

Practice Guide 2

Infants at risk of abuse and neglect





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Practice Guide: Infants at risk of abuse and neglect

Overview	1
Practice tool	12
Phase 1: Assessment	12
• <i>Information gathering</i>	12
• <i>Analysis</i>	18
Phase 2: Planning	22
Phase 3: Intervention	27
Phase 4: Reviewing Outcomes	34
Closure	35
References	37
Appendix	40

Overview

In this Practice Guide we take a resilience-led approach to assessment and intervention where infants are at risk of abuse and neglect. The Benevolent Society's Resilience Practice Framework provides an overarching model for working with children and families. Practice guides are designed to provide additional guidance in cases where specific problems exist or with specific vulnerable sub-groups. Practice Guides are designed to work in two parts : an overview on key issues and a practice tool to guide you.

What is infancy?

Infancy refers to the stage of child development from birth until the age of three years. In the first three years of life infants develop at a more rapid pace than any other time as they develop the capacity to experience, regulate and express emotions, to explore the environment and learn, as well as form close interpersonal relationships (Zero to Three, 2002).

The vulnerability of infants

The particular vulnerability of infants arises from their physical fragility, dependence on others for survival, under-developed verbal communication, and their social invisibility. The term "high risk infant" refers to that group which can be considered to be in danger of significant harm of child abuse and neglect as opposed to being generally vulnerable.



Due to their physical fragility, infants are the group at highest risk of fatal abuse (Victorian Child Death Review Committee, 2009).

Child Development: Ages and Stages

“Development is the outcome of transactions between the child and her environment” (Davies, 2004: 3)

Knowledge of the developmental ages and stages of children provides a significant foundation for informing clinical and casework with children and families (Davies, 2004). The path of development is somewhat predictable but there is variation in what can be considered ‘normal development.’ “No two children develop in exactly the same way” (DHS, 2008). Depending upon the age of an infant and the infant’s learning style and personality, their needs will differ. An overview of three developmental periods is provided below.

Birth to eighteen months: an overview

In the first eighteen months after birth, an infant makes miraculous progress. In this relatively short time span, an infant sees the world through their senses. Babies gather information through touch, taste, smell, sight, and sound. To help infants mature and learn, the caregiver should stimulate but not overwhelm them. The overall goal is not to “teach” your baby but to interact and explore her world with her. Older infants are on the move. They take great pleasure in discovering what they can do with their voice, hands, feet, and toes. Soon they practice rolling skills, crawling, walking, and other great physical adventures.

Eighteen months through two years: an overview

During the next stage of life, children begin to define themselves. During the toddler years, children get into everything, so it is important that parents/caregivers keep children safe from potential accidents. However, parents/caregivers need to be reassured that accidents can happen, even to the most careful parents and children.

Three year to five year olds: an overview

During the preschool years, children are incredibly busy. Cutting, pasting, painting, and singing are all daily activities. By 3 years the child’s conscience is beginning to develop. For example, children might begin to think “I would take it but my parents will be upset with me.” By 3 years a child will be able to carry on a conversation of 2 or 3 sentences, help with simple chores and may be toilet trained.

Source: The California Department of Education, 2009 and the Victorian Department of Human Services, 2008.

For more information on ages and stages of development see: www.cde.ca.gov/sp/cd/re/caqdevelopment.asp and <http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/child-development-trauma-guide>

For information about infants’ social-emotional development see the Californian Department of Education Infant / Toddler Learning and Development Foundations. This resource includes detailed information about what children’s interactions with adults and peers will look like at various stages during infancy, see: www.cde.ca.gov/sp/cd/re/itf09socemodev.asp - iwa

Attachment relationships and infant development: A Secure Base

The primary attachment figure (usually the mother) is a person with whom the infant has an ongoing relationship, to whom the infant turns and experiences as a source of safety comfort and care and who, in turn, is emotionally attuned to the infant.

Sensitive and responsive care-giving builds a secure infant–caregiver attachment relationship and promotes optimal physical, behavioural, social and emotional development, including a greater capacity for emotional regulation, positive social interactions and better coping skills. Interactions within the relationship need to be nurturing, protective, secure and consistent in order for infants to feel confident to explore their environment and to have the psychological resources available for learning.

Over the first few months of life, infants form attachment relationships with additional people with whom they have an ongoing relationship and whom they experience as a source of safety and nurturing (e.g., father, grandparent, sibling, carer, babysitter). These relationships are in a hierarchy and will be sought by the infant in hierarchical order, according to their availability when the primary caregiver is not available (Bowlby, 1969, 1980; Brisch, 2004). Infants' capacities to develop these new relationships are enhanced when they have a secure attachment relationship with their primary caregiver.

Attachment relationships can be characterised as secure, insecure (i.e., either avoidant or ambivalent, but organised) or disorganised (see Table 1, page 4).

A disorganised attachment relationship is among the greatest indicators of developmental and protective risks for the young child (DeBellis, 2001). This pattern of attachment relationship is frequently seen in research with participants who have been maltreated or are receiving mental health services. Unsurprisingly, research has demonstrated that up to 82% of maltreated infants suffer from serious disturbances of attachment with their caregivers (Carlson et al., 1989).¹

The information in Table 1 can be used:

- as a means of thinking about the relationship between the infant and their parent/caregiver
- when you are observing the parent/child relationship (see 'Observing the parent/child interaction' (on pages 13-14)
- to provide a guide on what to look for in the infant's behaviour and relationship with the caregiver.

In this guide, the term infant-caregiver relationship refers to the relationship between an infant and his/her primary caregiver (e.g., mother, father, grandmother, foster carer).

¹ *Disorganised attachment is the only pathological attachment pattern. The others are a way of being in a relationship and can change in the presence of new relationships formed (Bacon & Richardson, 2001).*

Table 1. Attachment relationship styles

Attachment style	Caregiver responses	Infant behaviour
Secure	Sensitive, responsive, consistent, attuned, reliable (e.g., prompt comforting when infant distressed, warm interested response to infant's wish to communicate or play, empathy and acceptance of infant's point of view)	Able to regulate emotions, seek help from others when distressed, adaptable to changing circumstances and able to explore their world
Insecure (avoidant)	Connected enough to protect the infant, but minimises the importance of attachment issues, can be dismissive of infant's attachment cues, insensitive to infant's signals and emotional needs	Shows little distress on separation, and minimal joy when reunited with caregiver; reduced spontaneity of emotional expression and over-controlled emotions; avoidance of affection; and focus on exploration of the environment to avoid closeness
Insecure (ambivalent)	Inconsistent or unpredictable emotional availability and response to infant's attachment behaviours and emotional needs (e.g., at times over-protective or over-stimulating and at other times rejecting or ignoring)	Overly engaged with attachment figure and may feel too anxious about caregiver's emotional availability to freely explore the environment
Disorganised	Unresponsive, intrusive, hostile or violent. Some parents/caregivers are frightening to infants, others may be frightened due to past or continuing trauma.	Responses to caregiver look chaotic and contradictory. Infant is trying to reconcile impulse to approach for care with need to avoid care giver as source of fear. Observable reactions and behaviours may include hyper-vigilance, freeze or fear when parent/caregiver appears, dissociative behaviours such as dazed expression, appearing emotionally numb or cut-off, not crying when distressed or hurt.

Aboriginal & Torres Strait Islander families and attachment

“While it is a survival strategy for infants to attach to a primary caregiver to meet their needs (Bowlby, 1969), the understanding and interpretation of the sensitivity and responsiveness of the caregivers are dependent on the values of the community in which the child resides” (Yeo, 2003, p. 295).

There are several issues that must be considered in assessing attachment relationships within Aboriginal & Torres Strait Islander communities.

- **The unresolved grief, trauma and depression in Aboriginal & Torres Strait Islander families and communities** as a result of the social and historical context of colonisation, racism, poverty, and the stolen generation continues today (Atkinson, 2002). In assessing the infant caregiver attachment relationship it is crucial to assess how these social and historical factors may be impacting on parent/caregiver’s capacity to provide responsive care and to assess what assistance can be provided to reduce the impact of these factors on the parent/caregiver’s emotional availability and parenting.
- In communal and collectivist cultures, where **several people may share in the care-giving of an infant**, it is important to **assess these relationships from the infants point of view**. It is important to avoid a narrow Western nuclear family lens that only looks at the mother infant dyad. For example, assessments of parenting in Aboriginal communities must explore the role of extended family, clans and kinship networks in parenting (Neckowaya et al., n.d.; Yeo, 2003). Infants usually have a hierarchy of relationships. Where there are multiple caregivers, it is important to assess whether the infant seems confident of who to turn to when in need, whether there is a central person who holds the infant and their needs in mind, and to ensure that the infant does not have to attempt to get care from many people to get their physical and emotional needs met.
- A further issue that must be considered is **the influence of cultural expectations on norms and understandings of social competence**. Western cultures encourage individuation and efficacy fostered through parents who provide a secure base for infants to explore. In comparison, Aboriginal culture values interdependence, group cohesion, spiritual connectedness, traditional links to land, community loyalty and inter-assistance (Yeo, 2003). When making assessments, practitioners need to be aware that parenting practices may differ across cultures as child rearing techniques will have evolved over time to foster development that is consistent with culturally expected goals (Neckowaya, n.d.; Reebye, Ross & Jamieson, 2008; Yeo, 2003).



Culturally and Linguistically Diverse Families and attachment

While the context and history are very different to that of Aboriginal children and their families, there is some similarity in the broad issues to be considered when working with other culturally and linguistically diverse groups. Specifically, when working with other Culturally and Linguistically Diverse Groups you must consider:

There are several issues that must be considered in assessing attachment relationships within Aboriginal & Torres Strait Islander communities. (Yeo, 2003, p. 295).

- The impact of past grief and trauma on the parent/caregiver's emotional availability and parenting** For example, refugee and migrant communities may have fled from war or oppression and still be struggling with unresolved trauma, grief and loss. This can impact upon the parent/caregiver's capacity to provide responsive care. Families who have newly arrived to the country can struggle with a range of issues, including settlement needs. These issues need to be taken into account when assessing the infant/caregiver attachment relationship.
- The role of extended family in parenting in communal and collectivist cultures:** some culturally and linguistically diverse families will come from cultures with a communal or collectivist structure. In these circumstances there may be multiple caregivers living in the same household and the primary caregiver may be less vigilant in their responsiveness to infant cues as they can reasonably expect that another carer will be available to attend to the infant's needs. These factors need to be taken into account when assessing parenting in these communities.
- The influence of different cultural expectations:** Overall, it is important to consider how Western cultural expectations can impact upon assessments of social competence. Parenting practices within culturally and linguistically diverse families may differ from Western cultural norms.

Infant development

The critical importance of early childhood is now well recognised (McCain & Mustard, 1999; Shonkoff & Phillips, 2000). Early experiences affect physical health (Royal Australian College of Physicians, 2006), emotional regulation and mental health across the life course, and the capacity for full engagement and participation in relationships, education, employment. Infancy is a time of rapid physical, cognitive, language, social and emotional development. Thus infants are extremely vulnerable to the effects of abuse and neglect or deprivation (Melmed, 2004). Brain development begins in utero and is about 25% of adult size at birth. In the next three years, the brain grows to 90% of adult size and develops the connections between nerve cells (Royal Australian College of Physicians, 2006).

New knowledge of factors effecting child development highlights that the brain is not mature at birth, in fact most synaptic growth happens after an infant is born. Synapse formation is different to neuron formation, which is completed during pregnancy (Moore, 2007). The formation of synapses is

a slow process that begins during pregnancy and continues into the second year of life (Moore, 2007).

The brain organises itself through the interaction of genes responding to the local environment (Frank Oberklaid, 2007). Thus, inherited genetic potential predisposes an individual to develop certain abilities, skills and characteristics. However, environmental influences, experiences and relationships in the early years determine the ultimate expression of these potentials in all the domains of development—physical, cognitive, language, social and emotional (Siegel, 2001; Stevenson, 2007; Melmed, 2004). If the brain experiences any kind of insult when it is organising itself (i.e. during the early childhood period) then this has far greater impact than if it happened after the brain is already organised (Antcliff, 2010a).

The relationship between brain development and attachment

Moore (2007) outlines a number of key points regarding the relationship between brain development and attachment:

Young children develop through their relationships with others: children’s development during the early years is governed by the quality of their attachment experiences. The attachment relationship between the infant and their parent/caregiver involves the immature brain using the functions of the mature brain to organise its own processes. “Attachment relationships form the foundation for the development of the mind and the brain” (Moore, 2007).

Hormonal / neurochemical reactions are involved in all aspects of brain development and functioning. As babies, the positive responses (e.g. smiles) we see in our parents/caregivers set off the release of pleasurable neurochemicals (opiates) that help the brain to grow. ‘Mirror neurons’ in the brain link motor action to perception: they are triggered if you watch another person doing something intentionally, and will fire if you do the same action. “Mirror neurons enable the brain to detect the intention of another person, that is, to ‘read’ other people’s minds and emotional states” (Moore, 2007).

Children’s emotional development is built into the architecture of their brains. Emotional development begins in the early stages of life. Emotional development is a vital process in the development of overall “brain architecture” that has very significant consequences over a person’s lifetime. “The foundations of social competence that are developed in the first five years are linked to emotional well-being and affect a child’s later ability to functionally adapt in school and to form successful relationships throughout life” (Moore, 2007).

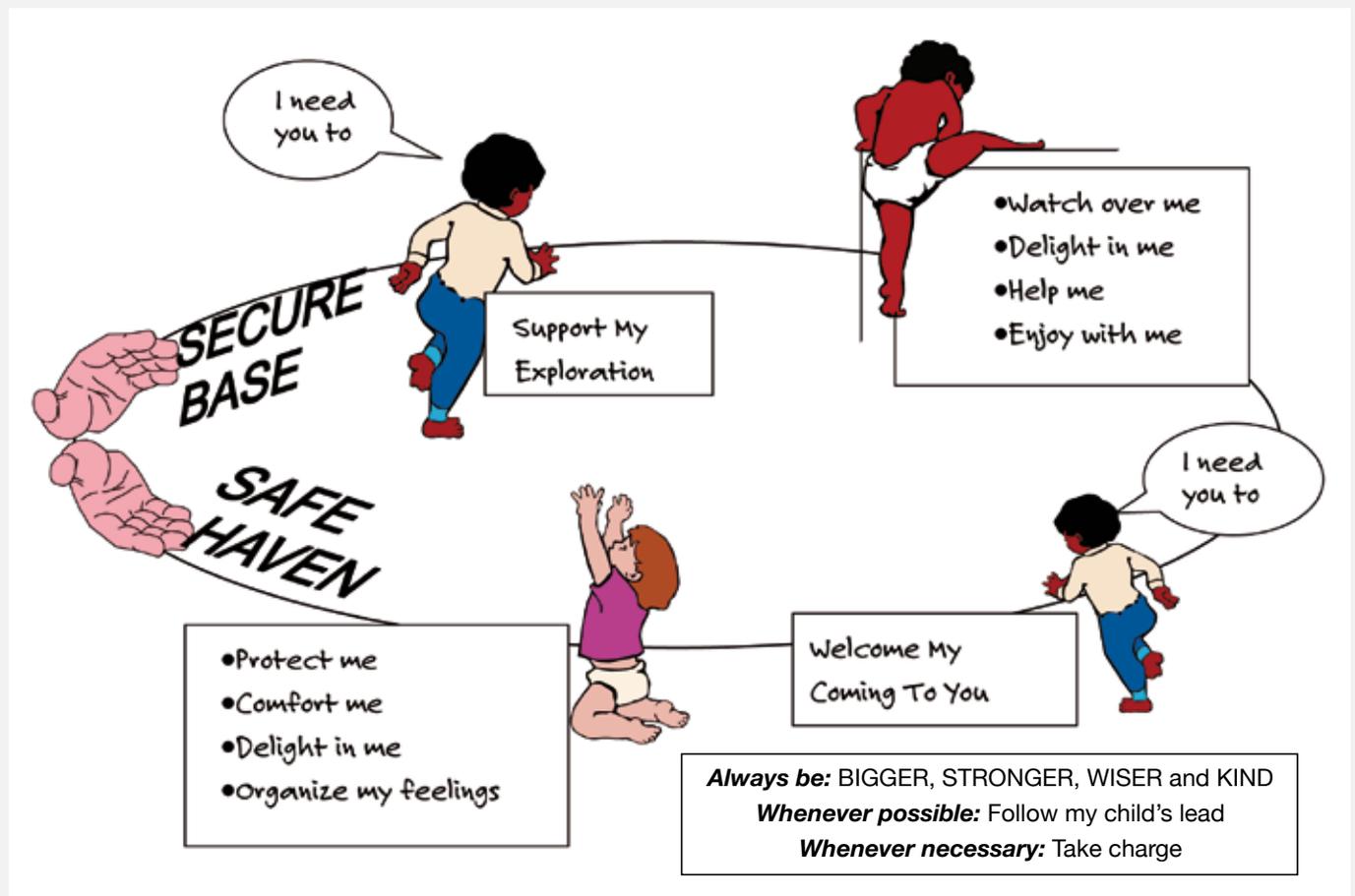
For more information on the relationship between brain development and attachment see: Shonkoff, J. & Phillips, D. (2001) (eds.) *From neurons to neighbourhoods. The science of early childhood development* (2nd ed). Washington D.C: National Academy Press.

Bacon, H. & Richardson, S. (2001). Attachment theory and child abuse. An overview of the literature for practitioners. *Child Abuse Review*, 10 (6), 377-397

The Circle of Security Map

A model that can be used to think about the relationship between attachment and learning is the Circle of Security map (Cooper, Hoffman, Marvin & Powell, 1998). The map depicts two hands providing a circle of security for the child.

www.circleofsecurity.org



One hand provides children with a secure base for play and learning (the 'secure base') and the other hand provides a 'safe haven' for children when they have had enough of exploring (Dolby, 2007).

The Circle of Security map gives parents and caregivers an opportunity to see beyond the child's immediate behaviour and consider that child's relationship needs (Dolby, 2007). It may also be useful to professionals working with the family who can use the map to create opportunities for children to learn by meeting their relationships needs with children and families (Dolby, 2007).

Impact of trauma, violence and neglect on infant development

Infants can suffer distress, emotional and physical pain and overwhelming fear or terror in response to sudden separations, neglect, being assaulted or witnessing violence. Experiences of neglect and abuse can undermine the infant's basic sense of trust in the world. Infants are especially vulnerable and powerless as they cannot request help when they feel threatened or unsafe (Hill & Solchany, 2005).

Exposure to trauma (e.g., abuse, neglect, exposure to violence) affects every dimension of an infant's psychological functioning (i.e., emotional regulation, behaviour, response to stress and interaction with others) (Perry, 2002).

Very young infants may be overwhelmed with intense negative emotions, manifesting in incessant crying, inability to be soothed, feeding problems, sleep disturbances, hyper-arousal and hyper-vigilance, and intense distress during transitions. Other infants will emotionally withdraw and become 'shut down'. They may become emotionally subdued, socially withdrawn, constricted in play and appear numb or dazed. They may not make appropriate demands on their caregivers (e.g., never cry, don't try and initiate play or interaction).

Toddlers may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, and constricted affect and play. They are likely to have reduced tolerance of frustration and problems with emotional regulation (e.g., intractable tantrums), non-compliance and negativism, aggression, and controlling behaviour. Extreme anxiety may be expressed as new fears, constricted and repetitive play, hyper-vigilance, reckless and accident-prone behaviour. Toddlers may also regress and have somatic complaints (Drell, Siegel, & Gaensbauer, 1993; Zeanah & Sheeringa, 1996).

Refer to the Victoria Child Development and Trauma Guide for further guidance on the impact of trauma on infant development

Mandatory Reporting

Mandatory reporting is defined as: "the legal requirement to report suspected cases of child abuse and neglect" (Higgins, Bromfield, Richardson, Holzer & Berlyn, 2009). All states/territories of Australia possess some form of mandatory reporting requirements, however the people who are required to report and abuse types that are mandatory to report differ (Higgins, Bromfield, Richardson, Holzer & Berlyn, 2009).

Information for mandatory reporters in NSW can be found at: http://www.community.nsw.gov.au/preventing_child_abuse_and_neglect/resources_for_mandatory_reporters.html

Information on mandatory reporting in Queensland can be found at: <http://www.childsafety.qld.gov.au/child-protection/mandatory-reporting.html>

For guidance on recognising, assessing and responding to cumulative harm refer to The Benevolent Society's Cumulative Harm Practice Guide.

Infants and cumulative harm

Cumulative harm refers to the impact of multiple adverse circumstances and events in a child's life. The constant daily effect of these adverse circumstances and events on the child can be significant and exponential, and negatively impact upon a child's sense of safety, stability and wellbeing (Bromfield and Miller, 2007).

Research into brain development refers to the term 'toxic stress' to describe the ongoing engagement of stress management systems without support. Stress prompts a multitude of neurochemical changes that help us to survive stressful circumstances and events (Bromfield and Miller, 2007). 'Toxic stress' can harm the developing brain (Shonkoff & Phillips, 2001).

Resilience

Resilience can be defined as: 'normal development under difficult conditions' (Fonagy et al. 1994). It is a complex issue, for example, although some children seem to cope well with adversity they may actually be internalising their symptoms (Luthar in Daniel & Wassell, 2002). Although many factors are related to resilience there are three basic concepts that underpin them:

- A secure base – the child feels a sense of belonging and security
- Good self-esteem – an sense of worth and competence
- A sense of self-efficacy – a feeling of mastery and control and an accurate view of personal strengths and limitations.

The resilient child can be described as one who can say:

- I have... "people who love me and people who help me"
- I am... "a likeable person and respectful of myself and others, and
- I can... "find ways to solve problems and can control myself (Grotberg, 1997).

These three categories are associated with the three building blocks listed above (i.e., I have (a secure base); I am (a likeable person); I can (find ways to solve problems) (Daniel & Wassell, 2002).

There are six domains of resilience according to the domains of resilience model (see Figure 1)

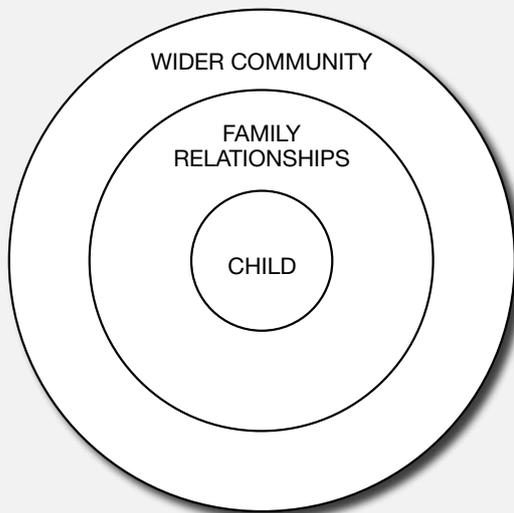
The Benevolent Society's definition of Resilience: Strength in the face of adversity. The capacity to adapt and rebound from stressful live events strengthened and more resourceful.

Figure 1: Domains of Resilience



The Benevolent Society uses the ‘domains of resilience’ model as a means of conceptualising each of three aforementioned basic building blocks. The model is used in combination with an ecological framework that demonstrates the levels at which resilience factors can be located.

Figure 2: The Ecological Framework



In practice this means that workers focus on all three levels (child, family relationships and the wider community) when considering how to assess and boost resilience in the infant’s life. For example, when thinking about a secure base one issue to consider for the infant might be does the infant appear to feel secure? When considering family relationships: is the parent/caregiver able to make time for the child? When considering the wider community: does the parent/caregiver have adequate emotional and material resources to support him or her in the parenting of the child? Each of the six individual domains of resilience should be considered in relation to the three levels of the ecological framework.

For more information about the Domains of Resilience model see: Daniel and Wassell, 2002

Practice Tool

If the family has been referred from another service, The Benevolent Society has a specific approach to referral which should be considered. See the Building Resilience resource (2005, p.7-8)

The aim of this tool is to provide some additional guidance about specific things you might consider when working with infants at risk of abuse and neglect, and their families. The tool consists of 4 sections representing each phase of casework: assessment (including information gathering and analysis), planning, intervention and reviewing outcomes.

Phase 1: Assessment

In this part of the guide, we provide specific tips and guidance for the assessment phase of your work with families with infants. Comprehensive assessment is an ongoing process of gathering, analysing, comparing and synthesising information from various sources in order to come to an understanding of family strengths and needs relating to the child's safety and well-being (U.S Department of Human Services, 2008). As all families have their own unique strengths and needs, there is no one size fits all model for assessment. Assessments should be individualised and respectful of the families' unique strengths and needs.

There are two steps involved in assessment:

- (1) information gathering
- (2) analysis

INFORMATION GATHERING

Information gathering is ongoing throughout the life of a case, and includes gathering information from existing case files, professionals involved with the family and most importantly from children and families themselves. Information also needs to be gathered about previous attempts to resolve the problems within the family - by the family themselves, and by professionals and agencies involved with the child and family.

Think broadly about family and the significant people for the infant

The primary caregiver is usually the starting point for collecting information about the infant. However, it is vital to involve other family members who may include extended family, formal and informal child-care providers, and other people who may be significant for the infant or their parent/caregivers.

- Who are the people who care for this infant? What is the nature and quality of their relationship?
- A family meeting should be held as soon as possible and be inclusive of extended family if appropriate.

Involving other family members and significant people in the infant's life in the information-gathering process practice ('inclusive practice') enables stronger engagement and exploration of concerns and supports.

Engaging with the family

Successful engagement with families is critical in the information-gathering phase. It is important to spend time planning the best way to engage with individual families. It may take time to come to a point where successful engagement with the family takes place. During the initial phases of engagement it is important that families feel they have a choice and consent to working with the service in the future. Developing an effective working relationship with a family is critical to bringing about required changes.

Observing the parent/child interaction

There are two situations where observations of a child with their caregiver can be made. They are known as structured moments and unstructured moments. Structured moments include activities such as eating, bathing, preparation for sleep, nappy changes or clothing changes. Unstructured moments include activities such as a play session. The difference between structured and unstructured moments is in the former the child follows the parent's initiative; in the latter the parent follows the child's initiative (see Appendix A for more information on what child and parent initiatives look like, the 'Marte Meo Developmental Elements' (Aarts, 2008).

Structured moments are good for observing the interaction between parent and infant where the parent has the lead (i.e. things that must be done). Some of the questions that could be asked of structured moments include:

- Can the parent take the lead in these moments?
- Does the child have a model of cooperating with their parent?
- Is the interaction warm and predictable?
- Does the parent name their actions/initiatives? For example when changing a baby there are many sequences of events. Naming actions/initiatives for this event might include: "I am going to take off your shirt now, then the undershirt, then the pants, then the nappy."?
- Does the interaction between parent and child look like an interaction moment or a business transaction?

Structured moments allow you to analyse the child's capacity to follow the adult's lead and the adult's capacity to lead the child through detailed guidance of the things that must be done. A child's capacity to follow the adult can develop at a very young age. For example, a child who follows a parent's lead you can see by the age of about 3 months they begin to lift their legs to assist in the nappy changing process – hence developing a model of cooperation. Structured moments involve a predictable sequence of events that happens many times throughout the day. If structured moments are not present they can become part of an intervention thereby enabling the parent to develop the necessary leading skills.

Be a 'holder of hope' for the family. The term 'holder of hope' is commonly used in the field of mental health however it is equally applicable to a range of other professions. A holder of hope "holds hope for those that cannot hold it themselves [and then] has the courage to hand it back to them" (Glover, 2002).

Use the Victorian Child Development and Trauma Guide to aid your observations and assessment. Check your observations with the Maternal and Child Health Nurse or other early year worker.

Unstructured moments are where the parent needs to follow the child's initiatives. Some of the questions that could be asked of unstructured moments include:

- In pre verbal children does the parent name the child's initiatives and follow their play ideas?²
- Does the parent follow the child's lead/initiatives and the child's spontaneous ideas?
- Does the parent give the child enough space to act on their own initiative?
- Is the parent able to enter into the 'child's world'?
- Is the child able to put initiatives on hold when directed?

(Aarts 2008)

In the presence of their caregiver, it is important to engage the infant in order to get to know them and gain a better understanding of how the family situation impacts upon them. Ensure that before you begin to engage with the infant you get the parent/caregiver's consent to do so.

While playing with or observing the infant, consider the following:

- Is the infant's play or communication developmentally appropriate?
- Is the infants' emotional regulation age appropriate and congruent with the situation?
- Does the infant seek comfort when they are distressed and from whom do they seek comfort?
- How does the infant respond to strangers (e.g., friendly and interested, hyper, vigilant, disinterested or unresponsive)?
- How does the older infant make use of toys? Do they create themes through their play that may represent a possible re-enactment of trauma, aggression or fear?
- Can the parent/caregiver follow the child's initiatives during free play?
- Think about what it is like to be this infant in this relationship, in these circumstances, at this time (Zeanah & Boris, 1997). Try and see the relationship from the infant's point of view – what does it look like and feel like to the child?

You may find the information regarding attachment and different attachment styles in Table 1 on page 4 useful in guiding your observations.

Be attentive to the fact that if children are in a new situation, interacting with someone they don't know, unwell or stressed then their behaviour is likely to be affected.

When gathering information, you need to be attuned to both risks and protective factors (see page 27), and to indicators of trauma or abuse in the infant's behaviour or presentation

² This has a profound effect on infant development as it helps to develop a child's social skills, self-efficacy and language skills.

Tips for engaging infants

Infants communicate through play, so take the opportunity to be playful and interact age appropriately with them. (Remember to seek the parent/caregiver's consent before you begin to play with the infant).

You do not need to set up a contrived 'play' situation. It can be as simple as sitting on the floor playing blocks with a one-year old. Bring the parent/caregiver into the interaction with the infant so they don't feel left out and encourage the parent/caregiver to learn from you as you engage with the infant. It is important that as a result of your engagement with the infant the parent does not feel as if they are failing as a parent because you can engage with the infant but they cannot. By encouraging the parent to participate you can help the parent feel as if they are a part of this positive interaction, rather than just an observer of it.

- Be warm, open and responsive to the infant's communication - babies are interested in social interaction and curious about people from birth
- Be playful and interested when engaging with the child
- Acknowledge the infant by speaking to them in age appropriate language
- Naming the initiative:
 - Name what you do as you play with the infant, e.g., "Now I'm pushing the truck."
 - Name what the child does as they play, e.g., "Now you're playing with the ball."
 - Encourage the child to name what they are doing.
 - Encourage the parent/caregiver to follow the three points above and explain why it's important (see text box number). (For more information about the Marte Meo model see Appendix B (Aarts, 2008).
- When working with the parent/caregiver to engage the child:
 - Don't use abstract information.
 - Provide step by step concrete guidance in supporting children's development.
 - Don't focus on the 'symptom' (i.e. any problem behaviours); rather, focus on the developmental message behind the problem behaviour (Aarts, 2008).
- Engage in eye contact (some children with autism spectrum disorders, however, will not be comfortable with eye contact and note that there may be issues surrounding eye contact in some cultures)
- Be playful and interested in interaction and the infant's point of view; enjoy getting to know the baby
- Speak using a warm tone of voice and repeat back cooing and babbling sounds. Explain to parent/caregiver that this is the beginning of developing;
 - A model of self; "I can have an impact on others, I am seen".
 - A model of connection; "I can influence others and interact with them".
 - Registration: "I have an awareness of what I am doing, feeling" (Aarts, 2008).
- Use the opportunities of everyday care (e.g., feeding, bathing times) to observe the infants emotional regulation and interaction with their care giver
- Play alongside a toddler without expecting co-operative play to engage the older infant/younger toddler
 - think of play as a window into the infant's point of view and observe sequences and repetitions
- Talk with the toddler, perhaps gently asking about the play you observe - remember that a toddler can understand more than they can express



Medically fragile infants

Premature or medically fragile infants can suffer from low birth weight; feeding, settling and sleeping difficulties; prolonged and frequent crying; and developmental delay, and they may have complex medical needs. These factors, in addition to long hospital stays, confinement in an incubator and loss or separation experienced by parents/caregivers have an impact on the relationship between the infant and their parents/caregivers (Brisch, 2004; Fegran, Helseth, & Fagermoen, 2008).

- What, if any, characteristics of the infant may place additional stress on the caregiver (e.g., fussy, difficult to feed or settle, physical or intellectual disability or delay, medically fragile, foetal alcohol syndrome)?
- Have you consulted with all hospital and community medical and other health professionals involved in the care of the infant? Have you accessed assistance from the medical team to develop an accurate working knowledge of the infant's condition, treatment, burden that the medical condition and treatments might place on the care givers?

Assessing the infant's daily life and environment

Daily Routine

Routine and consistency is important to infants; it gives them a sense of safety and stability. Having a routine is not the same as having a rigid or inflexible daily schedule – the parent's routine may include demand feeding. Talking with parents/caregivers about the infant's daily routine gives information about the infant's daily lived experience – their basic infant care, the infant's capacity to self regulate, strengths and sources of stress in the infant-caregiver relationship and how the caregiver views the infants impact on them.

- Is there a sleeping routine? How long does the infant sleep for?
- How is the infant settled to sleep?
- How often is the infant being fed (breastfeeding, formula or solids)?
- How do parent/caregiver and infant interact during feeding?
- Does the infant tend to fuss around the same times each day?
- How does the infant self-regulate (sleep, feeding, crying, fussing)?
- Is the infant given appropriate opportunities to play on the floor?

Physical environment

Observe the physical environment to assess the safety and physical wellbeing of the infant.

- Is the infant's environment safe or "child-proof", in line with the infant's development (e.g., electric cords out of infant reach, cupboards with locks)?
- Is the infant's environment comfortable, warm, and inviting for the infant?
- Is the environment hygienic (clean space for infant to sleep and to play on the floor?)
- Are there dogs or other pets in the house that impact on infant safety or hygiene?
- Is the infant's sleeping environment safe?

- What does the environment look like to the child? Does it feel comfortable and inviting? Try to see the environment from the child's perspective.

For further information on gathering information to form your assessment refer to the Benevolent Society Family Assessment Tool.

Creating safe sleeping environments

Safe sleeping environments are vital for infants. What is the sleeping environment for the infant like? Are there any risks for Sudden Infant Death Syndrome (SIDS)? Where the parent/caregiver resides in insecure housing, is transient, or staying with family it is particularly important to help parents/caregivers plan safe sleeping arrangements. For example you might assist them to purchase a portable cot that meets current Australian safety standards.

To reduce the risk of SIDS, parents and caregivers need to know and practice the following safe sleeping arrangements:

- Sleep baby on the back from birth – never on the tummy or side
- Sleep baby with face uncovered
- Keep baby smoke free, before and after birth
- Provide a safe cot, safe mattress, safe bedding (e.g., not cluttered with soft objects / bedding / bumpers which can cover infant's head, not damaged or broken and meets current Australian safety standards)
- Do not sleep baby in a pusher without appropriate restraints
- Do not place cot or pusher near other sources of danger

If a baby/infant sleeps in a portable cot:

- Only the mattress supplied with the portable cot should be used
- Extra padding should not be added under the mattress as the baby could get trapped face down in the gap between the mattress and padding
- The portable cot must meet current Australian safety standards (this might be particularly important if an infant is removed and placed with a family member or temporary carer who has an older portable cot)

Co-sleeping is a common parenting practice for many cultural groups. Where co-sleeping is practiced, it must be practiced safely. Parents/caregivers who choose to co-sleep with their baby need to be aware that taking baby into an adult bed may be unsafe if baby:

- Sleeps with someone who hard to rouse due to drugs or alcohol, depression, smoking induced sleep disorder, prescribed medication, or who sleeps very deeply.
- Is at risk of getting caught under adult bedding, loose fitting nightclothes or pillows
- Is at risk of becoming trapped between the wall and the bed
- Falls out of bed

Practice Guides provide a concise overview. They do not replace the need for ongoing supervision, consultation with specialists or professional development.

It is critical to work in partnership with families to identify their strengths and needs. Be inclusive. Have you considered and involved all possible partners within the family - the mother, father, extended family?

ANALYSIS

You need to be a critical thinker and to juggle multiple competing needs prioritising the infant's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Synthesise the information you have gathered about the current context and the pattern and history and weigh the risk of harm against the protective factors.

The postpartum period is demanding and challenging for all parents but some cope better than others. Risk factors only become meaningful to an infant through their effects on parenting capacities. The impact of mental health problems on parenting capacity, for example, can be different depending upon the individual and their circumstances. It is important to take into account both risk and protective factors impacting on the infant (see Parental problems and parenting capacity on page 22 and Protective factors on page 27).

If parent problems are present, the critical questions you must answer in your assessment is, how do they impact parenting, the parent-infant relationship and the infant's experiences and development? Is the infant physically and emotionally safe? Can the parent provide adequate care? Can the parent be supported to provide safe and appropriate care?

Make a holistic assessment

A holistic assessment will incorporate the information you have collected about the infant (e.g., current health, development and mental health), the parents/caregivers, and their environment. It will assist in the planning of interventions for the infant based on their individual needs.

- How are parenting problems impacting parenting capacity, and in turn, the infant's safety and development?
- What are the strengths of the parent/caregiver? Where does the parent/caregiver need support? (Use the domains of resilience to guide your thinking here)
- What resources are being utilised by the family within the wider community? What other resources in the wider community could be drawn upon by the family? (Again, use the domains of resilience to guide your thinking here)
- What needs to change? What could be done differently to ensure the safety and healthy development of the infant?
- What do the family see as the strengths and what do they see as the problems? What do they think might lead to solutions?

Daniel & Wassell (2002) provide a comprehensive list of questions that can be asked during the assessment phase, according to each of the domains of resilience.

Assessing parenting practices in Aboriginal & Torres Strait Islander families

Child rearing practices viewed as inappropriate in western cultures, may be normal in Aboriginal communities. Parenting practices in Aboriginal communities will differ from community to community because Aboriginal cultures are not homogenous. Aboriginal communities will have characteristics specific to geographic location and social networks with significant variation across urban, rural and remote communities (Neckowaya et al., n.d.). The extent to which Aboriginal families have maintained traditional parenting practices and the extent to which Western cultural norms and parenting practices have been adopted within the family will also occur along a continuum.

- Consult with Indigenous services and the local Aboriginal community to gain a better understanding of cultural differences in parenting practices.
- Be cautious about imposing Western parenting norms onto Aboriginal families – your role is to secure the safety and wellbeing of the child not to enforce a universal set of parenting practices. It may be useful to explore your own beliefs about parenting and what informs those beliefs.

Where problems are more complex than cultural differences in child rearing, intensive early support could be provided to assist Aboriginal families. For many, a lack of parenting skills has occurred as a direct result of their shared history of not receiving adequate parenting and nurturing (VACCA, 2008; Westerman & Wettinger 1997).

When planning interventions for Aboriginal children and families it is important to consider the following:

- Holistic healing approaches, which plan to provide for the physical, mental emotional and spiritual well-being of the infant/child and their family; and
- The healing value of culture, which views the affirmation and enhancement of Aboriginal culture as essential to treating the disconnection from culture (of which the lack of parental capacity is often symptomatic) and recognises culture as a protective factor which encourages resilience.



Assessing parenting practices in Culturally and Linguistically Diverse Families

Just as child rearing practices in Aboriginal families may differ from the Western norms so too may child rearing practices in other culturally and linguistically diverse families. For example, for some Sudanese families the eldest daughter may have caring responsibilities for younger siblings.

The term ‘culturally and linguistically diverse’ incorporates a vast range of cultures that differ significantly from one another. Hence, when considering culturally and linguistically diverse families it is important to note that parenting practices will differ from community to community.

- Consult with culturally specific services (e.g., migrant resource centre) and the local community to gain a better understanding of cultural differences in parenting practices.
- If traditional parenting practices are incongruent with the cultural context in which the family is now located (for example, it will not be safe for African families to leave children in a playground or other public place and assume that other adults present will watch them), work with parents to educate them about the cultural differences so they can understand the need for change – avoid being accusatory or blaming.
- Again, be cautious about imposing Western parenting norms onto families from culturally and linguistic diverse backgrounds. It is not your role to enforce a universal set of parenting practices. Think about what cultural resources support culturally specific parenting practices and whether equivalent supports need to be put in place. For example, in some cultures mothers are confined to the home for 40 days after giving birth. In these cultures the mothers are supported during this period by female relatives who tend to the mother’s domestic work and other caring responsibilities. If a new mother is also a new arrival to Australia without a social network, this cultural practice may increase her risk of depression due to social isolation and lack of nurturing care.

Working in partnership with other services

It is critical that services involved with infants and their families communicate with each other, sharing appropriate and relevant information on a regular basis to ensure that infants receive the optimal care they require. When services do not work collaboratively, they cannot provide the best possible assistance to families.³

Consider your possible professional and services partners in working with this infant and their family. For example, professionals or services such as the paediatrician, GP, community child health nurse, early parenting centre, Parenting Assessment and Skill Development Services, infant mental health worker, speech therapist, domestic violence, drug and alcohol, housing and disability services, migrant resource centres and relevant Government departments.

- Talk to and involve other key professionals involved with the infant and their family
- An early case conference is critical to assist with information gathering, analysis and planning
- Have you consulted the hospital at which the infant was born regarding their pre and post-natal care?
- Consider the use of multidisciplinary assessments for infants and parents. Be purposeful in regard to how these assessments will add value to your analysis and decision-making.

Refer to the Benevolent Society Family Assessment Tool and User Guide for more information on analysis of information gathered

A case conference is essential for professionals connected with the family – and the family themselves - to work together to explore solutions.

It is not enough to refer to a service and expect that the family will engage with that program or that the treatment will be suitable for a particular family. Because time is so critical, practitioners may ensure that the family have connected with a service, and/or to facilitate priority access to services.

³ Chapter 16A of the NSW Children's and Young Persons (Care and Protection) Act permits the sharing of information between agencies. For more information on this legislation see the Benevolent Society Confidentiality & Disclosure Policies and Procedures.

Phase 2: Planning

Notice and acknowledge infant and family strengths. Reinforce positive interactions between caregivers and infants and highlight the infant's contributions to these interactions.

Planning is the second phase of casework. Thoughtful consideration of what planning mechanisms are required will enable you to be purposeful in your action in developing and implementing plans.

Infant-caregiver relationship

The way in which a caregiver speaks about and interacts with the infant reveals the meaning of this infant to the caregiver and any projections and/or distorted perceptions of the infant. Observe the way in which the caregiver and infant play and interact. You are looking to gather (based on your own and others' observations) whether this relationship is positive and protective of the infant, has vulnerabilities that can be addressed with appropriate services, or is a source of harm for the infant. For example:

- How do the caregiver and infant interact (comfortable with each other, make eye contact, smiling, giggling, talking, play)? Note the description of this by significant others.
- Does the caregiver notice and respond to infant cues (e.g., if the infant seems distressed or overwhelmed, does the caregiver comfort)?
- What can the Circle of Security map tell you about the infant's attachment needs?
- Observe how the caregiver responds to the infant's emotional and safety needs (are medical problems/illness responded to appropriately, is baby left: crying, with bottle/dummy, in pram or cot for extended periods)?
- How does the caregiver describe the infant and interpret their communication and behaviour (e.g. five words to describe the infant)? Is this interpretation age appropriate and empathic? Do the caregiver's descriptions match your observations?
- What were the mother's experience of pregnancy and childbirth (was the pregnancy planned? were there traumatic circumstances or events that would impact on the mother-infant relationship)?
- What was the postnatal period like for caregiver and baby (e.g., illness, depression, relationship difficulties, supportive family and friends)?

Parental problems and parenting capacity

To help guide your assessment and planning, research regarding the effects of the key problems for parents of infants is discussed in this section. Specifically, the problems of parental substance misuse, mental health problems, family violence, parental intellectual disability, adolescent parents and social isolation and their impacts on infants are discussed in some detail. In addition to these specific problems, consider whether there are other social and contextual issues that are contributing to parents' distress and parenting problems (e.g., housing instability, homelessness, financial problems, physical health problems) and which may be alleviated with appropriate support.

Parental substance misuse

High rates of child maltreatment have been reported in families with parental substance misuse (Dawe, 2007). The numerous effects associated with intoxication, drug use and withdrawal symptoms include: poor coordination, memory and attention impairment, nausea and vomiting, and unpredictable mood swings. Parents may also become involved in a range of illegal or risky activities, such as theft or prostitution, in order to support their habit, which may also place their infant at risk (Dawe, Harnett & Frye, 2008). The effects of substance misuse can impair a parent's ability to:

- Be responsive and sensitive to their infant's emotional needs;
- Meet the infant's feeding and sleeping needs; and
- Ensure the infant and their physical environment is clean.

If an infant's caregiver(s) has a substance misuse problem, how is this impacting on their behaviour and capacity to provide adequate care for their infant?

Parental mental health problems

There are many different symptoms of mental health conditions, each of which may affect the safety and wellbeing of an infant in different ways (examples of some mental health conditions that can affect the infant include: depression, bipolar disorder and borderline personality disorder). Mental health conditions can cause the parent to withdraw, lack emotional engagement, be less responsive or be more negative (Newman & Stevenson, 2005; Siefer & Dickstein, 1993). Severe conditions involving hallucinations and delusions or fixed beliefs about the baby may put the infant at risk of serious harm including violence or abuse and, sometimes, death (Sved Williams, 2004). The parent may be unable to meet the physical and emotional needs of the infant. The worker should have a conversation with the parent which includes the following questions:

- Does the parent have a previous history of being affected by a mental health conditions? How do the symptoms manifest in the parent?
- Has this affected their parenting in the past? If yes, what were the interventions and how did they help?
- Has the parent accessed the local community mental health service or other medical intervention services? Do they have a mental health worker at present? What other supports are in place (e.g., family support service, playgroup, family daycare, friends)?
- Are they on medication and are there any side effects that may be causing the symptoms you are observing?
- Are there other family members (e.g., father, grandparent) who are able to assist the parent and provide emotional and physical care and safety for the infant while the parent's mental health condition is assessed and treated?



Refer to the ‘Family Violence Risk Assessment and Risk Management Framework’(2007) from the Office of Women’s Policy (www.women.vic.gov.au) to aid your planning and assessment.

Family violence

Family violence is “responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking” (VicHealth, 2004, p. 8). Where intimate partner violence is perpetrated against women, it frequently occurs during pregnancy and is targeted towards the abdomen and breasts (Australian Bureau of Statistics, 2007, Humphreys et al, 2008; McGee, 2000). In utero, the mother’s physical and emotional distress has a direct impact on the developing foetus (Davis et al, 2007; Johnson, 2007). Assault of a pregnant woman may result in miscarriage, premature birth, or the infant experiencing physical injury or disability (Huth-Bocks, Levendosky, & Bogat, 2002; McGee, 2000).

The physical and psychological impacts of violence on caregivers may affect their parenting particularly their emotional availability and attunement to the infant’s needs. Infants are also vulnerable to physical injury during an assault (e.g., if they are being held by their caregiver). For infants who have experienced abuse or neglect, people, sensations, images, situations and places may all act as traumatic reminders or triggers. In partner violence, the infant witnesses the parents as victim and aggressor and is unable to rely on either parent for their own protection and comfort. Given this scenario, it is likely that specific aspects of the parent’s behaviour, tone of voice and body movement and facial expressions may become traumatic reminders for the infant (Lieberman, 2004). Infants and their caregivers are likely to benefit from specialist Family Violence Services and programs that seek to enhance the attachment relationship between infants and caregivers (Bunston, 2008) and support the caregiver in her parenting.

In your planning:

- The first priority is to ensure that the infant and their caregiver are physically safe from further violence. If the caregiver or infant’s safety cannot be ensured in the home, detailed comprehensive planning needs to occur to help the caregiver exit from the crisis or from the relationship. Women are most vulnerable and unsafe when fleeing family violence situations. The decision to leave can push them into poverty and homelessness (NSW Women’s Refuge Movement Resource Centre & University of Western Sydney Urban Research Centre, 2009). Violence frequently escalates post-separation (Holt, Buckley, & Whelan, 2008) and women are most vulnerable to family violence homicides post-separation (Wilson & Daly, 1993). Liaison with police and specialist Family Violence Services is critical. Pre-exit planning and post-separation support needs to be proportionate to the level of risk and the family’s needs.
- Caregivers who have experienced domestic violence (usually mothers) are frequently held responsible for “failing to protect” their children (Holt et al., 2008). However, research shows that mothers can make considerable efforts to protect their children (Mullender et al., 2002) and may choose to remain with violent partners as they consider it too dangerous to leave. These findings suggest that it is important to carefully assess and sensitively explore the constraints on the caregiver’s capacity to act proactively and to protect the child. Identify the context in which the violence occurs and the repeating patterns of each partner.

- After the violent episode, the partner may express remorse and the mother may be drawn back into the relationship by her genuine belief that “he can change, he is sorry”. At this point the mother experiences intimacy and her desire for normality may seduce her back into the relationship so that “the baby can have a father”. It is important to enquire about the positive and negative feelings she may still have toward the violent partner. The history of the positive connections and hopes for the relationship now and in the past need to be explored, so that the cycle of violence and repeating patterns can be better understood, and planning and current actions can be more effective.
- Think about how you might also engage men who have been violent towards their partners to take responsibility for their actions and recognise the impact on their partner and infant. Make every effort to link him with appropriate services. Liase with local men’s behaviour change services and be proactive in ensuring other adult focussed services are aware of the children’s issues and the parenting role of their client.

Parents with intellectual disabilities

Intellectual disability and learning difficulties may impact the way in which individuals are able to live in the community and adapt to their environments including their communication, self-care, safety-awareness and the capacity for self-direction (NSW Department of Community Services, 2007). Parents with intellectual disability may struggle to flexibly respond to their infants’ changing needs, putting the infant at risk of neglect. However, there are great variations in severity of intellectual disabilities and in parenting skill levels and family circumstances. Studies do not agree as to whether it is the intellectual disability that causes child abuse and neglect, the accompanying socio-economic difficulties, or discrimination and prejudice faced by many of these families. Parental competence must be assessed on a case-by-case basis (Mildon et al., 2003). However, it is generally agreed that greater support is required for parents with intellectual disability and their infants (Booth & Booth, 1993; Dowdney & Skuse, 1993; Feldman, 2004; Feldman & Léger, 1997; Llewellyn & McConnell, 1998, 2003).

If you are working with a parent with an intellectual disability:

- Do not automatically assume a lack of competency in parents with low IQ
- Be conscious of the way in which you communicate (verbally and in writing) – is it appropriate to the individual’s ability to communicate?
- In what way, if any, is their disability impacting their ability to provide adequate care? Consider a referral to Parenting Assessment and Skill Development Services.
- Are there other issues associated with the intellectual disability that are putting additional stress on the individual’s parenting (e.g. housing, isolation, lack of support)?
- What services or supports might be of assistance?

Adolescent mothers

Most adolescent mothers do not abuse their children, but the infants of adolescent mothers are at a higher risk of parent–child relationship problems and neglect (Carter, Osofsky, & Hann, 1991). An Australian study found that 60% of pregnant adolescents had a major social or psychological problem adversely affecting their ability to carry out daily living activities (including parenting activities), and the

Research suggests that there are commonalities in the neuro-cognitive processes underlying physical pain and social rejection/exclusion. The part of the brain that is associated with the ‘unpleasantness’ of pain is activated during times of social rejection (Eisenberger, Jarcho, Lieberman & Naliboff, 2006). Hence, social rejection is not just a ‘social’ phenomenon; it is also a physical reality.

See *Infants at Risk of Abuse and Neglect: A Review of Literature* (Sketchley & Jordan, 2010) for a more comprehensive discussion on the ways in which different risk factors impact on parenting.

To assist in planning your interventions use the *Benevolent Society Planning Tool*.

consumption of drugs and alcohol was higher than that reported for the general adolescent population (Quinlivan, Peterson, & Gurrin, 1999). Studies have found that adolescent mothers talk less to their infants and frequently have difficulty interpreting infant cues or identifying the feelings of their babies (Carter, et al., 1991; Osofsky, Hann, & Peebles, 1993), all of which affect infant development and the infant–caregiver attachment relationship. However, it is worth noting that home visiting programs have been found to be effective for young parents, particularly in assisting young mothers to re-engage with education (Sweet & Appelbaum, 2004). It is preferable to engage with adolescent mother’s during their pregnancy to ensure they have the supports they need.

- Are young parents receiving the support and assistance they need?
- Are they struggling to cope with the demands of a new baby?
- Would they benefit from a referral to a home visiting or parenting program?

Social Isolation

Social isolation is a risk factor for child abuse and neglect. This may be explained by the fact that socially isolated parents have less emotional support and cannot rely on others to assist them with material aid and practical resources such as help with child-care. Parents/caregivers who are socially isolated may also lack positive parenting role models, and may feel less compelled to follow conventional standards of parenting behaviors. It is not clear, however, whether social isolation contributes to maltreatment or whether it is the result of the dynamics of maltreatment (Child Welfare Information Gateway, 2010). Holt-Lunstad, Smith and Layton (2010) analysed whether the extent of social relationships influences the risk of mortality. They found that the influence of social relationships on the risk of death was comparable with well-established risk factors for mortality such as smoking and alcohol consumption and exceeded the influence of other risk factors such as physical inactivity and obesity.

Protective factors

When undertaking assessment and planning it is important to consider not only the problems that can impact upon parenting capacity but also the factors that protect against child maltreatment (‘protective factors’). Whilst risk factors, such as those described above, heighten the probability of abuse and neglect, protective factors protect against abuse and neglect. A protective factor can also be the absence of a risk factor (such as those risk factors described above) or a factor that reduces the impact of a known risk factor (Beyer, Higgins & Bromfield, 2005). The existence of protective factors can help explain why one child may manage adverse life events better than another child (Daniel & Wassell, 11).

Protective factors that are associated with long-term social and emotional well-being can be found at all levels of the child’s social environment, that is, at the child, family and community level (Daniel & Wassell, 2002; NAIC, 2004). Child factors include: good health, a history of adequate development and personality factors (e.g. easy temperament, good social skills). Parent and family factors include: positive and warm parent-child relationships, household rules/structure and extended family support and involvement. Environmental factors include: adequate housing and access to health care and social services (NAIC, 2004).

Phase 3: Intervention

Intervention is the third phase in casework. Timely interventions are important for all children, but time is especially critical for infants. Use your assessment and planning to inform your intervention. It is important to remember that prior to taking action a period of reflection is required. Take time to *reflect* upon the information you have gathered during the assessment and planning phases. This may be difficult if you are focused on ‘doing.’ What services, supports or interventions do the parents need? What interventions, supports or services might help assist the infant in recovery? What services are available to assist with the infant-caregiver relationship?

Take care not to ‘over-refer’ parents to services. A key worker needs to take responsibility to ensure that the family is engaged in a staged and coordinated process – common sense should prevail. Professional involvement needs to be manageable, supportive and change oriented rather than overwhelming. Build on non-professional supports and consider referral to:

- Professionals/services to assist with parent problems, such as housing assistance, home visiting, family support, drug and alcohol, mental health, family violence, men’s behaviour change, victims of crime assistance, sexual assault services, family counselling, refugee and culturally specific services (e.g., migrant resource centres).
- Infant specific services - maternal and child health nurse, paediatrician, CAMHS (specialist infant mental health), early parenting centres, and specific therapeutic groups (e.g. for mothers and infants who have experienced family violence or mothers with postnatal depression).
- In-home, day-stay, or residential Parenting Assessment and Skill Development Services (PASDS) to assist parents develop the skills they need to meet the needs of infants and young children
- Connections to universal services or community programs/clubs (e.g., housing services, health services, child care, mentoring programs, community centres, neighbourhood houses, first mothers groups, playgroups, parenting groups, toy libraries)
- If the infant is of Aboriginal or Torres Strait Islander descent consider referral to Aboriginal Child & Family Service, Aboriginal Maternal and Child Health, “Aboriginal In Home Support Services”, any other appropriate Aboriginal Services/Programs in the area.

Infants must be seen regularly. Who is responsible for visiting the infant and family and assessing that change is occurring within the infant’s developmental timelines? How is this being coordinated across services? Are observations being fed back to all partners involved in the case?

The reason for family services involvement must be clearly understood by the family. The impact of these parental problems on parenting capacity and the infant must be clearly articulated without jargon. Clear goals and outcomes need to be established in relation to what needs to change *for the infant*

Working with infants and families

The goals of the intervention need to be developed with the family. Work collaboratively with the family, and any other agencies involved, to put into place goals for change. It is important to advocate for a realistic case plan and assist in its development in order that the family is set up for success rather than failure. The goals need to be specific otherwise the family may not grasp exactly what it is that they are trying to change. Intervention strategies can be integrated into everyday activities such as nappy changing. These everyday activities will strengthen the parent-child relationship and, as they occur regularly during the course of a day, they provide consistent opportunities for positive experiences. For further information on developmental intervention strategies based on 'action moments' see: Aarts, 2008; Antcliff, 2010b.

- Engage parents in thinking about how their family life could be different. What are their hopes for their family? For their infant? What gets in the way (explore the constraints)? What have they tried already? What would help to change their circumstances?
- Caring for a new baby is hard for any parent – are there extended family or friends who can provide support and assistance?
- Do parents have any time out from their infant? High quality childcare can provide respite from the unceasing demands of infants and toddlers and contribute to positive child outcomes. Can you assist the family in securing a childcare place for the infant?
- Parents with past histories of abuse or neglect may struggle to meet the needs of their baby or toddler. Help parents and extended families to understand your concerns about their infant in terms of rapid change, developmental milestones, trauma and attachment.

It is important that the six principles for goal setting are followed:

- (1) Focus on what needs to change to assist the child
- (2) Realistic and achievable goals
- (3) Properly resourced goals
- (4) Able to address any bottom lines (as stipulated by statutory agencies, e.g., Community Services (NSW) and the Department of Child Safety (Queensland))
- (5) Developed collaboratively
- (6) Acceptable to and understood by all parties involved.

Aboriginal & Torres Strait Islander children and families

Culture and the maintenance of culture is central to healthy infant development and identity formation in Aboriginal communities. “The Aboriginal person’s sense of security is ultimately derived from having a positive Aboriginal identity” (Yeo, 2003, p. 299). An Aboriginal & Torres Strait Islander child knows who they are according to how they relate to their family, community and land. The Aboriginal & Torres Strait Islander perspective is holistic and community-based and sees the:

- whole child, not just the child’s educational, physical or spiritual needs in isolation;
- child’s relationship to the whole family, and not just their mother or father;
- child’s relationship to the whole community, not just the nuclear family; and
- child’s relationship to the land and the spirit beings which determine law, politics and meaning.

Using the Resilience Model in the Intervention Phase

The domains of resilience offer a method for putting into place deliberate strategies that, applied with persistence and consistency, can enhance the child’s sense of security and belonging. Use the domains of resilience, along with the ecological framework (child, family and wider community) to think about what strategies could be put into place. Fostering resilience in one domain (otherwise known as fostering ‘resilience strings’) can have a ‘knock-on’ impact on other domains. For example, interventions strategies that focus on talents and interests can have positive impacts on a child’s secure base and friendship networks.

Remember to consider what interventions or services might assist the infant with their physical and psychological development as well as promote, encourage and support secure attachment relationships for the infant.

Practical Intervention Techniques

Daniel & Wassel (2002) provide examples of interventions that can be used in each domain. Some of these examples are:

Secure base

Helping the child to feel secure

“Shape interventions deliberately in response to the child’s attachment style, and remember that persistence will be required. For example, a child who avoids contact (avoidant attachment pattern) will need patiently available carers who do not press the infant to come close but whose availability to offer support is nevertheless predictably present.”

Ensuring the child has a secure base

“The child who has difficulty separating needs to develop trust in the carer which can be encouraged by leaving the child for short periods with a known adult. At first the carers may go only into another room. As the child’s trust grows, so longer separations can occur. The child should not be tricked by the carer disappearing without any explanation.”

Education

“Exploration can be encouraged by ordinary activities like storytelling or baking, but can also include special activities, for example outings... Model safe boundaries around play activities to enhance the child’s confidence in exploring without putting them at risk.”⁴

Friendships

“It is not uncommon for parents/caregivers to underestimate the benefits to young children of spending time with other children. In such circumstances parents may need advice and guidance about the value of such contact and about how to organise it.”⁵

Talents and Interests

“Talents and natural abilities or potential may be seen from ordinary activities and may become apparent during the course of play activities, either structured or spontaneous... Some children who have been profoundly neglected, however, will be slow to take any initiative in play and may be preoccupied with maintaining closeness with the adult. Gradually, from this base, as the child becomes more confident, play activities become an important pleasurable feature of the child’s daily life.”⁶

Positive values

“Children learn about emotions through play. Play sessions with other children [could] be arranged and supervised and the adult can make simple comments that label the emotions. For example, if a chasing game is organised, the one running away can act out fear. With imagination a whole range of games and role plays can be devised that involve emotions.”⁷

Social competence

“Ensure that the child has contact with other children, either by an informal arrangement between a group of parents, or in a formal nursery or family centre setting.”

For more examples of intervention strategies for infants and young children in each of the domains and at each level of the ecological framework (child, family, wider community) see: Daniel and Wassell, 2002, p.85-113.

Use the Benevolent Society Intervention Plan Tool to assist in the development of a coordinated and participatory case plan.

Holding the family through transitions

“Holding the family whilst assisting them to make transitions to, and become engaged with, appropriate services, is fundamental to good practice and positive early engagement” (Victorian Government Department of Human Services, 2008, p. 13).

If you have referred the parent/caregiver to another service or agency keep contact with them during the referral process until you know they’re linked in with the service. Closure should be considered only after the family has engaged with services to which they were referred. Keep cases allocated following exit until after the family’s engagement with support services. Delays or failure to hold families and manage risk during transitions can be detrimental for infants.

Contact arrangements for infants in care

Arrangements for infants to visit their parents need to ensure that the infants are feeling as secure and alert as possible in order for them to have the curiosity and emotional energy to invest in getting to know and to interact with their parents. This is especially true if the parents have never been the primary caregiver for the infant. Visiting arrangements also need to ensure that the infant is not further harmed. Parents often need coaching to read the cues of the infant. Try to ensure contact time is used to support the parent in a therapeutic and educational way to heal and develop their relationship with their infant.

For a discussion of infant contact with parents while in out-of-home care see *A stitch in time saves nine: Can a public health model protect infants at risk of abuse and neglect?* National Child Protection Clearinghouse Issues paper no. 30 www.aifs.gov.au/nch

⁴ The importance of early childhood education has been consistently identified in research (Melhuish, 2003; Sylva et al., 2004). A longitudinal study in the United Kingdom known as the Effective Provision of Pre-School Education (EPPE) Project examined the effects of pre-school education in 3,000 children and found that factors that were associated with high quality education were positive caregiver interactions, staff qualifications, adequate resources and a broad curriculum (Sylva et al., 2004). It was also found that children who attended high quality centres showed better intellectual and social functioning during their early school years (Sylva et al., 2004).

⁵ Research has consistently shown associations between friendships and positive outcomes for children and there is a growing evidence base that friendships have a strong link with resilience (O’Neil, Welsh, Parke, Wang & Strand, 1997; Legaut, Anawati & Flynn, 2006).

⁶ Building the talents and interests domain can be good starting point for impacting on the secure base domain.

⁷ If positive values are not present then it must be a priority area for intervention as research demonstrates a correlation between empathy and prosocial behaviours and positive outcomes in adulthood (Bagwell, Newcombe & Bukowski, 1998; Legaut, Anawati & Flynn, 2006).

Be aware that research shows that Aboriginal children are less likely to have contact with their families in the first few months after being placed in care and are less likely to be reunified with their family than non-Indigenous children (Delfabbro, Barber & Cooper, 2002).

Frequency of contact

The literature usually argues for “frequent” contact. However, there is no agreed definition of what constitutes “frequent” with interpretations ranging from once a week to once a day (Goldsmith, et al., 2004; Smariga, 2007). High-frequency visiting schedules (four or more contact visits) are not necessarily associated with increased rates of reunification. A Victorian study reported 23% of high-frequency contact, compared with 22% of low-frequency contact infants were reunited with one or both of their parents (Humphreys & Kiraly, 2009).

The potential benefits of contact will not automatically eventuate as a result of face-to-face contact alone. The potential value of contact is likely to be undermined if contact places excessive stress on infants. Disruptions in routine, breaks in continuity of care, transport, and the quality of the parent-child interactions during contact may all impact on the stress to the infant associated with contact.

Disruption to infant’s daily routine

Infant visits to parents may be scheduled around agency needs rather than the daily patterns of the infant, disrupting the infant’s biological rhythms and impacting the visit. For example, when an infant is woken from their sleep to be taken to a visit, they are likely to arrive tired and cranky, they may be fed whether a feed is due or not, and the infant may become so overwhelmed that they fall asleep to cope with the visit, which is unsatisfying for both infants and parents.

Breaks in continuity of experience with foster or kinship carers

In the first few weeks and months of life, babies are still developing the capacity for emotional regulation and self-soothing and are highly reliant on the sensitive and emotionally available presence of their carer (Brazelton & Cramer, 1990). Most can only tolerate brief periods of separation from their primary caregiver. It is critical that visiting schedules do not involve unmanageable separations from the foster or kinship carer that will undermine the infant’s developing relationship with the carer and cause emotional distress or further traumatise the infant.

Transport

Unless the caseworker accompanying the infant is known to the infant and is sensitive and responsive, the infant is left to their own emotional resources to manage the emotions evoked by separation from their carer, being accompanied by an unknown adult, travel, reunion with parents, interaction with parents, separation from parents, travel home again with unknown adult, and reunion with their foster carer. This is not optimal for relationship-building.

Infants' experience of contact

The quality of parent-infant interactions during contact may cause the infant distress (e.g., mis-attuned or non-responsive interactions, parents fighting with each other during the visit). The parent's voice, body movement or facial expression, can be a reminder of past trauma, abuse or neglect. Infants can remember experiences from birth. Particular states of mind in an infant (e.g., fear or terror) can be encoded as an implicit form of memory and these states of mind can be reactivated in the presence of the abusive parent (Lieberman, 2004; Siegel, 2001). Visits in these circumstances are likely to cause emotional suffering, hyper-vigilance, and effects similar to the impact of the original abuse. These dangers are heightened when the visits occur without the infant having their primary caregiving adult present.

Planning towards reunification

Where the protective concerns have been addressed and there is a reunification plan, access should be gradually increased and work towards overnight access prior to reunification. The pace must be determined based on the infant's needs. Contingency plans should be put in place to support the family and every opportunity to use access therapeutically to develop the infant-parent relationship and parental skills should be taken.

Creating stable environments from the point of first contact

It is still a common misconception that (especially younger) infants are "resilient" and can manage moves from one foster carer to another. However, the disruption of attachment ties with foster parents is likely to constitute a severe trauma that reinforces feelings of abandonment (Gauthier et al., 2004; Goldsmith et al., 2004; Melmed, 2004). With each disruption come progressively more difficulties in managing the stress of transition, and with each loss, the capacity to adapt and adjust to new challenges is compromised, as is the capacity to develop trusting relationships.

- Minimise the number of placements wherever possible.
- Think about the impact on the attachment relationships of the infant of other children coming in and out of the carer's household.

Phase 4: Reviewing Outcomes

The progress and outcome of your intervention needs to be assessed more frequently for infants.

Reviewing outcomes is the final phase of casework. The reviewing outcomes phase is important because we need to remain curious about our effectiveness, and constantly review our assessments and planning, in light of emerging information and the outcomes of our actions. Practitioners are reminded that a referral to another service will not ensure that the family will engage with that service, that change will occur in time for infants or that it will be sustained over time.

Good practice may involve trying several strategies or interventions before coming up with an approach that works. Infants may not be able to afford the time to wait for their parents to recover from risk factors such as mental illness or drug addiction when these seriously impair parenting capacity. The infant's immediate safety (physical and emotional) is paramount. Attention also needs to be given to the long-term effects of multiple disrupted attachments in infancy.

Previous service system responses and outcomes of interventions need to be assessed more frequently for infants:

- What have been your previous responses as a practitioner?
- What services and approaches have been most effective? Are there any strategies that are not working, well? What needs to change?
- How would the parents and significant others rate themselves in terms of 'where they're at' in relation to 'where they want to get to'?
- Have we provided practical and material help?

Parents do need to be given a chance to improve their situation, but practitioners need to continually ask some key questions:

- Have parents been provided "the widest possible assistance"?
- What is their capacity for change? Has change been demonstrated/ sustained over time?
- Will it be fast enough given the infant's needs for safety and secure attachment relationships with biological parents or other carers?
- Practitioners also need to give themselves permission to say 'enough is enough' (Cousins, 2005, p. 6).

Keep in mind the need to assess the effectiveness of responses and outcomes for infants:

- What's changed for the infant? How do we know?
- Is the infant more able to play, self regulate, communicate and learn?

For further information on preparing for review with families refer to the User Guide of the Benevolent Society Family Assessment Tool and the Review Outcomes Tool.

Closure

Closure is an important aspect of the relationship with families, parents/caregivers and children. There should be a lead up to saying goodbye to the family and time allocated to mark this period of transition. Some of the things that can be done during closure include:

- Acknowledge the hard work parents/caregivers have done to bring about changes in their lives;
- Ask the parents and the children for feedback about the service.

It may not be possible to conduct a face-to-face closure; in these cases the transition period you could say goodbye by letter or in a phone conversation.

Resources for practitioners: Infants at risk of abuse and neglect

Sketchley, R., & Jordan, B. (2009). *Infants at Risk of Abuse and Neglect: A Review of Literature*. Melbourne: Victorian Government, Department of Human Services. www.dhs.vic.gov.au

Jordan, B., & Sketchley, R. (2009). A stitch in time saves nine: Can a public health model protect infants at risk of abuse and neglect? *NPCPC Issues*, 30. Melbourne. Australian Institute of Family Studies. Retrieved from www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html

Victorian Government Department of Human Services. (2008) *Best Interests Case Practice Model: Summary Guide*. Melbourne, Victorian Government Department of Human Services, Melbourne. www.dhs.vic.gov.au

Victorian Government Department of Human Services. *Child Development and Trauma Guide*. Melbourne, Victorian Government Department of Human Services, Melbourne. www.dhs.vic.gov.au

Victorian Government Department of Human Services (2007). *Strategic Framework for Family Services*. Melbourne, State Government of Victoria www.cyf.vic.gov.au/family-services/library/publications/strategic_framework

Other relevant resources:

Ages and stages of development

For more information on ages and stages of development see: <http://www.cde.ca.gov/sp/cd/re/caqdevelopment.asp> and <http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/child-development-trauma-guide>

For information about infants' social-emotional development, including detailed information about what children's interactions with adults and peers will look like at various stages during infancy, see:

<http://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp> - iwa

For more information on the 'Circle of Security' early intervention program see: <http://www.circleofsecurity.org/>

Child protection legislation

For information on child protection legislation in NSW see: www.legislation.nsw.gov.au



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For information on child protection legislation in Queensland see: www.legislation.qld.gov.au/OQPChome.htm

For information on child protection legislation in other states see: <http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html>

Risk factors

Parental mental illness – Children of Parents with a Mental Illness: <http://www.copmi.net.au/cpj/index.html>

Family Violence – Australian Domestic & Family Violence Clearinghouse: <http://www.adfvc.unsw.edu.au/>

Parental intellectual disability – Healthy Start: http://www.healthystart.net.au/about.php?p=healthy_start

Parental substance misuse – Drug Info Clearinghouse: <http://www.druginfo.adf.org.au/>

Other

For resources on early intervention and prevention to the Communities and Families Clearinghouse Australia: <http://www.aifs.gov.au/cafca>

For resources on postnatal depression go to the Health Insite website at http://www.healthinsite.gov.au/topics/Postnatal_Depression

For information on theory of change see: 'Theory of Change Online' at <http://www.theoryofchange.org/index.html>

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Appendix A

Marte Meo Developmental Elements

By being able to name their own initiatives a child shows development of (but not limited to);

- An internal model of self; ‘I know I am now doing this’, ‘I know that I am feeling this’, ‘I know who I am’.
- And external social model; ‘I know that you exist and I can interact with you’.
- Model of self efficacy and self esteem; ‘I know I can do this, and I’m letting you know I can’. ‘People take notice of me, I am important, I have something to offer’.
- Social development model; can introduce play ideas e.g. ‘I am pushing the truck’. By telling a peer what they are doing, they are inviting that peer into play.
- Language development; all areas.
- Model of self-regulation; child needs to have an awareness of their own initiatives before they can learn models of expressing appropriate initiatives and regulating their initiatives.

When the carer names their initiative it:

- Develops respect model by showing child they are seen and valued by giving information on what carer is going to do.
- Makes carer predictable.
- Teaches child how to name own initiatives.
- Language development.
- Teaches ‘you and me’ model.
- Develops model of co-operation
- Develops model of concentration by bringing child into a central focus.
- Supports all areas of development.

When the carer names the child’s initiative:

- The child knows that they are seen.
- Develops model of registration –“these are my ideas”, “other people like my ideas”.
- Develops model of self-efficacy –“I have good ideas”
- Develops play skills and model of social development.
- Develops language.

For more information about the Marte Meo Developmental Elements see:
Maria Aarts, 2008; Antcliff, 2010b.



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