to support program retention and better meet the complex needs of families. Team members undertake a range of roles including:

- service coordination
- case management
- therapeutic assessment and intervention
- early parenting support and practical assistance
- advocacy and service brokerage

The Cradle to Kinder service provides each family with a key worker who seeks to establish a strong relationship with the young woman and family and provide them with a clear point of contact. The key worker will play a lead role in initial engagement, assessment and planning processes.

5.5.2 Core competencies

Service providers will have policies, processes and/or practices in place to ensure all staff (including volunteers) have the required skills, qualifications, knowledge, values and competencies (including cultural competence) for their positions and responsibilities in order to meet the needs of children and their families.

All staff working in the Cradle to Kinder program are required to have the following competencies:

- An ability to actively engage families that may be unwilling to receive services. This requires personal attributes, such as the ability to demonstrate empathy, openness and honesty in communications and casework with families. It also requires an ability to actively engage families in decision-making processes.
- A sound knowledge of services and interventions that can address factors associated with family vulnerability and the ability to undertake multi agency working, including advocating on behalf of families to support access to services and supports.
- An understanding of the inter-generational factors and complex inter-relationships that can promote and impede the capacity of families to collaboratively provide good care of a child.
- An understanding of child development and factors that can impede a child's development, including early indicators and patterns of behaviour that may constitute cumulative harm.
- An understanding of relevant risk and needs assessment frameworks and the appropriate application of these.
- A sound knowledge of service responses and interventions that can positively impact on a child's development, as well as those that can assist in promoting changes in behaviour so as to increase parenting capacity.
- High level communication skills that include the ability to constructively provide open and honest feedback to families in relation to both strengths and deficits in parenting skills/practices.
- A sound understanding of Aboriginal culture and society, the issues relating to Aboriginal child and family welfare and the ability to effectively communicate with Aboriginal families.
- An ability to work effectively with young people, including young people from culturally and linguistically diverse and refugee backgrounds and young people with a learning disability
- An ability to establish, and maintain positive and productive working arrangements with practitioners within Child Protection and other key services.

5.5.3 Induction processes

Cradle to Kinder practitioners participated in a statewide induction process at the commencement of Stage 1 of the program in 2012. Practitioners who commence work in the Cradle to Kinder program after this initial period will participate in individual agency induction processes. Induction processes are required to provide practitioners with the information they require to fulfil their role in the program, including an understanding of relevant program and practice guidelines.

5.5.4 Core training

The policies and practices of service providers should provide opportunities for professional development and training that is aligned with the demonstrating of the core competencies listed at section 5.6.2 above. Core training should be available to staff based on competencies they require to meet their job requirements, as well as in relation to aspects of their practice that are identified as areas for their own professional development (i.e. through reflective practice, supervision and/or agency-wide service improvement processes).

5.5.5 Reflective practice and supervision

Reflective practice

Reflection means stepping back from the immediate, intense experience of hands-on work and taking the time to wonder what the experience really means. What does it tell us about the family? What does it tell us about ourselves? Reflective practice strives to identify knowledge for practice that is derived not only from sources external to the practice arena but also from within the practice itself. Reflective practice acknowledges the relevance of diverse sources of knowledge – practice wisdom, intuition, tacit knowledge and artistry, as well as theory and research – for understanding human behaviour (Ruch 2005 p 116).

It is clear that practitioners need to reflect on their practice and the practice of those they interact with. This reflection allows practitioners to consider their role and their associated practical, emotional and cognitive involvement with families within the work environment. Reflection is a conscious process, a descriptive accounting that either informs practitioners of what they should do or enables them to change what we are doing. These processes are called 'reflection on action' and reflection in action'.

Through reflection, practitioners can examine their thoughts and feelings about their experience of working with a family and can identify the interventions that best meet the child and family's goals for safety, growth and development. The practitioner's mind is communicated to the client/baby and so having a welcoming mind, wherein the parent and the baby are enjoyed, seems to make a difference.

Over time, practitioners can begin to feel the very same things that their clients feel. This is because the primary tool in their tool kit, attunement, enables practitioners to connect with the suffering of others. Practitioners need to care for themselves but their managers must also ensure that there are sufficient structures and processes in place within the agency to support practitioners in their role. Reflective space needs to be available within supervision, but also be part of a team process.

Working with individuals, families and communities who have experienced trauma can lead to a workforce that mirrors some of the trauma related interactions. As noted in the Sanctuary model, working with traumatised clients can lead to agencies becoming 'trauma organised' or 'trauma saturated'. It is important to ensure that the services offer ways to recognise, respond to and restore safety and promote healing for everyone including the clients, staff and management (Bloom, 2005).

Supervision

Reflective supervision is focused on experiences, thoughts and feelings directly connected with the work with families. Reflective supervision is not therapy. It is characterised by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer their own questions, and to provide the support and knowledge necessary to guide decision-making.

The provision of professional support for staff engaged in work with vulnerable families is seen as essential for effective service provision, as well as for staff wellbeing and retention. Staff who work with vulnerable families require high quality supervision and access to good quality professional development in order to maintain objectivity, to prevent drift from program guidelines and to provide an opportunity for reflection and professional growth. “Supervision is the worker’s most essential helping relationship. It is a necessity, not a luxury” (Knapman & Morrison 1998: 17). It is crucial that the organisation provides both supervision and opportunities for reflective practice to practitioners who are undertaking work that is complex, that deals with risk and that potentially involves different opinions regarding the best course of action.

The organisations providing the Cradle to Kinder programs will no doubt already have supervisory structures and processes in place. There may be some additional challenges with this program for which supervision will be beneficial, such as:

- Clarification regarding who is the ‘client’, when the child and parents needs do not coincide,
- Exploration of differences and challenges that can arise in multi-disciplinary teams,
- Acknowledgement of any of the feelings that arise in complex work with at-risk families,
- Problem solving when families or situations appear stuck,
- Helping to keep the child and the parent ‘in mind’

Dealing with the intensity and longevity of involvement with families can also lead to fatigue, stuckness and transference issues for the practitioner. The supervisor becomes their life line in some of these situations, someone who can help draw them out when they need to take air and look at the situation from a different perspective.

The Cradle to Kinder program provides a unique opportunity to work intensively over time with families. It is also important to acknowledge that this brings particular challenges for practitioners, for example with respect to boundaries and worker fatigue. It is important for practitioners to acknowledge these challenges and discuss them in supervision. It is also important to focus on and prioritise self-care.

Reflective team process

Each Cradle to Kinder consortium may be configured differently in terms of the organisations and roles involved but they are all predicated on the idea of a team coming together to achieve positive outcomes for families who access the service. However the team is shaped, it is important to build in opportunities for the team to meet as a group in order to plan, communicate and reflect. Whether there is an external facilitator or the lead agency plays the leadership role in this process, it is crucial that opportunities are made available to jointly reflect on the work, the challenges and the aspirations for the service. The process needs to be ‘owned’ by the group rather than by a collection of individual workers.

An excellent resource for further reading around supervision is the work of Tony Morrison (Morrison 2005).

5.5.6 Worker safety

Responding to the health, safety and wellbeing needs of staff is a core management responsibility of the Cradle to Kinder service providers and an essential element in effective service provision. The Occupational Health and Safety Act 2004, provides the Victorian legislative framework and employer obligations related to the occupational health and safety of staff. Service providers are expected to have a range of systems, policies and procedures in place to promote the health, safety and wellbeing of their staff and to manage risks posed by the work environment (in compliance with the Department of Human Services standards).

The principles of workplace safety include:

- Promotion of a healthy and safe workplace
- Commitment to the continuous improvement of the health and safety of employees
- Reduction of risks and zero tolerance of work related illness and injury

All staff have roles and responsibilities in maintaining a workplace that supports the health and safety of staff, as specified in position descriptions and contracts of employment. Activities that should be undertaken by staff in order to promote and maintain a safe workplace include:

- Taking responsibility for participation in training that equips them with appropriate knowledge and skills
- Complying with policies and procedures
- Reporting incidents and near misses
- Participating in supervision and other forms of staff support.

There is a comprehensive range of resources to assist employers in providing for the health and safety of employees at <http://www.dhs.vic.gov.au/funded-agency-channel/management-toolkit/work-health>

All client activities with the potential to cause harm must be carefully assessed for the likelihood of exposure to occupational violence. The risk assessment is formed by understanding the nature and likelihood of harm and the potential degree of harm that may be caused. Staff must be aware at all times of changes in the situation which might cause an increase in the level of risk. The most important indicator of the risk of violence is the client's past pattern of violent behaviour, therefore information gathering and sharing is paramount to ensuring staff safety.

Home Visiting

It is more difficult for service provider organisations to control and manage the risks for staff delivering services offsite, particularly in clients' homes. Risks can be associated with drug use, unknown people present in the home, client access to weapons and aggressive animals. Service providers must have systems and policies in place and provide suitable resources to support the occupational health and safety of staff when they are engaged in home visiting. This includes policies related to car travel and the transportation of clients. Staff must be provided with adequate means of communicating with the organisation and for calling for help in an emergency. Appropriate consideration should be given to the additional risks associated with out of office hours visits to clients in their home.

More information including a hazard identification checklist suitable for home visitors is available at: <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/462570/cp-and-jj_staff_safety.pdf>

5.6 Quality Assurance

5.6.1 The Department of Human Services standards

Cradle to Kinder service providers are expected to have systems in place to meet the program requirements, maintain quality service delivery and promote positive outcomes for clients receiving the service.

All Cradle to Kinder service providers are required to be registered as a "community-based child and family service" under the *Children, Youth and Family Act* and to meet specified quality standards. From 1 July 2012, these are the *Department of Human Services Standards* (Department of Human Services 2012). These standards constitute a single set of service delivery standards covering a range of the Department of Human Services-funded programs that provide services to clients. Organisations are externally reviewed against the Department of Human Services Standards once every three years by one of a panel of independent review bodies endorsed by the department. For more information about the Department of Human Services Standards, visit the department's website at: <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-andlegislation/department-of-human-services-standards>.

The Department of Human Services Standards can be summarised as:

Empowerment: people's rights are promoted and upheld

Access and engagement: people's right to access transparent, equitable and integrated services is promoted and upheld

Wellbeing: people's right to wellbeing and safety is promoted and upheld

Participation: people's right to choice, decision making and to actively participate as a valued member of their chosen community is promoted and upheld.

Service providers' governance and management systems are also reviewed using the standards of the independent review body. The Department of Human Services Standards enables programs and services to both internally assess strengths and use emerging practice to reflect on and refine the way services are delivered. In providing for an external critique of an agency's service delivery processes, the Department of Human Services Standards also build community confidence in those services.

In addition, the *Program requirements for family and early parenting services in Victoria (Department of Human Services 2012)* set out the expectations and requirements that guide, support and inform the quality service delivery of the Cradle to Kinder program. These program requirements are underpinned by legislative and policy requirements and provide service providers with detailed information about how to deliver services in order to meet their obligations under their service agreement with the department.

5.6.2 Internal agency policies

Cradle to Kinder service providers should have organisational policies and systems in place that ensure that the legislative, departmental and program requirements of service provision are met.

5.6.3 Service review and improvement

Service providers should continually explore better ways of providing services through strategic planning, identifying learning opportunities, utilising developments in evidence-based practice, professional development and participation in evaluation processes. Service providers should use client feedback, service data and outcomes of complaints and allegations, where appropriate, to support individual program and wider organisational improvement.

Service providers must report critical client incidents to the Department of Human Services in line with departmental requirements. Service providers should have a system in place for reviewing aggregated reported incidents that enables them to learn from and prevent the reoccurrence of serious incidents. For more information regarding the Department of Human Services *Critical Client Incident Management Instruction 2011*, visit the Department of Human Services website at: <http://www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services>.

Service providers will have documented procedures in place for managing complaints and allegations by staff, children, young people, families and the community. The procedures are required to meet all legislative and the Department of Human Services guidelines.

Services providers are expected to have processes and disciplinary actions in place to respond to allegations of misconduct or abuse in ways that ensure children and young people are protected from future harm.

5.6.4 Service user involvement

Gathering feedback from service users and using this feedback to inform service planning and development strategies is an important aspect of quality service provision. In order to facilitate this process, Cradle to Kinder Service providers should have:

- Information that defines the standards of service that clients can expect to receive in a form and language that is accessible to all clients.
- A system in place for obtaining feedback from staff and families, including their views on the organisation's management and service delivery.
- Well maintained records of client feedback.
- Evidence that client and staff feedback is used to inform service planning.

Clients who have low levels of literacy and are from CALD backgrounds might not feel confident to provide feedback in written form. Adequate translation and interpreting services need to be made available if required. Offering face-to-face follow up with someone independent from the service provider agency can allow for more honest feedback. It can also be useful to utilise creative ways of obtaining feedback, such as encouraging parents to draw pictures or use cards to describe their feelings and experiences (e.g. by utilising resources developed by St Luke's that are available at <http://www.innovativeresources.org/Pages/Our_Publications.aspx>.

5.7 Recording Systems

Cradle to Kinder service providers are expected to:

- Use information systems to ensure electronic documents and records are secure, safe and accessible only by appropriate management and staff.
- Store physical client records safely and securely, in a manner that can only be accessed by appropriate management and staff.
- Manage all personal information in accordance with the *Information Privacy Act, the Health Records Act, the Children, Youth and Families Act* and their service agreement (where applicable).
- Collect data and client information in line with the reporting and accountability requirements detailed in the service agreement and other the Department of Human Services guidelines.
- Store client records and information safely and securely at the closure of the case so as to enable retrieval in accordance with legislative requirements and the Department of Human Services policy.

Current and former clients of family and early parenting services will be able to access information regarding services provided to them in line with the freedom of information provisions detailed in the Health Records Act and the Information Privacy Act.

5.7.1 Case file recording

Service providers will have in place policies and processes to ensure that case file recording is done in line with legislative and the Department of Human Services requirements.

Practitioner case file recording is an extremely important aspect of quality service provision and it provides a legal record of the service provider's involvement with the family. Case files must clearly document and provide identification of the person making the entry and the date on which the entry was made.

One of the most important aspects of case file recording is the recording of direct behavioural observations that enable practitioners to record relevant information that they see and hear during their work with families. Observations must be objective, unbiased and factual. Careful, objective observations are helpful in building a picture of the behaviours that parents use in different contexts. The record of actual behaviours of both the parent and the child provide an important comparison with other assessments and measures to give an overall picture of how things are going for the family.

Recording observations and events supports good practice in a number of ways. These include:

- Supporting effective partnerships with families through drawing on their own experiences and behaviour as the basis of work with families
- Allowing exploration of patterns of behaviour that might enable or constrain the family
- Assisting continuity and sharing of information when staff change
- Enabling analysis and reflection on information over a period of time (i.e. observations conducted over multiple points in time can increase the confidence of conclusions drawn)
- Providing an account of families' involvement with the program
- Supporting ongoing professional development and reflective practice

As demonstrated through the 'Who Am I' project, many young people in out-of-home care will have had poor experiences or limited access to their own records. Their experience highlights the value of always writing case notes with the possibility that the client may read them, whether that is the parent or, at a later date, the child themselves. As described on the Centre of Excellence website at <http://www.cfecfw.asn.au/know/research-and-evaluation/sector-research-partnership-projects/out-home-care/who-am-i>, *"client records represent explanation, connection, identity, belonging, context and meaning."*

5.7.2 IRIS

IRIS is the principle mechanism through which service provider agencies are accountable to funders.

Service providers are expected to collect service data and provide data reports to the Department of Human Services in accordance with their service agreement and Cradle to Kinder program requirements. Service data is used to inform:

- government about performance, accountability and the value of its investment in services delivered to vulnerable children and families
- the Department of Human Services about the progress of legislative and policy implementation at the statewide and regional levels
- community service organisations about client needs, service capacity, service planning, operational management and service coordination
- practitioners and managers about allocation, prioritisation, supervision, workload and service responses

IRIS data provides essential information to inform evaluation, research and service planning strategies that will shape the ongoing development of the Cradle to Kinder program. Completion of the IRIS data is an important component of service delivery and one for which practitioners must take responsibility. In order to provide a complete and comprehensive representation of the service, practitioners must ensure that all issues identified as relevant to the family are entered into the IRIS database. IRIS data should be entered on the day that the work is carried out. Team leaders and supervisors responsible for planning the workload of staff need to take into consideration the time taken to complete the recording and data gathering tasks so as to avoid overload and non-compliance.

Practitioners should refer to the IRIS users manual at <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/family-and-parenting-support/iris-family-services-user-manual?SQ_DESIGN_NAME=print>

5.7.3 Privacy and information sharing

Privacy practice has become an important element of best practice and risk management for all organisations providing human services. New technology, advances in privacy laws and the demand for more integrated service provision can make privacy practice seem complex and difficult to implement. Analysis shows, however, that the main cause of breaches in privacy is human error, not a failure to understand complex rules or complicated interactions of laws governing privacy and Child Protection.

Cradle to Kinder Service providers are required to have information sharing policies in place that comply with the relevant Acts:- the *Information Privacy Act 2000*, the *Health Records Act 2001* and the *Health Services Act 1988*.

The *Information Privacy Act 2000* establishes a regime for the responsible collection and handling of personal information in the Victorian public sector and defines when members of the public can have access to that information. The Act set out ten Information Privacy Principles (IPPs):-

1. Collection
2. Use and Disclosure
3. Data Quality
4. Data Security
5. Openness
6. Access and Correction
7. Unique Identifiers
8. Anonymity
9. Transborder Data Flows
10. Sensitive Information

The *Health Records Act 2001* establishes privacy standards for the handling of health information (including information collected in providing a health, mental health, disability, aged care or palliative care service) and regulates the handling of health information including collection, use, disclosure and access.

These Acts permit the disclosure of information in certain circumstances, including:

- Where there is consent
- Where the disclosure is made for a related purpose and, in the case of sensitive health information, where disclosure is directly related to the purpose for which it was collected and the person who is the subject of the disclosure would reasonably expect to have this information disclosed
- Where disclosure will prevent or lessen a serious and imminent threat to an individual's life, health, safety or welfare
- Where disclosure is required or authorised by law.

For more information on privacy and information sharing please refer to:

<http://www.dhs.vic.gov.au/__data/assets/pdf_file/0009/590517/information-sharing-guidelines-community-services.pdf>

<http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/information-privacy-principles>

6. Supporting documents

Relevant legislative requirements

Children, Youth and Families Act 2005, Victorian Government

Child Wellbeing and Safety Act 2005, Victorian Government

Health Services Act 1988, Victorian Government

Health Records Act 2001, Victorian Government

Information Privacy Act 2000, Victorian Government

Occupational Health and Safety Act 2004, Victorian Government

United Nations, *Convention on the Rights of the Child 1990*

United Nations *Declaration on the Rights of Indigenous People 2010*

Victorian Charter of Human Rights and Responsibilities Act 2006, Victorian Government

Working with Children Act 2005, Victorian Government

Policy resources

Aboriginal cultural competence framework 2008, Victorian Government, Department of Human Services

Cultural diversity guide 2006, Victorian Government, Department of Human Services

Language services policy 2012, Victorian Government, Department of Human Services

Department of Human Services Standards 2012, Victorian Government, Department of Human Services

Department of Human Services privacy policy 2006, Victorian Government, Department of Human Services

Providing support to vulnerable families: An information sharing guide for registered community services 2007, Victorian Government, Department of Human Services

A strategic framework for family services 2007, Victorian Government, Department of Human Services

Supporting parents, supporting children: a Victorian early parenting strategy 2010, Victorian Government, Department of Human Services

Victoria's vulnerable children: our shared responsibility 2012, Victorian Government, Department of Human Services

Practice resources

Best Interest Case Practice Model Specialist Practice Resources 2012 Victorian Government, Department of Human Services

Best interests case practice model summary guide 2012, Victorian Government, Department of Human Services

Best interests principles: a conceptual overview 2011, Victorian Government, Department of Human Services

Child development and trauma guide 2011, Victorian Government, Department of Human Services

Cumulative harm: a conceptual overview and specialist practice resource 2010, Victorian Government, Department of Human Services

IRIS data dictionary, Victorian Government, Department of Human Services

Working with Aboriginal Children and Families: A Guide for Child Protection and Child and Family Welfare Workers 2006, Victorian Government, Department of Human Services

Building Respectful Partnerships: The Commitment to Aboriginal Cultural Competence in Child and Family Services 2010, Victorian Aboriginal Child Care Agency (VACCA)

Child Protection and Integrated Family Services Statewide Agreement (Shell Agreement) 2010, Victorian Government, Department of Human Services

Program Requirements for family and early parenting services in Victoria 2012, Victorian Government, Department of Human Services

7. References

Australian Bureau of Statistics (ABS) (2007). *Australia's babies*. Canberra: ABS.

Australian Deptment of Families, Housing Community Services and Indigenous Affairs (2009). *Father-inclusive practice guide: A tool to support the inclusion of fathers in a holistic approach to service delivery*. Canberra: Australian Deptment of Families, Housing Community Services and Indigenous Affairs.

Australian Institute of Family Studies (2012). Taking self-control of the future. *Prevention Action*. July 2012. AIFS discussion paper retrieved from <http://aifs.govspace.gov.au/2012/07/04/what-works-taking-self-control-of-the-future/>

Ancharoff, M.R., Munroe, J.F. & Fisher, L.M. (1998). The legacy of combat trauma: Clinical implications of intergenerational transmission. Y. Danieli (Ed) *International Handbook of Multigenerational Legacies of Trauma*, Plenum Press, New York.

Auerhahn, N. & Laub, D. (1998). Intergenerational Memory of the Holocaust, in Y. Danieli (Ed)., *International Handbook of Multigenerational Legacies of Trauma*, New York: Plenum Press.

Barlow, J. & Parsons, J. (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children (Review). *Cochrane Database of Systematic Reviews* (2).

Barlow, J., Smailagic, N., Huband, N., Roloff, V. & Bennett, C. (2012). Group-based parent training programmes for improving parental psychosocial health. *Campbell Systematic Review*, 15.

Belsky, J. (1999). Infant-parent attachment. In L. Balter & C. S. Tamis-LeMonda (Eds), *Child psychology: A handbook of contemporary* (pp. 45-63). Philedelphia, PA: Psychology Press.

Braaf, R. & Barrett Meyering, I. (2011). *Seeking Security: Promoting women's economic wellbeing following domestic violence*. Australian Domestic and Family Violence Clearinghouse for the Department of Families, Housing, Community Services and Indigenous Affairs retrieved from website <http://www.austdvclearinghouse.unsw.edu.au>

Brazelton, T. B. and J. D. Sparrow (2006). *Touchpoints: Birth to three. Cambridge*, MA: Da Capo Press.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage.

Bromfield, L., Sutherland, K. & Parker, R. (2012). *Families with multiple and complex needs: Best interests case practice model, Specialist practice resource*. Melbourne: Department of Human Services.

Bromfield, L. & Miller, R. (2012). *Cumulative harm: Best interests case practice model: Specialist practice resource*. Melbourne: Department of Human Services.

Brotherhood of St Lawrence (2004). *Breaking cycles, building futures: Promoting inclusion of vulnerable families in antenatal and universal early childhood services. A report on the first three stages of the project*. Melbourne: Department of Human Services.

Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the literature. *Psychological Bulletin*, 99, 66-77.

Carbone, S. & Fraser, A., et al. (2003). Breaking cycles, *Building futures: Promoting access and inclusion in antenatal and early childhood services: A review of the literature*. Fitzroy, Australia, Brotherhood of St Laurence.

Cashmore, J. and Paxman, M. (2007) *Longitudinal study of wards leaving care: Four to five years on*. Sydney: Social Policy Resource Centre, University of New South Wales.

Centre for Community Child Health (2006). *Practice resource: Behaviour problems*. Parkville, Australia: The Royal Children's Hospital, 51.

Chan, C (2005). Alcohol issues in domestic violence. *Australian Domestic and Family Violence Clearinghouse Topic Paper*. Retrieved from <http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/Alcohol_Issues.pdf>.

Clarke, P. (2009). *Supporting children in learning English as a second language in the early years (birth to six years)*. Melbourne: Victorian Curriculum and Assessment Authority.

Coade, S., Downey, L. & McLung, L. (2008). *Yarning up on trauma: Healing ourselves, healing our children and families, healing our communities*. Richmond, Australia, Berry Street.

Cohen, N. J., M. Lojkasek, et al. (2006). Watch, wait, and wonder: An infant-led approach to infant-parent psychotherapy. *The Signal*. East Lansing, MI: World Association for Infant Mental Health, Michigan State University, 14, 4.

Coren, E., Barlow, J. & Stewart-Brown, S. (2003). The effectiveness of individual and group-based parenting programmes in improving outcomes for teenage mothers and their children: a systematic review. *Journal of Adolescence* 26 79-103.

Coren, E. Hutchfield, J., Thomae, M. & Gustafsson, C. (2010). Parent training support for intellectually disabled parents. *Campbell Systematic Review*, 3.

Council of Australian Governments (2009). Protecting children is everyone's business: National framework for protecting Australia's children 2009-2020. *F. a. children*. Canberra: Commonwealth of Australia.

Cummins, P., Scott, D. & Scales, B. (2012). Report of the Protecting Victoria's Vulnerable Children Enquiry, Volume 1. Melbourne: Department of Premier and Cabinet.

Darlington, Y. & Feeney, J.A. (2008). Collaboration between mental health and Child Protection services: Professionals' perceptions of best practice. *Children and Youth Services Review*, 30, 187-198.

Department of Education and Early Childhood Development (DEECD) (2010). *The state of Victoria's children 2009: Aboriginal children and young people in Victoria*. Melbourne: DEECD.

Department of Health (2011). *Chief psychiatrist's guideline: Priority access for out-of-home care*. Melbourne: Department of Health.

Department of Human Services (2007). *A strategic framework for family services*. O. f. Children. Melbourne: Department of Human Services.

Department of Human Services (2010). *Supporting parents, supporting children: A Victorian early parenting strategy*. Melbourne: Department of Human Services.

Department of Human Services (2011a). *Child Protection and Integrated Family Services statewide agreement (Shell agreement)* 2010. Melbourne: Department of Human Services.

Department of Human Services (2011b). *Human services: The case for change*. Melbourne: Department of Human Services.

Department of Human Services (2012a). *Child and family snapshot - Practitioner field tool and genograms*. Melbourne: Department of Human Services.

Department of Human Services (2012b). *Family Violence: Risk assesssment and risk management framework and practice guides 1-3* (2nd ed). Melbourne: Department of Human Services.

Department of Human Services (2012c). *Program requirements for family and early parenting services in Victoria*. Melbourne: Department of Human Services.

Department of Human Services. (2012d). *Registration standards for community service organisations*. Melbourne: Department of Human Services.

Department of Human Services (2012e). Sudden Infant Death Syndrome (SIDS) and safe sleeping arrangements. *Victoria Protecting Victoria's Children – Child Protection Practice Manual*. Melbourne: Department of Human Services.

Department of Human Services (2012f). *Victoria's vulnerable children: Our shared responsibility directions paper*, 36. Melbourne: Department of Human Services.

Department of Planning and Community Development (2012). *Victorian Aboriginal affairs framework 2013-2018*. Melbourne: Department of Planning and Community Development.

Downey, L. (2009). *From isolation to connection: A guide to understanding and working with traumatised children and young people*. Melbourne: Child Safety Commissioner.

Dozier, M., Stovall, K.C., Albus, K.E., Bates, B. (2001). Attachment for infants in foster care: The ole of caregiver state of mind. *Child Development*, 72.

Easterbrooks, M., Chaudhuri , J. & Gestsdottir, S.(2005). Patterns of emotional availability among young mothers and their infants: A dyadic, contextual analysis. *Journal of Infant Mental Health*, 26(4), 309-326.

Egeland, B., Jacobvitz, D. & Sroufe, L. (1988). Breaking the cycle of abuse. *Child Development*, 59(4):1080-1088.

Finkelhor, D. & Browne, A (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530-541.

Fletcher, R. (2003). Fathers' role in family services: The engaging father's project. *Focus on fathering*. R. Sullivan. Camberwell, Australia: ACER Press. 125-142.

Fletcher, R. (2010). Including fathers in work with vulnerable families. In Arney, F and Scott, D (Eds). *Working with vulnerable families: A partnership approach*. Cambridge University Press, 135-154.

Fonagy, P. (1999). Transgenerational Consistencies of Attachment: A New Theory. *Dallas Society for Psychoanalytic Psychology*. Paper to the Developmental and Psychoanalytic Discussion Group, American Psychoanalytic Association Meeting, Washington DC 13 May 1999. Retrieved from <http://www.dspp.com/papers/fonagy2.htm> on 12 September 2012.

Foundation for Alcohol Research and Education (2012). *The Australian Fetal Alcohol Spectrum Disorders Action Plan 2013-2016*. Deakin, Australia.

Fraiberg, S., Adelson, E., Shapiro, V. (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child & Adolescent Psychiatry*,14(3), 387-421.

Frederico, M., Jackson, A. & Black, C. (2010). More than words: *The language of relationships. Take Two Third Evaluation Report*. Bundoora, Australia: La Trobe University.

Frederico, M., Long, M., McNamara, P. & McPherson, L. (2012). *A Coordinated service framework for parents with a learning difficulty/intellectual disability*. Bundoora, Australia: La Trobe University.

Frederico, M., Long M., McNamara, P., McPherson, L., Rose, R. & Gilbert, K. (2012). The Circle Program: An evaluation of a therapeutic approach to foster care. Melbourne: Centre for Excellence in Child and Family Welfare.

Gardner, M. & Steinberg, L. (2005). Peer influence on risk taking, risk preference, and risky decision making in adolescence and adulthood: An experimental study. *Developmental Psychology*, 41(4), 625–635.

Gibbons, J., Gallagher, B., Bell, C. & Gordon, D. (1995). *Development after physical abuse in early childhood*. London: HMSO.

Glaser, D. (2002). Emotional abuse and neglect: A conceptual framework. *Child Abuse & Neglect*, 26, 697-714.

Harris, N. (2007). Mapping the adoption of family group conferencing in Australian states and territories. Adelaide, Australia: Australian Centre for Child Protection, University of South Australia.

Harris, N. (2008). Family group conferencing in Australia 15 years on. *Child Abuse Prevention Issues*, 27(20).

Healthy Start. Practice Point: Parenting Assessment. Retrieved from the Healthy Start website <http://www.healthystart.net.au/> on 12 September 2012.

Healthy Start (2009). Practice Point: Parent Education Retrieved from the Healthy Start website <http://www.healthystart.net.au/> on 12 September 2012.

Hellett, J. & Simmonds, J. (2003). *Parenting a child who has been sexually abused*. London: BAAF,

Herman, J. (1997). *Trauma and recovery: The aftermath of violence - from domestic abuse to political terror.* New York, NY: Basic Books.

Herman, J. L., Perry, C. & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, 490-494.

Hughes, D. A. (2009). *Attachment-focused parenting: Effective strategies to care for children*. New York, NY: W.W. Norton.

Holt, S, Buckley, H & Whelan, S (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect*. 32, 797-810.

Human Rights and Equal Opportunity Commission (1997). B*ringing them home: Report of the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney: Human Rights and Equal Opportunity Commission.

Humphreys, C & Stanley, N. (Eds). (2006) *Domestic Violence and Child Protection: Directions for good practice*. London: Jessica Kingsley Publishers.

Iwaniec, D. (1997). An Overview of Emotional Maltreatment and Failure-to-Thrive. *Child Abuse Review*, 6, 370-388.

Jackson, A.L. Waters, S.E. Meehan, T.L. Hunter, S. & Corlett, L.R. (2013). *Making Tracks: A Trauma-informed Framework for Working with Aboriginal Young People Leaving Care*, Melbourne: Berry Street.

Jordan, B. & Sketchley, R. (2009). *A stitch in time saves nine: Preventing and responding to the abuse and neglect of infants*. Melbourne: Australian Institute of Family Studies.

Jordan, B., Sketchley, R., Bromfield, L. & Miller, R. (2010). *Infants and their families: Best interests case practice model, Specialist practice resource*. Melbourne: Department of Human Services.

Katz, I., C. Spooner, et al. (2006). *What interventions are effective in improving outcomes for children of families with multiple and complex problems?* West Perth, Australia: Australian Research Alliance for Children & Youth.

Kaplan, S. J., Pelcovitz, D. & Labruna, V. (1999). Child and adolescent abuse and neglect research: A review of the past 10 years: Part I. Physical and emotional abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(2), 1214–1222.

Kelly, J., Zuckerman, T., Sandoval, D. & Buehlman, K. (2008). *Promoting First relationships: A program for service providers to help parents and other caregivers nurture young children's social and emotional development*. (2nd ed). Seattle, Washington: NCAST-AVENUW publications.

Kroll, B. & Taylor, A. (2003). *Parental Substance Misuse and Child Welfare*. London: Jessica Kingsley.

Lieberman, A. F., Silverman, R. & Pawl, J. H. (2000). *Infant-parent psychotherapy*. In Zeanah, CH. Handbook of infant mental health (2nd ed). New York, NY: Guilford Press.

Lieberman, A. & Van Horn, P. (2004). *Don't hit my Mommy: A manual for child-parent psychotherapy with young witnesses of family violence*. Washington DC: Zero to Three.

Lillas, C. & Turnbull, J. (2009). *Infant child mental health, early intervention, and relationship-based therapies*. New York, NY: WW Norton.

Loundes, J., Borkowski, J., Whitman, T., Maxwell, S. & Wee, K. (2005). Adolescent parenting and attachment during infancy and early childhood. *Parenting: Science and Practice*, 5(1).

Shaw, M. E. & Lawlor, D. A. (2007). Why we measure teenage pregnancy but do not count teenage mothers? *Critical Public Health 17* (4), 311-316.

Laws, P. & Hilder, L. (2008). Australia's mothers and babies 2006. *Perinatal statistics (22)* 46. Canberra: AIHW.

Lynch M, & Roberts J. (1982). *Consequences of child abuse*. London: Academic Press.

Main, M., Kaplan, K. & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development, 50* (1–2).

Mares, S., Newman, L. & Warren, B. (2005). *Clinical skills in infant mental health*. Camberwell, Australia: ACER Press.

Marvin, R. S., Cooper, G., Hoffman, K. & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, 4, 107-124.

McAuley, C., Pecora, P. J. & Rose, W. E. (Eds). (2006). *Enhancing the well-being of children and families through effective interventions: International evidence for practice*. London: Jessica Kingsley.

McDonough, S. C. (2000). Interaction guidance: An approach for difficult-to-engage families. *Handbook of infant mental health*. C. H. Zeanah. New York, NY: Guilford Press, 485-493.

Mildon, R., Matthews, J. & Gavidia-Payne, S. (2003). *Best practice in parenting education: Understanding and supporting parents with learning difficulties*. Melbourne: Victorian Parenting Centre.

Miller, R. (2012). *Best interests case practice model: Summary guide*. Melbourne: Department of Human Services.

Miron, D., Lewis, M. L. & Zeanah, C. H. (2009). Clinical use of observational procedures in early childhood. *Handbook of infant mental health*. J. Zeanah, C. H. New York, NY: Guilford Press.

Munro, E. (2002). *Effective Child Protection*. London: Sage Publications.

National Aboriginal Controlled Community Health Organisation and Oxfam Australia (2007). Close the gap: Solutions to the indigenous health crisis facing Australia. Fitzroy, Australia.

Shonkoff, J. P. & Phillips, D. A. (Eds). (2000). F*rom Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, D.C.: National Academy Press.

Newman, L.K., Mares, S. (Eds). (2012). *Contemporary approaches to infant and child mental health*. Camberwell, Australia: IP Communications.

NCAST. (2012). PCI Information Page. from <http://www.ncast.org/index.cfm?fuseaction=category.display&category_id=24>.

O'Leary, T. (2012). *A report into the benefits of father involvement*. North Fitzroy, Australia: The Australian Fatherhood Initiative.

Olds, D., Eckenrode. J., Henderson, C. R. Jr, Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M. & Luckey D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15 year follow up of a randomised trial. *JAMA*, 278(8), 637-43.

Olds, D. L., Henderson, C. R., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., Pettitt, L. M., Sidora, K., Morris, P. & Powers, J. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behaviour. *The Journal of the American Medical Association, 280* (14), 1238-1244.

Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J., Anson, E. A., Luckey, D. W., Knudston, M. D., Henderson, C. R., Bondy, J., & Stevenson, A. J. (2010). Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Maternal Life Course and Government Spending: Follow-up of a Randomized Trial Among Children at Age 12 Years. A*rchives of Pediatric and Adolescent Medicine, 164* (5), 419-424.

Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., et al. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics, 114* (6), 1550–1559.

Olds, D. L., Sadler, L. & Kitzman, H. (2007). Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry 48* (3-4), 355-391.

Perry, B. D. (2001). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood.* Retrieved from ,<http://www.childtrauma.org/index.php/articles/attachment>

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The Neurosequential Model of Therapeutics. In N. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). New York, NY: Guilford Press.

Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the Neurosequential Model of Therapeutics, *Journal of Loss and Trauma, 14*, 240–255.

Perry, B.D., Colwell, K. & Schick, S. (2002). Child Neglect In D. Levinson (Ed). *Encyclopedia of Crime and Punishment Vol 1*. Thousand Oaks: Sage Publications.

Perry, B. D. & Pollard, D. (1997). *Altered brain development following global neglect in early childhood. Society For Neuroscience: Proceedings from Annual Meeting*. New Orleans, 1997.

Raphael, B., Swan, P. & Martinek, N. (1998). International aspects of trauma for Australian Aboriginal people. In Y. Danieli (Ed). I*nternational Handbook of Multigenerational Legacies of Trauma*. New York, NY: Plenum Press.

Raising children's network, Play and Learning. Retrieved from <http://raisingchildren.net.au/articles/babies_play_nutshell.html>

Reder. P. & Fitzpatrick, G. (2003). Can Adolescents Parent?, chapter 8. In P. Reder, S. Duncan and C. Lucy. *Studies in the Assessment of Parenting*. East Sussex, UK: Brunner-Routledge.

Rice, F., Jones, I. & Thapar, A. (2007). The impact of gestational stress and prenatal growth on emotional problems in offspring: A review. *Acta Psychiatry Scandanavia, 115* (3), 171-183.

Robinson, E. & Maloney, L. (2010). Family violence: Towards a holistic approach to screening and risk assessment in family support services, Australian Family Relationships Clearing House Briefing No.17.

Robinson, E., R. Miller, Price-Robertson, R. & Carrington, A. (2012). *Children and their families: Best interests case practice model, Specialist practice resource*. Melbourne: Deptartment of Human Services.

Robinson, E., Power, L. & Allan, D. (2011). What works with adolescents? Family connections and involvement in interventions for adolescents problem behaviours. *Familly Matters, 88*, 57-64.

Roisman, G. L., Padrón, E,, Sroufe*, L. A. & Egeland B. (2002). Earned-secure attachment status in retrospect and prospect. Child Development,73* (4), 1204-1219.

Royal Children's Hospital (2009). Bringing baby home: Safety information for new and expectant parents. Retrieved from RCH website <http://www.rch.org.au/safetycentre>

Sanders, M., Cann, W. & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: A Universal Population-Level Approach to the Prevention of Child Abuse. *Child Abuse Review, 12* (3), 155–171.

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 201-269.

Scott, D., Higgins, D. & Franklin, R. (2012). *The role of supervisory neglect in childhood injury*. (CFCA Paper No. 8 2012). Melbourne: Australian Institute of Family Studies.

Shonkoff, J. P. & Meisels, S. J. (2000). Handbook of early childhood intervention: The biology of developmental vulnerability, chapter 2. In J. P. Shonkoff & S. J. Marshall. *SIDS and Kids: How to sleep your baby safely*. Retrieved from <http://www.sidsandkids.org/safe-sleeping/>.

Shonkoff, J. P. & Phillips, D. A. (Eds). (2000). *From neurons to neighborhoods: The science of early childood development*. Washington, D.C.: National Academy Press.

Steinberg, L. (2009). Should the science of adolescent brain development inform public policy? *American Psychologist, 64* (8), 739–750.

Stojadinovic, T. (2003). *For the first time somebody wants to hear: The effects of childhood sexual abuse on women's experiences of pregnancy, birth and mothering*. A research report for Health Professionals, SA: Women's Health Statewide.

Telethon Institute for Child Health Research (2012). *Fetal Alcohol Spectrum Disorder (FASD)*. Retrieved from <http://alcoholpregnancy.childhealthresearch.org.au/about/fetal-alcohol-spectrum-disorders-(fasd).aspx>.

Thompson, A. & Kaplan, C. (1995). Childhood emotional abuse. *Child Abuse Review, 4* (1), 63-67.

Thomson Salo, F., Paul, C. et. al. (2007). Free to be playful: Therapeutic work with infants. *The baby as subject: New directions in infant - parent psychotherapy from the Royal Children's Hospital, Melbourne*. In F. Salo Thomson and C. Paul. Windsor, Australia: Stonnington Press.

Towner, E., & Dowswell, T. (2002). Community-based childhood injury prevention: What works? *Health Promotion International, 17*, 273–284.

Tunnard, J. (2002). Parental Drug Misuse: A Review of Impact and Intervention Studies. *Research In Practice*.

Turner, H. A., Finkelhor, D. & Ormrod, R. K. (2006). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine, 62* (1), 13-27.

United Nations (2011). *Men in families and family policy in a changing world*. New York, NY: Department of Economic and Social Affairs.

Van der Kolk, B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America, 12*, 389–411.

Van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics, 12*, 293 - 317

Van der Kolk, B. A., McFarlane, A. C., & Van der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder. In B. Van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (417-440). New York, NY: Guilford.

Van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the adult attachment interview. *Psychological Bulletin, 117* (3), 387-403.

Victorian Aboriginal Child Care Agency (VACCA) (2008). *Aboriginal cultural competence framework*. Melbourne: VACCA.

Victorian Aboriginal Child Care Agency (VACCA) (2010). *Building respectful partnerships: The commitment to Aboriginal cultural competence in child and family services*. Northcote, Australia: VACCA.

Victorian Child Death Review Committee (VCDRC) (2009). *Victorian Child Death Review Committee Annual Report 2009: Information for Practitioners*. Melbourne: VCDRC.

Vivekananda, K. (2000). Integrating models for understanding self-injury. *Psychotherapy in Australia, 7*, 18–25.

Watson, J., White, A., et al. (2005). *Prevention and early intervention literature review*. N. C. f. P. Research. Ashfield, Australia: Department of Community Services.

Wulczyn, F., R. P. Barth, et al. (2005). *Beyond common sense: Child welfare, child well-being, and the evidence for policy reform*. New Brunswick, N.J: AldineTransaction.

Zero to Three (2009). *Early experiences matter: A guide to improved policies for infants and toddlers*. 2009, Zero to Three.