



***Independent Evaluation Final Report:***

***Being with Baby Program***

***Delivered by***

***FamilyZone Ingle Farm Hub***





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# Contents

Acknowledgements	1
<b>Section one: Introduction</b>	<b>4</b>
Background	5
The effect of perinatal depression on maternal health and wellbeing	6
The effects of perinatal depression on early childhood development	7
The impact of children's environment on their development	8
Communities for Children programs	9
Our clients: The Salvation Army Ingle Farm, FamilyZone Community Hub, Being with Baby program	9
Exposure to poverty and child development	14
Significance of the Being with Baby program and this research	15
The CfC strategy of using community hubs and place-based approaches to service delivery: Aims of FamilyZone Community Hub	16
The purpose of this evaluation	17
Objectives of the evaluation research	17
Approach to evaluation research	18
Mixed methods	19
Qualitative methodology	19
Social and power implications of narrative analysis	20
Data management and analysis	20
Quantitative methodology	22
Selection of participants	22
Exclusion and inclusion criteria	23
Interview questions	23
Community engagement strategies	24
<b>Section two: The Being with Baby program</b>	<b>26</b>
Introduction	26
Enhancing parenting skills	27
Economic rationale/social return on investment	28
Facilitator qualifications	29
The program	31
<b>Section three: Literature review</b>	<b>33</b>
Literature review methodology	35
Scoping literature review results	36
Theoretical basis for the program model: Literature review	37
Community hubs build community capacity	37
Multi-component programs	38
Targeted relationship-based programs	38
Targeted playgroup programs	40
Attachment theory	41
Circle of Security	42
Home visiting	44
Introduction and background: Trauma-informed principles of child care	44
Trauma-informed care	45

Principles of trauma-informed care	46
Therapeutic models of care	46
Being with Baby and FamilyZone Community Hub aims (objectives)	46
Parental attributes that increase levels of vulnerability in children	48
Migrant and refugee families and parenting	48
Edinburgh Postnatal Depression Scale (EPDS)	50
Models of service delivery (applying the theories)	50
The aims of Being with Baby and FamilyZone Community Hub	53
Key elements of an integrated approach	53
Family-centred and holistic approach	53
Establishment of strong links with state and local government departments	54
Multi-agency and multidisciplinary	54
Subcontracting provision of key services to established local service providers	54
Cross-cultural competence	54
Facilitating access to different groups that operate in the hub	55
Co-location of services	55
Unlimited access timeframe	55
Perception of workers as friends	55
Research methods for the evaluation of the Being with Baby Program	56
Research process	56
<b>Section four: Results</b>	<b>57</b>
Introduction	57
The broader aims of the Being with Baby program delivered in a community hub model	57
Findings	58
General information	58
Qualitative results	66
Themes	67
Theme 1: Improved child development knowledge and improved caring for children	67
Theme 2: Decreased perinatal and postnatal depression and kept baby safe	68
Theme 3: Links to education and then future employment	70
Theme 4: Isolation	71
Theme 5: Increased racial tolerance and understanding	72
Summary	73
<b>Section five: Discussions and conclusions</b>	<b>75</b>
Limitations	77
Conclusion	78
<b>References</b>	<b>79</b>
<b>Appendices</b>	<b>84</b>
Appendix 1: Program manual	84
Appendix 2: Program logic: Being with Baby	118



## ***Section one:***

### ***Introduction***

Presented here is the evaluation of one of the programs provided by the Communities for Children (CfC) initiative. This report commissioned by The Salvation Army, FamilyZone Ingle Farm Hub is divided into five sections. The first section presents the background information on the CfC initiative including an outline of the demographic and epidemiological outcomes for children in the Ingle Farm, and surrounding areas. This section addresses the need for CfC interventions given the high rates of vulnerability in the children living in this area. Additionally, the introduction outlines briefly some of research process used. Section three provides the theoretical and evidence base for the models of care and the therapeutic models of care that are commonly used in the FamilyZone Community Hub model and in the Being with Baby program. The literature review provides substantial international evidence base for the Being with Baby and use of the community hub model for service delivery, such as FamilyZone, for decreasing accumulative harm, abuse and neglect of infants and small children. Subsequent sections provide research evidence and results on the therapeutic models of care specific to the Being with Baby

program. The report also provides a conclusion for the Being with Baby program in the FamilyZone setting.

## **Background**

There are known linkages between child maltreatment and levels of economic and social stress that are generally prevalent in areas of relative disadvantage (Access Economics Pty Limited 2008; Maggi, Irwin et al. 2010; AIHW 2012). Accordingly, Communities for Children (CfC) was established in 2004 following a decision by the then Australian Government to establish the 'Stronger Families and Communities Strategy' (2004–08). Communities for Children was one of four streams of the Strategy, with the aim of addressing the risk factors for child abuse and neglect before they escalate, and to help parents of children at risk to provide a safe, happy and healthy life for their children and thus circumvent the deleterious health, education and welfare outcomes for children at risk.

The CfC strategy's key feature sought to engage parents and care-givers in activities that enhanced their children's health, development and learning. The CfC program funding through Facilitating Partners and service providers have developed activities, such as home visiting, supported playgroups, early learning and literacy programs, early development of social and communication skills, parenting and family support programs, and child nutrition programs (Allen 2011; AIHW 2012; Australia 2014). Communities for Children is a community based strategy aimed at improving an areas' childhood disadvantage factors through programs that target disadvantaged families living in these areas. An area of childhood disadvantage can be determined by the Australian Early Development Census (AEDC) levels of vulnerability scores for children in the area.

The community based delivery of children's and parents' programs aims to enhance broader community outcomes (Muir, Katz et al. 2010). The CfC initiative aimed to improve the coordination of services for children 0-12 years and their families to minimise the impact of area-based disadvantage (Muir, Katz et al. 2010). Further, the initiative aimed to build community capacity to provide appropriate, targeted and enhanced service delivery, and improve the community context for children (Muir, Katz et al. 2010). The whole of community approach to improving child development incorporates the needs of the community (Muir, Katz et al. 2010). Hence the use of community based hubs is foundational in meeting the CfC strategy aims.

The Being with Baby program situated at the FamilyZone Community Hub directly engages with mothers of at-risk infants. These infants are at higher risk of developmental delay, AEDC identified levels of vulnerability, and the known impacts of peri and postnatal depression. The use of the FamilyZone Community Hub provides the Being with Baby program with an integrated service delivery approach supporting parents to; build their capability to meet their child's developmental needs; provide essential early interventions programs that promote child development and wellbeing, and improve their relationships with their infants/children. The Being with Baby program also aids parents in accessing other programs through the FamilyZone Community Hub, community concept, individually tailored support, and links with referral agencies, and the broader community service sector. This holistic approach to supporting families enhances child development through the access to services in a timely fashion. This approach is well documented, evidence-based and supported by international research as best practice (Brockmeyer Cates et al. 2016; Jutte et al. 2015; Tas. Dept. Edu 2016). Thus, the Being with Baby program delivers preventative interventions based on evidenced based theories that meet the needs of at-risk infants and young children. The Being with Baby program also assists parents in preparing young children to integrate into playgroups, kindergarten, preschool, and school.

While the Being with Baby program maintains its strong links to its evidence based theoretical background it has also evolved over several years to meet the different levels of vulnerability found in the area, the needs of the parents and children, and the needs of staff/workers who may work directly or indirectly with children. For example, mental health professionals may work addressing parental mental health, therefore, child developmental knowledge provided by Being with Baby is mindful of the parental mental health issues that may impact on the cognitive abilities of parents to retain information on children's developmental needs. This respectful and reflexive delivery practice enhances parental and child outcomes (see the theme section).

### **The effect of perinatal depression on maternal health and wellbeing**

The adverse impact of perinatal and postnatal depression on mother, infant, and child has been well documented and researched. Maternal physical complications of perinatal depression include: premature birth, surgically assisted births, impaired obstetric outcomes, and obstetric complications (Bergink et al. 2011; Bowen et al. 2013). Along with the maternal psychological impacts including: self-harming thoughts, suicidal ideation, and psychosis (Bergink et al. 2011; Bowen et al. 2013). Therefore, perinatal depression impacts

on the interaction between the infant, mother and family both physically and psychologically pre-birth and during the initial stages of maternal bonding. Attending to the needs of the infant is impacted by perinatal depression.

### **The effects of perinatal depression on early childhood development**

For infants the consequences of maternal depression include: premature birth, low birth weight, lower Apgar scores, poor weight gain, increased admissions to Neonatal Intensive Care Units, and prolonged irritability (Bergink et al. 2011; Bowen et al. 2013). The outcomes for children of mothers with perinatal depression include ongoing physical, psychological, emotional, social, behavioural, cognitive, and developmental problems (Bergink et al. 2011; Bowen et al. 2013). Additionally, the longitudinal consequences of untreated perinatal depression and its impacts compound accumulatively and exponentially for the mothers, infants, children, and families (Bergink et al. 2011; Bowen, Baetz, Schwartz, Balbuena, & Muhajarine 2014; Bowen et al. 2013; Ji et al. 2011). The aforementioned research illustrates the pathophysiological links between perinatal depression, and maternal, infant, and child outcomes. Importantly universal and effective screening using tools, such as the EDS, identifies perinatal depression in a timely fashion (Bergink et al. 2011; Ji et al. 2011). Further, programs that do not directly address perinatal depression have been shown to be ineffectual and detrimental to the families dealing with perinatal depression (Bowen et al. 2014). Given the accumulative detrimental impact of perinatal depression on mothers, infants, children, and the family, programs that address perinatal depression can significantly change deleterious physical, psychological, behavioural and social outcomes for mothers, infants, and children. Consequently, models of service delivery in the Being with Baby and the use of the FamilyZone Community Hub include care and support that directly address prenatal and postnatal depression. Being with Baby as a program delivered within a community hub setting also enables the unique inclusion of the local disadvantaged populations, such as new migrants and refugees, rather than a discredit model of service delivery which can alienate sections of the community (Department of Social Security 2017). This model of service delivery provides the opportunity for all children and families to play and learn together and develop supportive friendships and the inclusion of disadvantaged groups from across the community (Department of Social Security 2017). This type of place-based/community hub approaches to delivering interventions for disadvantaged is supported by the Department of Social Security (Department of Social Security 2017).

## **The impact of children's environment on their development**

The health of children is determined within the context of the environments in which they are born, grow, live, play, and learn (Krieger 2001; Marmot & Wilkinson 2006; Brandt & Gardner 2008; Solar & Irwin 2010). A range of determinants have been identified that shape the health of children and families. These are education, housing, employment, health access, income, gender and social processes, such as social support and social exclusion are coined the Social Determinants of Health (SDH) (Krieger 2001; Marmot & Wilkinson 2006; Brandt & Gardner 2008; Solar & Irwin 2010). As such the SDH are the aspects of people lives in which they are born, grow, live, work, and age (Maggi, Irwin et al. 2010). This definition incorporates a variety of factors that impact on children and influence their adult health status. The SDH represent a broad array of characteristics that are not biological or genetic but result from the social, physical, and community environments (Maggi, Irwin et al. 2010) and as such need to be addressed at the societal and community level (Marmot & Wilkinson 2006; CSDH, WHO 2008).

Along with SDH there are other aspects of a child's environment includes things, such as the mental health of their parents that can impact profoundly on how the child develops, and the developmental milestones that the child achieves. Internationally, the use of community based hubs has been found to mitigate the SDH and other complex aspects of a child's environment to ensure the child's developmental, health, and educational outcomes remain optimal (Jutte et al. 2015; EUROCHILD 2012; Marrow 2013). The iterative conceptual frameworks used in this evaluation are based on an understanding of citizen-centric, targeted relationship interventions and place-based approaches, to service delivery and preventative intervention programs (Press et al. 2015). This conceptual framework acknowledges that each community hub responds uniquely to the local environment (Press et al. 2015). The FamilyZone Community Hub responds to the physical, cultural, social and economic characteristics of the Ingle Farm community and surrounding area. This enhances the delivery of the Being with Baby program as it incorporates community needs. It also ensures that there is a strength and flexibility to the delivery of the Being with Baby program to provide ongoing support to the most vulnerable families in South Australia.

Using place-based approaches to program and service delivery can safe-guard children against abuse and neglect (Jutte et al. 2015; EUROCHILD 2012; Marrow 2013; NSW FSC 2014). The development of community-based models of care that address health inequities have been shown internationally to deliver significant improvements (25%) in children's development, behaviour, education, and health outcomes using community-based

partnerships in the delivery of targeted parenting programs (Parry 2012; Parry & Abbott 2016; Jutte et al. 2015; EUROCHILD 2012; Marrow 2012). As the programs often provided by CfC promote the community based delivery ethos, using the SDH approach for citizen-centric, targeted relationship interventions and place-based approaches to program delivery is highly appropriate in addressing the complex impacts of disadvantage and vulnerability on the community.

The Being with Baby program addresses the needs of all community members including Refugee, Aboriginal and Culturally and Linguistically Diverse (CALD) members. Acknowledging that improving child developmental outcomes involves parents (Hannar & Rodger 2002; Marrow 2013; NSW FSC 2014). The importance of interventions that directly change parenting behaviour are paramount in addressing child vulnerabilities. The Being with Baby program directly addresses parenting along with directly addressing child development through appropriate language development, play and learning activities.

## **Communities for Children programs**

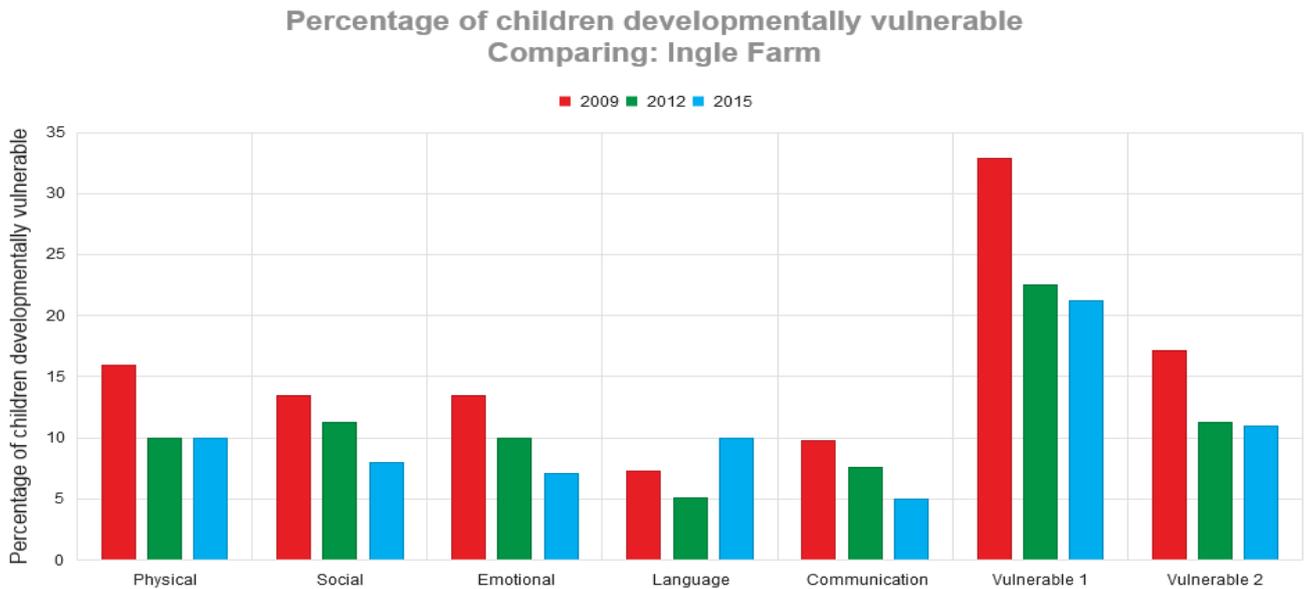
### **Our clients: The Salvation Army Ingle Farm, FamilyZone Community Hub, Being with Baby program**

The Communities for Children Facilitating Partner programs are funded by the Australian Government Department of Social Services and aimed at delivering strong outcomes for Australian families with a focus on early intervention and prevention to provide programs for children aged 0-12 years and their families (AIHW 2012; Stewart 2014). Research shows that children living in poverty are exposed to higher levels of stress and this interferes with their ability to learn and meet developmental milestones (Margolin & Gordis 2004; Suor, Sturge-Apple et al. 2015). Furthermore, there are noticeable differences in cognitive ability evident at aged four (Margolin & Gordis 2004; Suor, Sturge-Apple et al. 2015), therefore addressing child development and wellbeing through early interventions is imperative in preventing long term cognitive deficits that impair school performance and outcomes. Salisbury and surrounding suburbs in South Australia have been recognised as an area where children experience high rates of developmental vulnerability (Australian Early Development Census 2015). There are five measures that outline domains of vulnerability for Australian children in the Australian Early Development Census (AEDC). The five domains are: physical health and wellbeing; social competency; emotional maturity; language and cognitive skills (school-based); and communication skills and general

knowledge (AEDC 2015). In Australia 6.8% of all children aged 0-12 years are assessed as being developmentally vulnerable in one or more domains (AEDC 2015). In the Salisbury and surrounding suburbs of South Australia in 2009, as many as 50% of children were assessed as developmentally vulnerable in one or more domains in some areas, and a further 46.8% assessed as developmentally vulnerable in two or more domains (AEDC 2015). Of significance is the stagnation in the percentage of children assessed as vulnerable during the time the Communities for Children (CfC) programs have been implemented. In 2015, for example, 15% of children in Salisbury were assessed as developmentally vulnerable in one or more domains and this has remained stable since 2009 (AEDC 2015). This is of concern as during this period funding for community centres such as FamilyZone Community Hub and programs such as Being with Baby has decreased significantly by 50%. This has also coincided with a decrease in jobs in Salisbury, Ingle Farm, and surrounding suburbs. This is evident in the graph below comparing levels of developmental vulnerability across the domains and between years 2009, 2010 and 2015.

Graph 1.1 (below) indicates the decreasing AEDC vulnerability scores. This is a positive finding especially considering the increase in the Salisbury area as a whole. AEDC measurements in the different suburbs provide a more helpful story. AEDC domains of vulnerability in Ingle Farm has decreased significantly despite a recent marked increase in vulnerability for children in the neighbouring suburbs, such as Salisbury. There has been recent large influx of humanitarian entrants into the area over the past few years. This has coincided with job losses and increasing levels of unemployment for families in the Ingle Farm and adjacent Salisbury areas. Graph 1.1 illustrates the difference in AEDC vulnerability across a number of years.

**Graph 1.1: Developmental vulnerability from 2009 to 2015 in the Ingle Farm area, a subset of the Salisbury Community data**



Graph 1.1 (above) indicates that in Ingle Farm there has been a marked improvement in the levels of vulnerability as assessed by the AEDC measures. This is in stark contrast to the Salisbury and the surrounding areas as while there has been some improvement in children being assessed as having one level of vulnerability between 2009 and 2012 that levels of children with one vulnerability have increased overall in 2015. The improvement is reliable and shows a demonstrated improvement in the infant and children in the five components of developmental vulnerability. The use of the Being with Baby program and the FamilyZone model of service delivery may be one of the factors assisting to improve the outcomes for vulnerable children in the Ingle Farm area. Conversely in the Salisbury neighbouring area vulnerabilities have increase as indicated in Table 1.1 below.

In Table 1.1 (below), for children living in Salisbury assessed as having two or more domains of vulnerability, there was some improvement between the years 2009 to 2012, however, this improvement has stagnated between 2012 and 2015 (AEDC 2015). For individual suburbs in this area, some of the impacts have been more profound, with an increase in levels of vulnerability placing more children at high risk of developmental issues. This is evident from the Australian Early Development Census (2015) data provided for the Salisbury Community in the table.

**Table 1.1:**



**TABLE:** Salisbury Community

**Legend:**   Significant increase   No significant change   Significant decrease

Year	Physical	Social	Emotional	Language	Communication	Vuln 1	Vuln 2
Developmentally vulnerable in 2009 (%)	14.10	12.50	14.40	9.20	12.00	30.70	16.50
Developmentally vulnerable in 2012 (%)	10.70	13.50	11.20	9.00	12.30	28.80	15.00
Developmentally vulnerable in 2015 (%)	13.60	12.50	11.70	8.70	11.10	29.50	15.00
2009 vs 2012 (%)	-3.40	1.00	-3.20	-0.20	0.30	-1.90	-1.50
2012 vs 2015 (%)	2.90	-1.00	0.50	-0.30	-1.20	0.70	0.00
2009 vs 2015 (%)	-0.50	0.00	-2.70	-0.50	-0.90	-1.20	-1.50

Table 1.1 (above) highlights the limited changes in children’s vulnerability levels for children living in the Salisbury area. This indicates that there has been some improvement, however much of the vulnerability scores have remained the same. Table 1.2 (below) shows the neighbouring Ingle Farm area which has demonstrated several areas of improvement.

**Table 1.2: Ingle Farm only**

**TABLE:** Ingle Farm

Domains explained [↗](#)

**Legend:** ■ Significant increase ■ No significant change ■ Significant decrease

Year	Physical <small>i</small>	Social <small>i</small>	Emotional <small>i</small>	Language <small>i</small>	Communication <small>i</small>	Vuln 1 <small>i</small>	Vuln 2 <small>i</small>
Developmentally vulnerable in 2009 (%)	15.9	13.4	13.4	7.3	9.8	32.9	17.1
Developmentally vulnerable in 2012 (%)	10	11.3	10	5.1	7.6	22.5	11.3
Developmentally vulnerable in 2015 (%)	10	8	7.1	10	5	21.2	11
2009 vs 2012 (%)	-5.9	-2.1	-3.4	-2.2	-2.2	-10.4	-5.8
2012 vs 2015 (%)	0	-3.3	-2.9	4.9	-2.6	-1.3	-0.3
2009 vs 2015 (%)	-5.9	-5.4	-6.3	2.7	-4.8	-11.7	-6.1

The Australian Early Development Census (2015) data in Table 1.2 (above) indicates that the percentage of children assessed in this area as developmentally vulnerable in one or more domains in 2009 was 17.1%, and in 2015 this had decreased significantly to 11%, a decrease of 5.8% (AEDC 2015). As the Australian average for one or more vulnerabilities is 6.8% the Ingle Farm result is not optimal (AEDC 2015) but does indicate that initiatives such as the CfC programs aiming to address children’s vulnerability can improve outcomes for children living in areas of disadvantage if, as a nation, we are going to circumvent serious lifelong deficits created by disadvantage. Conversely, Table 1.1 (above) from the AEDC website indicates the improvements for children in the Salisbury area of South Australia are minimal. The Salisbury results could be explained by the impact of the economic downturn on levels of parental employment with less parents being employed and therefore placing more children at risk of developmental vulnerability.

The stark contrast for the results in Ingle Farm could be explained using the FamilyZone Community Hub model of service delivery offering intensive support Monday to Friday 9 to 5. The improvements have occurred despite a decrease in funding to the area for programs such as CfC, and the decrease in funding for community hubs such as FamilyZone Community Hub. These economic factors are outside of the families control and

compound the impacts on children through increasing developmental vulnerabilities. Funders need to be mindful that funding decreases will eventually impact on service delivery, and community social capacity building, and will therefore impact negatively on children’s levels of vulnerability with subsequent decreases in school readiness and longer term family outcomes. Figure 1.1 (below) from the AEDC (2015) illustrates the decreasing vulnerabilities for children in Ingle Farm.

**Figure 1.1:**

**5: Emerging trends in child development in this community**

As data is available from three points in time, we can start to consider emerging trends. Figure 2 shows change in the percentages of developmentally vulnerable children in this community from 2009 to 2015.

The following pages show emerging trends for each AEDC domain in more detail.

The graphed data in Figure 2 is repeated in Table 7, below.

**Figure 2 – Emerging trends in developmental vulnerability for this community, showing change in percentage (2009 to 2015).**



The comparison of Ingle Farm and the neighbouring Salisbury unambiguously demonstrates the importance of comprehensive and targeted supports for vulnerable families. The results from this evaluation presented in section 4 support the AEDC findings.

**Exposure to poverty and child development**

The SDH perspective highlights aspects of the environment that impact directly on the child’s development and lifelong health, welfare, and educational outcomes. These SDH aspects, such as poverty, are well beyond the control of the parents and community and impact directly on the child and their access to timely services (Parry 2012; Parry & Willis 2013). The impact of poverty on child development and school readiness has been described internationally as a public health crisis (Brockmeyer, Cates et al. 2016). The impacts of poverty, and economic disparities, and the subsequent deleterious long-term

outcomes are well researched (Parry 2012; Brockmeyer, Cates et al. 2016). Reduced school readiness is one outcome of exposure to poverty in childhood (Brockmeyer, Cates et al. 2016). The delivery of programs that support parenting during exposure to poverty have been demonstrated to effectively circumvent the long-term effects of poverty (Brockmeyer, Cates et al. 2016).

### **Significance of the Being with Baby program and this research**

Programs targeting parents of children who are at risk aim to decrease the impact of the poverty, and potential abuse and neglect, and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Keys 2009; Gibson & Johnstone 2010; Muir, Katz et al. 2010; Solar & Irwin 2010; Department for Education 2011; Nelson & Mann 2011; Kilmer, Cook et al. 2012; McCartney 2012; McCoy-Roth, Mackintosh et al. 2012). Importantly, research shows that the use of parenting programs has effectively decreased emotional and behavioural problems in children (Wyatt Kaminski, Valle et al. 2008; Sandler, Schoenfelder et al. 2011). This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt, Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011). In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective (Access Economics Pty Limited 2008; Wyatt Kaminski, Valle et al. 2008; Sandler, Schoenfelder et al. 2011).

The Communities for Children, FamilyZone Community Hub, Being with Baby program provides an early intervention and prevention program based on community need through Community Consultation targets the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. This report details research that aimed to explore the relationship between CfC programs delivered in the Ingle Farm area in South Australia and the social determinants of health for the children and families who have used the service. Whilst such programs appear sound from a theoretical perspective, unless there is evidence of the outcomes of the program, the work cannot be validated for continued funding or for wider application. This type of analysis and research provides the bridge between policy objectives and the practice applications of policy. This research provided the next keystone step in examining the broader impact of individually tailored programs. The research presented here provides validation of the Being with Baby program as an evidence-based practice, along with the

supporting documentation for its potential wider application. The research also highlights the limitations of the program and makes recommendations for future research evaluations.

### **The CfC strategy of using community hubs and place-based approaches to service delivery: Aims of FamilyZone Community Hub**

The Being with Baby program delivered using a community based hub model of service delivery is based on the principles of child-centred and family focused service philosophy and delivery guidelines (Marrow 2012). The FamilyZone Community Hub philosophy, practice guidelines and service delivery processes are based on the principles of child-centred and family-focused practice. As a community hub, the FamilyZone Community Hub aims to:

- Connect disadvantaged families and individuals to programs and services provided by Local, State and Federal governments
- Improve access and engagement with existing services
- Enhance the capacity of families to support their children
- Set goals for families
- Breakdown silos between programs and services
- Provide a coordinated and tailored package of services for local families and their children in a safe, family and child friendly environment
- Provide individualised and holistic family programs
- Model appropriate parenting behaviours
- Provide strategies to be practiced between sessions
- Provide evidence-based best practice curriculum and parenting skills

The aims of this community hub are in direct alignment with the overall aims of the CfC strategy (AIHW 2012; Stewart 2014). The principles include child-centered and family-focused necessities, open and productive two-way communication that facilitates the participation of children, young people and their families in active decision making, goal-setting and intervention engagement, planning and service utilisation (Marrow 2013). FamilyZone meets these principles and adheres to this philosophy. This ensures that infants, children and young people are provided with direct opportunities to participate in decision making and express their concerns, as age-appropriate. This responsibility is adhered to by the staff and organisation. Additionally, the FamilyZone community hub provides programs that are strength-based and recognise the aspirations of parents to provide appropriate and supportive care to enhance the wellbeing of their children.

Furthermore, meta-analysis of interventions and methods of delivery support those used by the Being with Baby program and FamilyZone Community Hub model of service delivery (CDC 2009). The US meta-analysis found that successful parenting programs taught parents; emotional communication skills, consistency of parent responses, positive parent-child interaction skills, and required parents to practice these skills during sessions and model parental consistency in response to children's behaviour (CDC 2009). Being with Baby and FamilyZone meets these strict criteria (results section and Appendix A). Therefore, the Being with Baby program meets internationally recognised best practice approaches for effective parenting programs.

## **The purpose of this evaluation**

The use of independent researchers was to establish the improvements in families who participated in the Being with Baby program based at the FamilyZone Community Hub. The independent researchers were commissioned in the context of the establishment of evidence to address the question of 'whether there are improved outcomes for parents (and thus children) completing the Being with Baby program. The desired outcomes (aims) for families include:

- Improved pathways to employment for parents through enhanced connections to education and social programs.
- Improved attachment of parents to child (this provides protective factors for children).
- Improved access to other programs and services as required by vulnerable families.
- Increased learning opportunities and outcomes for children through connections to educational services (co-located).
- Increased connections of children to existing services.

Given the aims of the Being with Baby program outlined above this independent evaluation provides insights into the effectiveness of the program in meeting its aims.

## **Objectives of the evaluation research**

1. To identify the vulnerabilities impacting on the children and families using the service (as covered in the introduction above and the results section)
2. To explore the relationship between participating in the Being with Baby program and changes in parents, parenting and their children (as covered in the literature review, themes, and discussion sections of this report)

3. To develop a set of recommendations that would enhance the programs' capacity to improve the intended outcomes for the staff/workers, parents and children (as presented in the recommendations sections of this report)

These objectives represent the first step in determining the extent to which the CfC programs impact on the children broader social outcomes. The provision of a comprehensive program logic (Appendix A) and the manual for the program ensures the program is available for wider dissemination, application and use in other settings (Appendix B).

### **Approach to evaluation research**

The mixed methods methodology and data management processes informed this research project. The qualitative methods were used predominately in this evaluation research project which was undertaken in two stages. The use of mixed methods and multiple stages using various sources of information improves the robustness of the research process.

The first stage involved:

1. The literature review explores the theoretical and evidence bases for the programs provided.

Stage two included:

1. The results of pre and post program EPDS were obtained and analysed.
2. A combination of interviews and focus groups with professionals, providers, staff, and parents.
3. Thematic analysis to provide an in-depth understanding of the impact of these programs on several health, welfare and social outcomes.

The leading research methodology used in this evaluation is qualitative. However, some quantitative data collected by FamilyZone Community Hub staff as part of the performance analysis and quality improvement of their programs was fundamental in the analysis in the first instance as it informed the qualitative data collection. Using this multiple method approach (Patton 2002; Parry & Willis 2013) ensures that this evaluation is more robust. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

## **Mixed methods**

The strength of mixed methods is that it has the potential to reduce bias linked to a single methodological design. Mixed methods also afford the ability to triangulate data through a more comprehensive collection process (Johnson & Onwuegbuzie 2004; Johnson, Onwuegbuzie & Turner 2007; Pluye, et al. 2009; Sosulski & Lawrence 2008) by using two or more data sets to confirm, refute, or question the findings of each other. In addition, mixed methods designs are a powerful process capable of illuminating policy deficits and solutions by providing directions for social action that arise from qualitative comments (Sosulski & Lawrence 2008; Whitehead & Popay 2010, Parry & Willis 2013).

Social actions require the use of inductive and deductive reasoning processes in order to understand complex interactions, and the appropriate application of mixed methods (Creswell & Plano Clark 2007; Brenner, Hughes & Sutphen 2008, Parry & Willis 2013) is therefore important to determine a construct's validity. The concepts of construct mixed methods validity are determined by asking the following questions; i) What empirical evidence is available that links the data in meaningful ways? (see data in the Background, Introduction and Results sections of this report) ii) What evidence is used to justify the relevance of the data linkages? (literature review and results section), iii) What are the consequences and appropriateness of the data interpretation? and, iv) What are the societal consequences, either intentional or unintentional, of the interpretations? (Dellinger & Leech 2007, Parry & Willis 2013). These questions inform the process and analysis of the data collection and the sequencing used in this study.

## **Qualitative methodology**

The qualitative component of the study was undertaken within a broad framework of critical social theory. This enabled the researchers to consider multiple positions, such as gender, race and poverty, as they affect the SDH outcomes of children and families. Importantly, it situates the research as inquiry to inform change.

The subjective nature of qualitative enquiry has several relatively stable criticisms. The qualitative researcher selectively collects and analyses data that is not representative (Bogdan & Taylor 1975). Generalisations are consequently not appropriate. Qualitative enquiry is only appropriate as a research design where an in-depth understanding is required of a group of people who have been purposefully selected (Patton 1990). This is imperative here as this research project sought to explore the changes made by participation in the Being with Baby program facilitated by FamilyZone. Here the data

selected specifically explores the outcomes of the FamilyZone Rural Region of South Australia programs on the parents and children.

While quantitative data provides a broad understanding of some influences on family circumstance, such as attendance, qualitative data, stories and narratives provide a personal perspective on life and family circumstances. Both sources of information are useful and highlight the influences on how children and families cope with adverse life circumstances and make decisions (Bogdan & Taylor 1975; Parry & Willis 2013). The qualitative data provided in the interviews represent how the participants see themselves, their young children and their family within a social structure and their capacity for empowerment and self-determination (Parry 2012). This in turn informs a parent's ability to deal with stress and seek help when needed.

### **Social and power implications of narrative analysis**

Researchers have found the use of narrative analysis important in discovering the underlying socio-political impacts on population groups (Kohler Riessman 1993; Lieblich et al. 1998; Czarniawska 2004; Daiute & Lightfoot 2004). As Kohler Riessman (1993) notes:

*The use of narrative analysis is important as all narratives are socially constructed and laced with social discourse and power relations.* (Kohler Riessman 1993 p. 65)

Such qualitative research using narratives provides a useful insight into the social and power relations that influence the participant's decisions. This allows for the inclusion of the family story within the SDH framework and demographic data that explains the impact of the Being with Baby program on the care and development of young children and the intra-family relationships. Thus, the inclusion of narratives allows parents to express how the program impacts on their lives and their families. Qualitative research and narrative analysis is the broad term used to describe a research act that aims to obtain from the participants detailed accounts of their lived experience through their stories. In practice, many such projects have focused their attentions on vulnerable or marginalised groups, thus containing an emancipatory emphasis, but the method can be used with any group of people (Davies 2007; Duffy 2008; Parry 2012; Parry & Willis 2013).

### **Data management and analysis**

All copies of transcripts and any other pertinent qualitative and quantitative data sets are kept in a locked cabinet at Flinders University for seven years and then destroyed to comply with A.F.I. legislation.

Qualitative data management and analysis were completed in two separate but related steps in a procedure recommended by Patton (Patton 1990). The recordings were transcribed verbatim and pseudonyms assigned as the initial step to managing and analysing the data.

Qualitative data was analysed manually. Transcripts were disseminated into their component parts regarding the original question categories. Respondent selections were separated and colour coded in a procedure outlined by Cavana et al. (2001). Care was taken at this point as all data taken at the first instance as relevant and useful. There was a need to carefully identify statements that were made by the participants on issues that were not core to the focus of study, yet remained important, and those statements that were more clearly relevant.

The data was then inductively analysed. Patton (1980, p.306) describes inductive analysis as patterns, themes and categories of analysis which come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis. Themes that emerged from the data were analysed in terms of the constant comparative method as described by Glaser and Strauss (1967). This method requires that themes be examined as they emerge directly from the raw data and compared to each other to ensure they are not different aspects of a previously designated theme (Glaser & Strauss 1967; Cavana, Delahaye et al. 2001). Themes were derived from the interviews and focus group reaching themes saturation process as outlined by Mason (2010).

Additionally, the thematic data was deductively analysed using an iterative process to connect the Being with Baby program results to the theoretical basis and themes arising from the interviews and focus groups (Grant & Booth 2009). Critiquing the qualitative results against the literature review improves the robustness and validity of the research findings and here ensures the program under evaluation is soundly theoretically based.

Marshall and Rossman (1999) note that an alternate understanding will always exist and the job of the researcher is to argue and reason why the explanation associated with the data is a better explanation than the alternate understanding. Patton (1990) warns that researchers are always at risk of being accused of imposing an understanding that reflects the researcher's world better than the world being studied. The search for alternate understandings was considered as one method that could be used to counter this accusation.

## **Quantitative methodology**

The quantitative component of the data that met adequate standards was analysed. For example, the quantitative data from the Edinburgh Postnatal Depression Scale (EPDS) questionnaire was of good quality and consistent with international standards on the use of a quantitative collection instrument provided to participants of the program. Further, the analysis performed on the data was consistent with approximate data analyses technique for the data provided (Barnhofer, Duggan et al. 2011; Statistics 2011a; Foster, Diamond et al. 2015). The EPDS questionnaire is acknowledged to provide a depth of information regarding a plethora of issues that impact on levels of depression that can influence choices on many aspects of family life. The qualitative approaches, such as interviews provided an extra dimension to the research by providing the opportunity for staff and participants to reflect on the experiences provided during the program. This is reflected in the inclusion of narratives that allow families and staff to express how the issues and the programs impact on their children and families.

For example, aspects of the EPDS questionnaire and information from the in-depth interviews, observation data and focus groups methods of data collection each informed the use of different types of analysis. These characteristics were explored further in the qualitative data collection process. The qualitative data will inform future survey questions and evaluations of such programs. This circular process ensures triangulation and robustness of all data collection and the research process.

The predominant research methodology used in this evaluation is qualitative. However, use of the EPDS questionnaire constitutes quantitative data and is collected by Lutheran Community Care staff as part of their family assessment to tailor appropriate program tools and resources to best assist their clients, provided foundational data to inform the qualitative data collection. Using this mixed-method approach (Patton 1990; Patton 2002; Parry & Willis 2013; Foster, Diamond et al. 2015) ensures that this evaluation will be more robust. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by the quantitative data.

## **Selection of participants**

The use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry & Willis 2013). Therefore, selecting participants in the qualitative phase entailed an evaluation of their delivery of the programs, as staff/worker (along with their continuing education activities), collaborative referral recipients, or parents

which then resulted in their inclusion due to their key informant status. This process constituted a critical snowballing approach to participant recruitment. Furthermore, the managers (The Salvation Army, Ingle Farm) and staff (including volunteers) employed in the programs provided important theoretical knowledge and background on program development and implementation.

### **Exclusion and inclusion criteria**

The use of multiple sources of information and informants enhances the validity and robustness of the research results. The family participants selected for interview/focus groups were recruited using a critical snowballing method (Hansen 2006; Parry 2012). Critical snowballing uses key professionals to provide information on possible suitable participants for research (Hansen 2006; Parry 2012). The method of sampling was also important to enhance rigour and whilst random sampling is preferred it is not appropriate for qualitative studies (Hansen 2006; Parry 2012). To maintain confidentiality and enhance the inclusiveness of the study the participants were selected by the staff of the Being with Baby program. This constitutes a form of critical appraisal, chain, or snowballing sampling, where by key informants, in this case the staff, suggest families to be involved in the research (Hansen 2006; Parry 2012). The participants then self-select to be involved in the research. The extensive list of potential participants was provided by the staff. This ensured that the researcher had no prior knowledge of the participants or their family situations, and additionally, ensured the staff did not know which participants had agreed to participate, providing anonymity and confidentiality. Those parents using the Being with Baby program were then identified by the staff and then approached via a letter/phone call for recruitment into the study. All participants volunteered freely to participate in the research, and had participated in all the Being with Baby sessions. Additionally, all participants spoke English well enough to understand and answer the questions.

Qualitative research and narrative inquiry uses the narratives that emerge from interviews and examines the material within the context of how the data and participants are situated in the social world. Meanings are derived through the deconstruction and reconstruction of the narratives defining structural elements (Duffy 2008; Parry 2012).

### **Interview questions**

The rationale for questions selection is based on Tong, Sainsbury and Craig's (2007) 32 item checklist for interviews and focus groups. The checklist encourages researchers to use

broad open questions that remain reflexive and responsive to participants (Tong et al. 2007). This enhances the exploration of the participant's perspectives and their meanings, and attributions of the phenomena under investigation (Tong et al. 2007). This process adheres to narrative analysis methodological frameworks and theoretical principles. Questions asked were open ended and simple in structure to elicit the participant's in-depth responses and to obtain responses unconnected with the researcher's experience or bias. The interview and focus groups covered several characteristics highlighted by the literature and past evaluations:

- The type of program;
- The usefulness of the program;
- The impact of the program(s) on other aspects of the participants lives (e.g. the SDH, community environment);
- Implications for changes; and
- Impact on health (mental and physical).

The above considerations were used as a guide for the design of the questions. The interviews were of 20 minutes to 120 minutes in length and the focus groups were between 60 minutes and 120 minutes in length. The interviews were either face-to-face or via the phone depending on the participant's preference. The initial data collection took place in the FamilyZone Community Hub, Ingle Farm, South Australia. However, the data collection in some instances occurred over the phone to accommodate the life circumstances and preferences of the participants.

### **Community engagement strategies**

A research reference group was established from the staff and key stakeholders. The research reference group aided in the data analysis of de-identified data and the development of the major themes. This process enabled the collaborative involvement of the service providers in the research ensuring the inclusion of key stakeholders in a democratic process. Furthermore, it assured the final recommendations are usable. The research reference group verified the thematic definitions, theoretical basis for the program, and the importance of a community hub delivery model for stage one and assisted in the development of the qualitative questions for stage two interviews and focus groups.

The researchers analysed the interview responses from staff, community service providers (staff/workers in continuing development programs), and parents. The analysis

was presented to the reference group for consideration and comment. The results of the first two phases informed the development of a set of recommendations for future service delivery of interventions of children at risk and their families. In addition it provided a framework for future service evaluations and data collection. These could be used to ensure the effectiveness and viability of the CfC programs using an evidenced based perspective. This report is divided into five sections with each section reporting on one aspect of the research evaluation. The first section (above) provides an overview and background on the CfC program nationally and the AEDC demographics of the area where the Being with Baby program is delivered. The second section reports on the program economic rationale and the facilitator qualifications. The third section provides the literature review of the program target population, the theoretical models informing professional practice, and the preventative interventions used. The fourth section reports on an evaluation and results of the Being with Baby program delivered by The Salvation Army, Lutheran Community Care and the FamilyZone Community Hub, Ingle Farm. The fifth section provides a discussion linking the results and the literature providing the evidence for the program's success and the conclusions for the use of the program along with recommendations for future data collection and research.





## ***Section two: The Being with Baby Program***

### **Introduction**

Recent Australian research found that growing up in disadvantaged areas negatively impacts on the brain development that continues into adulthood (Whittle, Simmons & Allen 2017). However, positive parenting practices can mitigate these effects (Whittle, Simmons & Allen 2017). This research project explored the impacts of a parenting program designed to mitigate the negative impact of disadvantage that includes poverty, maternal mental illness and other deleterious life circumstances. The Being with Baby program is delivered in the Ingle Farm and surrounding areas by The Salvation Army as the Facilitating Partner of Communities for Children (CfC), a federal government initiative. The organisation directly involved in the Being with Baby program delivery is Lutheran Community Care and the CfC-funded programs provide prevention and early intervention approaches to improve outcomes for children (0-12 years old) and families who are at risk. These programs are sound from a theoretical perspective. The Being with Baby program incorporates fundamental theoretical aspects of improved parental care, such as Targeted Relationship Building, Attachment Theory, and the Circle of Security Theory, while addressing the broader constructs of the Social Determinants of Health (SDH), such as education, access to services and aspects of service delivery (Parry 2012; Parry et al. 2016). Furthermore, the

SDH frameworks provide a means of exploring the impact of social phenomena, for example limited: income, health access, community capacity, and family support, on individual aspects, such as health and wellbeing outcomes. The type of analysis and research undertaken for this evaluation provides a bridge between policy objectives and the practice applications of policy on SDH outcomes (Parry 2012; Stewart 2014).

The Being with Baby program commenced in 2009 to provide activities free of charge, and include food, nutritional information, toys and equipment use e.g. play equipment, books etc. This encourages the participation of families experiencing disadvantage and social isolation. Evaluated by this research project is the extent to which the Being with Baby program meets the aims of increasing parents or carers capabilities and provides strategies to parents to meet their child's developmental needs and the subsequent child developmental improvements in reducing social isolation and providing positive community outcomes. It found that these aims were met and for the families involved it exceeded all expectations.

## **Enhancing parenting skills**

The Being with Baby program provides intensive and comprehensive support for parents (mainly mothers) who recognise the need to address behavioural problems in their young children or mental health issues in themselves. Parents are also referred to the program by other education and health professionals in Salisbury, Ingle Farm and surrounding suburbs. Behavioural problems can include: toilet training; eating and food refusal; sleep and sleeping routines; or not meeting social developmental milestones, such as sharing, locus of control and ability to concentrate on an age appropriate tasks.

The Being with Baby program also provides intensive and comprehensive support for parents (mainly mothers) who recognise, or are referred to the program, to learn more about their infants and children's early development, are feeling/behaving disengaged with their children and/or have parenting issues, such as child behaviour issues, or, for example, issues with toilet training. The combination of the supportive care of the mothers or carers and an intensive intervention strategy and activity program is vitally important in providing a successful intervention to mitigate the profound effects on children who fail to meet developmental milestones (Taylor, Moore et al. 2009). Additionally, place-based service delivery models enhance large scale social change and the development of interventions approaches and goals that are shared by community governments and other stakeholders,

and recognises the value of local knowledge, locally attuned programs, and the primacy of social relationships (Department of Social Security 2017).

The targeted interventions aim to provide parents with strategies to enhance a child's development so the child has the best possible start to schooling. The health professional and trained volunteers providing the program effectively engage with the parents and caregivers to devise realistic, achievable, measurable and specific goals for the child to attain with the support of the parents. This process also empowers the parenting skills through the practical application and use of 'strengths-based interventions'.

## **Economic rationale/social return on investment**

Failure to meet developmental milestones can be a form of abuse or neglect (Taylor, Moore et al. 2009). In Australia, Access Economics et al. (2009) estimate that in 2007, between 177,000 to 666,000 children under the age of 18 were abused or neglected and this costs between \$10.7 billion and \$30.1 billion to the community (Taylor, Moore et al. 2009). The ongoing costs of child abuse and neglect for Australians could be as high as \$38.7 billion. For every \$1 spent in Australia on early intervention programs for preventing child abuse and neglect, there is a \$15 saving in adult health costs (Taylor, Moore et al. 2009; Allen 2011; Deloitte Access Economics & PANDA 2012). The use of early detection, prevention and intervention programs for parents, and carers in caring for children has the potential to save public expenditure. The Being with Baby program provides preventative and therapeutic interventions delivered by a perinatal infant mental health social worker. To provide these services one-on-one to parents would not be cost-effective. For example, if 10 parents attend a two-hour program per week, this equates to 20 hours per week of individual sessions to deal with the same child behavioural and developmental issues. The targeted playgroup and parenting support format enables the delivery of this information and intervention in a method that is cost-effective. Additionally, to provide one-on-one therapeutic interventions for the numbers of clients currently using the service would require 6 FTE staff instead of the current 1 FTE (the staff are part-time). The use of group work here is cost-effective and appropriate as parents who have previously participated in the Being with Baby program can return when extra support is needed, for example, at times of family stress, and it often encourages other parents to participate.

The Being with Baby program evaluation used a concurrent mixed/multiple methods research project design to explore the use of directed preventative interventions, such as

Targeted Relationship Building, Attachment Theory, and Circle of Security Theory, along with support and relationship based programs that aim to improve parent/carer relationships and practice within the family. Stage one involved an extensive literature search, the analyses of which allowed for evidence-based practices and themes. This stage provided an understanding of the theoretical foundations of the Being with Baby program. Stage two consisted of the collection of data, including the number of attendees as a quantitative data source, (this data is already collected by CfC), and the outcomes of the Being with Baby program assessed in the interviews and focus group data. Qualitative data included interviews/focus groups with providers (managers and staff), community human, health, and education staff/workers, and interviews/focus groups with parents. Data was analysed thematically to provide in-depth understandings of the impact of these programs on the families. These two stages together provide a broader and deeper understanding of whether the CfC program improved health, educational, emotional and social outcomes for children and families. This is consistent with the focus of the AEDC measurements and outcomes.

## **Facilitator Qualifications**

Lead clinicians: The current lead clinicians have Bachelor/Degree or recognised qualifications in Social Work, specialising in childhood physical, cognitive, and social development, along with postgraduate qualifications in:

- Perinatal infant mental health;
- Sociology of family;
- Infant observations;
- Child-centred professional practice;
- Physical, cognitive, social and language development; and
- Trauma-informed principles of intervention.

Additional training in the following areas has been completed:

- Attachment Theory;
- Circle of Security Theory;
- Bringing Up Great Kids;
- Toolbox;
- Seasons for Growth;
- Mindfulness/meditation development programs; and

- Child development.

The Being with Baby program also provides family support work such as home visiting and has well-established and maintained referral pathways and community links. The play and activities provided by the Being with Baby program improve child development. Play is important for a child's health, growth and development. The use of play is also an important aim of the Being with Baby program as it enhances the parent's understandings of the importance of play and models how to play with children. Regular activity and play has many benefits for children. These include:

- Enhancing listening skills
- Building strong hearts, muscles and bones
- Fostering social interaction skills
- Developing movement and co-ordination
- Improving problem solving skills
- Encouraging self-esteem
- Developing emotional skills
- Expanding communication skills
- Developing self-regulation and impulse control

The activities highlighted above involve the children and parents participating in safe and positive skill development that result in significant behaviour changes in the targeted families and children. The Being with Baby program staff model support and encourage a safe environment where children can develop and learn. Additionally, the use of the theories, models of care, programs, and equipment involved in the activities provided has necessitated the training of staff in a variety of programs and methods of delivery. For example, the Being with Baby program staff receive regular training and continuing professional development in perinatal infant mental health. The Supported Playgroup attached to the Being with Baby program provides parental education that promotes the child's development through early language interventions, skills, and social interactions development for children identified with potential language, social and communication difficulties (Hanen Centre 2016).

## The program

Participants are referred to Being with Baby and engage in the program following interview/conversation. Participants are often referred as a consequence of high anxiety and/or high Edinburgh Depression Scale scores when CYH nurses complete the universal routine ante-natal check. Most have a diagnosis of postnatal depression.

Crèche is provided for participants – the choice is theirs to keep their child(ren) with them during the course or engage the crèche.

A series of topics are covered:

- Week 1 Welcome, introduction, housekeeping, pre testing  
Causes and incidence of perinatal mental health.
- Week 2. Stress response – stress reduction strategies
- Week 3 CBT – introduced as an effective means of tackling symptoms of anxiety and depression.
- Week 4 Attachment and the infant – what is attachment  
Infant development
- Week 5. Assertiveness, negotiation, planning – management
- Week 6 Relationships with your child – child development  
Ages and stages of development  
The importance of play
- Week 7. Dads, parents, family, friends, support
- Week 8 Celebrations and consolidation of other supports where necessary; post testing, evaluation.

Although this is a standalone program it is important to recognise there are strong connections to other programs. We need sustainable outcomes for the families and with this in mind, women who attend Being with Baby are offered a range of other services. One of those services is home visiting but other options include connection to one-on-one psychological services (using a mental health plan gained from their GP), connections to child care, as well as help to connect to supported playgroups, libraries, and other services available within the community. Many of the women who attend Being with Baby do take up the option for home visiting, but not all.

Topics covered in the Being with Baby group are designed to address the issues women often experience as a part of postnatal depression. Recognition of these issues, naming them and building a repertoire of strategies to manage those issues and/or feelings

is of prime importance. There is a strong emphasis on attachment, child development, relationships and support. Sharing within the group setting can 'normalise' some of the experiences. Bonds often build between group participants and long-term friendships continue beyond the time within the group.

Successful parenting is likely to be compromised for women experiencing postnatal depression. Addressing the topic within the group setting as well as with the individual is an attempt to support the mother and family whilst keeping the baby safe. Although involvement in the group setting has its benefits, each participant will also bring an agenda of individual needs which needs to be recognised and addressed. This can often be achieved with the support of a family support worker and/or home visiting. Strategies learned in the group can also be supported with input from a family support worker.





## ***Section three: Literature Review***

In Australia, and internationally, the use of community hubs to support effective and evidence-based parenting programs, such as Being with Baby, has been shown to be an imperative and integral part of the whole of community-based service delivery. This is true of FamilyZone and the Being with Baby model of care for at-risk infants and families. National evaluations of community hubs have found that the use of the community hubs' model of service delivery enhances social inclusion and social cohesion, providing a 'citizen-centric' based point of access to families and communities (Press et al. 2015; Parry et al. 2015). Essential to this innovative, preventive, intervention program and community hub development was the actively sought feedback from the local community to enhance the program to meet the community's and parents' needs. The Being with Baby program broadly consists of two main strategies or aims. The first is to enhance the skills of parents and caregivers in addressing children with behavioural, language, communication and socialisation problems. The second is to upskill the other professionals working with children

directly or indirectly in the local area, thus creating a broad child-centred approach to community engagement with local children. The program meets the needs of children who are aged 0-5 years and are marginalised, vulnerable, and disadvantaged. As an activity-based program it delivers evidence-based theoretical content and behaviour change through activities such as reading, play (both indoor and outdoor), and through active engagement that involves parents/carers connecting to their children. This ensures that those with limited literacy skills or other marginalised or disadvantaged groups, such as CALD and ATSI peoples, can participate easily, without stigma or exclusion. This guarantees that the parents' and community's diversity and unique perspectives are included in the activities, and are supportive of the development of the infants and young children. The parents attending are often isolated, for example, migrant families, families involved in rural work and settings, or isolated through relocation for work far from supportive family members. The families are disconnected from family supports that are imperative at the time of an infant's birth, development and growth. Thus, the Being with Baby program supports parents and carers in their aspirations to be effective and responsible parents/adults caring for children. The use of extended family and family substitute/support programs are paramount in improving children's health and wellbeing at a time of developmental vulnerability for the child. The Being with Baby program provides an innovative opportunity for disadvantaged, isolated, and stressed parents and carers to change their parenting style to encompass evidence-based understandings of child development that directly addresses children's developmental needs. Furthermore, the program encourages the active participation of all the parents in all activities and provides an early identification or basic assessment process, as well as the use of extensive clinical knowledge to advise parents of the broader referral system and opportunities for children in need of extra support.

The Being with Baby program has been instrumental in aiding parents in linking to other support services in a timely manner. For example, the manager uses her clinical knowledge and expertise to identify young mums or children with difficulties in mental health, social communication, social interaction, and restricted or repetitive behaviours (interests that may be associated with possible autism), and postnatal depression. Any of these issues or behaviours that are identified, or other deficit disorder issues that may need referrals, are brought to the awareness of the parents, and the parents are advised of organisations and support services that may provide help. This has aided the families in

obtaining timely and appropriate interventions for themselves or interventions that have supported the development of their children. Early intervention in potential mental health issues, deficit disorders, behavioural, language, and social issues, ultimately assists the parents and children by helping in addressing issues to facilitate the integration of the children into mainstream kindergarten and school. This is particularly important for disadvantaged, new migrants and refugee parents as it assists in linking the parents to the local community acknowledging that children in the most disadvantaged areas are 4.1 times more likely to be developmentally delayed (Department of Social Security 2017).

## **Literature review methodology**

A scoping literature review was used as the foundational format for this study. A scoping literature review is a form of literature review and exploratory study that uses a critical framework to develop a research question and the dissemination of review findings (Askey & O'Malley 2005; Mitton et al. 2007; Dagenais et al. 2013; Parry et al. 2015). Contrary to a systematic literature review, this type of review obtains an overall picture of an issue or field of research (Askey & O'Malley 2005; Mitton et al. 2007; Dagenais et al. 2013; Parry et al. 2015). This preliminary type of literature review determines the feasibility of a systematic literature review and future research (Askey & O'Malley 2005; Mitton et al. 2007; Dagenais et al. 2013; Parry et al. 2015).

The advantage of a scoping study is the inclusion of various study designs in the literature under review (Askey & O'Malley 2005; Parry et al. 2015). In addition, scoping studies include material from a range of sources (Askey & O'Malley 2005). Scoping literature reviews provide a set of tools that differ from systemic literature review (Askey & O'Malley 2005; Mitton et al. 2007; Dagenais et al. 2013). The scoping study was used here to determine the need for future research and to identify gaps in the evidence base.

A scoping study is iterative in nature using broader search terms in order to allow the researcher to reflexively engage repeatedly with the literature in a comprehensive way (Askey & O'Malley 2005; Parry et al. 2015). We explored the literature databases using scoping study methods of literature review (Dagenais et al. 2013).

The inclusion criteria were based on the relevancy to the topic under discussion rather than the research specification described in the studies (Askey & O'Malley 2005; Mitton et al. 2007; Dagenais et al. 2013), and therefore, we included grey literature. Our framework

for conducting the study was based on the methodological framework suggested by Askey and O'Malley (2005). This scoping study used the following stages:

- Stage 1: identifying the research question
- Stage 2: identifying the relevant studies
- Stage 3: study selection
- Stage 4: collating, summarising and reporting the results (adapted from (Askey & O'Malley 2005, p. 22).

The review of the literature will be used to develop this research project (Stage 1). The search of online databases, ProQuest, Science Direct, Sage and OVID, for relevant articles was conducted using terms that arose from an initial meeting between the researchers and the community partners. The search terms included: 'community hubs', 'community hub models of service delivery', 'targeted parenting programs', 'mindfulness parenting', 'maternal depression', 'attachment theory', 'Circle of Security', and 'trauma-informed care/interventions'. Subsequently, a more comprehensive search was used which aimed to identify:

- The use of multi-component programs to significantly improve parenting and the care of infants and children
- The impact of the community hub model of service delivery on family and community engagement with programs
- Specific aspects/theoretical foundations of the Being with Baby program that are delivered to parents/carers and infants

## **Scoping literature review results**

The search initially found 7,587 references and we selected 56 studies that were directly related to the Being with Baby program. Additionally, we searched for community hubs and from the 157 references we selected 17 studies. The scoping review integrated only articles after 2004, as the policy changes are recent (Stage 2). Furthermore, as per Stage 3, through the posthoc development of an increasing familiarity with the literature, most of the irrelevant references were excluded (Askey & O'Malley 2005). Stage 4 collated the government reports on parenting programs (8) and studies that explained the policy change were included. This scoping study also included references that described the need for policy change – for example, the impact of the use of community hubs on children and

family wellbeing (17), programs to improve parenting and parent/child relationships (43) and the potential impacts on communities (12). Some articles covered two or more areas of relevance.

Furthermore, the scoping process highlighted the importance of multi-component parenting programs and demonstrated the significant effectiveness of these when compared to single component interventions alone.

## **Theoretical basis for the program model: Literature review**

### **Community hubs build community capacity**

Internationally the use of community hubs has been shown to improve long term health, welfare and educational outcomes for children, families, and communities (Brockmeyer Cates et al. 2016; Jutte et al. 2015; Tas. Dept. Edu 2016). Exposure to childhood poverty has been shown to have lifelong detrimental impacts on children's health, wellbeing and educational outcomes despite advances in medical technology and treatments (Jutte et al. 2015). Community capacity to compensate for adversity impacts significantly on childhood exposure to stress (Jutte et al. 2015). Community adversity impacts significantly on the stress responses, creating toxic stress, which interferes negatively with brain development and epigenetics (Jutte et al. 2015). Community-based hubs with programs that directly support parents and children provide emotionally protective environments (Jutte et al. 2015). Neighbourhood features and increased level of toxic stress have been shown to respond positively to the community hub model of service delivery (Jutte et al. 2015; Tas. Dept. Edu 2016). Community hubs create a 'positive ripple effect of enhancing child health, education and welfare outcomes in childhood' along with other unexpected community outcomes, such as increased local employment (Jutte et al. 2015; Tas. Dept. Edu 2016).

Rigorous evaluations have found that the use of community hubs have successfully tackled neighbourhood distress and dysfunction simultaneously and on numerous fronts (Jutte et al. 2015; Tas. Dept. Edu 2016). The community hubs that use tailored programs to meet community needs, involve residents, improve employment options and opportunities, and build on the unique local assets of the community with flow-on effects for increasing parental support and children's longer term health, education and welfare outcomes (Jutte et al. 2015; Tas. Dept. Edu 2016).

Community hubs build community capacity by developing partnerships with parents and the community which respond to child and family need in a seamless and holistic manner (Jutte et al. 2015; Tas. Dept. Edu 2016). Community hubs are centres that offer a suite of integrated, high quality, evidence-based programs that change to meet the local community needs in a safe and responsive environment (Jutte et al. 2015; Tas. Dept. Edu 2016). Community hubs provide integrated models of service delivery (Tas. Dept. Edu 2016). FamilyZone is such a community hub.

### **Multi-component programs**

Internationally and nationally there is an increasing evidence-base for the significant improvement in family and child wellbeing provided by the use of multi-component programs (NSW FSC 2014; EUROCHILD 2012; Thomson et al. 2010). The use of compatible, multi-component programs decrease risks of abuse and neglect of infants and children, while increasing the protective factors in the home, school and community (NSW FSC 2014; EUROCHILD 2012; Thomson et al. 2010). Multi-component programs have consistently been found to lead to more positive outcomes that directly address the complexities of risk significantly more effectively than single component interventions, especially for high risk children (NSW FSC 2014; EUROCHILD 2012; Thomson et al. 2010; Tully 2007).

Additionally, multi-component programs that provide behaviour and skills-based interventions that include psychosocial support, self-help strategies, skill development, relationship development, build connections to family and education, and, specialised and multidisciplinary care or treatment, have been found to be the most effective (NSW FSC 2014; EUROCHILD 2012; Thomson et al. 2010; Tully 2007). The Being with Baby program is a multi-component program that meets the international criteria outlined previously.

### **Targeted relationship-based programs**

Early human development impacts on health, learning, and behaviour throughout life (Mustard 2010). Programs targeting parents of children at risk aim to decrease the impact of the negative characteristics of some of the Social Determinants of Health (SDH) (Parry 2012; Solar & Irwin 2010) and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Mackintosh, White et al. 2006; Noble-Carr 2007; DoCS 2009; Keys 2009; Dockery, Grath et al. 2010; Gibson & Johnstone 2010; Parry et al. 2013; Solar & Irwin 2010; Marcynyszyn, Maher et al. 2011; Nelson & Mann 2011; Kilmer, Cook et al. 2012; McCartney 2012; McCoy-Roth, Mackintosh



Figure 3.1 (above) from Bowie (2015) highlights the importance of 'place-based' service delivery that enhances and empowers local communities while providing parenting support that improves children lives and development. Furthermore, Bowie (2015) states that silo approaches to service provision adds to family disadvantage and slows timely access for families to supports and services they require to mitigate disadvantage. Supporting children and parents through community-based programs is soundly theoretically-based as Figure 3.1 is based on the bio-ecological theory of development (Bowie 2015; Sawyer, Gialamas et al. 2014). Additionally, Bowie's (2015) research found the flow-on impact of programs that support and improve parenting to then influence other unforeseen areas of the parent's lives, such as improved employment opportunities and a sense of connectedness by parents to their community. This significant finding is supported by an increasing body of evidence from nationally and internationally renowned researchers (NSW FSC 2014; Jutte et al. 2015; Marrow 2012).

The Being with Baby program targets the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. An evaluation of whether the programs efficacy is necessary to ensure funds have been well spent and to secure continued funding and expansion of such programs.

### **Targeted playgroup programs**

The Being with Baby program preventative interventions include targeted playgroups. These playgroups may be located at FamilyZone or offsite. Being connected to a playgroup close to the home of the participant is more sustainable in the longer term. A mum is assigned to a longer term parent/participant/volunteer to help make the referral 'warm'. The 'buddying' process has the impact of improving the confidence to the new parent/participant to attend (see results section Themes). Targeted playgroups are effective in mitigating the influences of poverty, isolation, young maternal age and parental mental health issues on infant and child development (Lakhani & Macfarlane 2015; Pourliakas, Sartore et al. 2016). Targeted playgroups for children aged from birth to five years strengthen parent/child relationship through an understanding of children's appropriate behavioural, cognitive and social development, and can empower parents to effectively intervene with young children with expressive and receptive language disorders (Hanan Centre 2016). Participation by parents in these types of playgroups promotes protective factors for children experiencing vulnerable circumstances and developmental delays (Lakhani & Macfarlane 2015; Pourliakas, Sartore et al. 2016). For example, young parents, parental mental illness,

parents with drug and alcohol issues or isolated parents (Lakhani & Macfarlane 2015; Pourliakas, Sartore et al. 2016).

Targeted playgroups are structured playgroups that provide evidence-based, targeted knowledge and services to enhance and promote infant/child development, health and wellbeing (Lakhani & Macfarlane 2015; Pourliakas, Sartore et al. 2016). These preventative intervention types of playgroups improve child socialisation consistent with increasing child wellbeing and health, while reducing the risk factors for children by keeping the children visible and connected to the community (Arney & Scott 2013; Parry, Grant et al. 2015). Further, targeted playgroups enhance parental wellbeing by improving parental connections to community, and reducing social isolation (Lukie, Skwarchuk et al. 2014). Additionally, the preventative interventions provided by targeted playgroups mentioned above improve numeracy and literacy in the child, promote school readiness, and enhance academic attainment (Lukie, Skwarchuk et al. 2014; Gregory, Harman-Smith et al. 2016). These types of activities, interventions and services are also consistent with policy approaches and the key strategic outcomes of the Communities for Children Intervention.

### **Attachment theory**

Attachment theory was developed in the 1970s by John Bowlby to explain the carer/child connection in terms of biological and psychological functioning (Van IJzendoorn 1995; EUROCHILD 2012). The theory describes the sensitivity and responsiveness of the parent or caregiver to meet the child's developmental needs as early attachment impacts on lifelong functioning (Van IJzendoorn 1995; Van IJzendoorn, Schuengel et al. 1999; Centre for Parenting & Research 2006). Additionally, the measures used in the attachment assessments illustrate dysfunctional parent or caregiver responses to infants and children (Van IJzendoorn 1995; Centre for Parenting & Research 2006). Responses from prolonged separations, either physically or psychologically impact on the child and their subsequent adult functioning and behaviour (Van IJzendoorn 1995; Van IJzendoorn, Schuengel et al. 1999; Centre for Parenting & Research 2006; EUROCHILD 2012). Longitudinal international research supports the use of attachment theory to predict infant, child and adult outcomes for appropriate parental responses to children's needs and for the development of adults' significant interpersonal relationships (Van IJzendoorn 1995; Van IJzendoorn, Schuengel et al. 1999; Centre for Parenting & Research 2006; Suchman 2010). Further, attachment theory research explains the cognitive organisation and representations of interpersonal relationships and parenting behaviors (Van IJzendoorn 1995; Centre for Parenting &

Research 2006). The predicative capacity of the attachment theory measurements provides self-reporting and professional assessment items that consistently calculate levels of attachment and identify intervention pathways for program implementation (Van IJzendoorn 1995; Van IJzendoorn, Schuengel et al. 1999; Centre for Parenting & Research 2006). Successful interruption of reactive-attachment disorder, insecure-resistant, insecure-avoidant, or insecure-ambivalent attachment through target programs is evidence-based and well documented (Van IJzendoorn 1995; Centre for Parenting & Research 2006). The CfC programs offered through FamilyZone directly address manifestations of interrupted attachment that subsequently decrease levels of vulnerability for children. This is achieved by working with parents and children using evidenced-based parenting and early childhood interventions in targeted and supportive playgroups that assist in the development of new positive responses to behaviours that enhance the parent/child relationship and can have lifelong impacts for the children and their families (Van IJzendoorn 1995; Centre for Parenting & Research 2006). Consequently, programs delivered by Being with Baby are collaborative, inter-disciplinary, and professional programs that provide an environment that supply consistency, professional supervision, personal support, and commitment to the development of productive, positive and therapeutic relationships with the parents, caregivers, and children participating in the programs.

The Being with Baby program reflectively and responsively engages with these aspects of program delivery and this is acknowledged in the Results section of this report. Additionally, the Being with Baby program has responded to community needs to involve parents, grandparents and carers of children aged 0 to 5 years. Furthermore, the Being with Baby program promotes and models interactions between fathers, mothers, caregivers and children based on a 'strengths-based model' of interactions, thus emphasising a range of skills processed by parents/caregivers and seen as enabling positive paternal and maternal care.

### **Circle of Security**

Being with Baby delivers a program that includes Circle of Security as a theoretical basis for evidence-based practice and uses the practical activities provided by the Circle of Security training, such as the recognition of the child's needs to explore and return, and the parents need to engage with, and respond to, the child (Dolby 2007; Dykas & Cassidy 2011). Circle of Security is an internationally-based early intervention program based on attachment theory and relationship theory (Dolby 2007). Circle of Security is one component

of the many relationships-based type programs used in the Being with Baby program as described in the introductory section at the beginning of this report. The Circle of Security theory explains the importance of secure attachment and relationships for early child development, acknowledging that child development is ongoing, not linear and dependent on quality caregiver relationships (Dolby 2007; Dykas & Cassidy 2011). The theory is based on international academic research which confirms the key role of the use of increased empathy towards children and childhood as well as developing enhanced attachment between parent and child (Dolby 2007; Dykas & Cassidy 2011). Additionally, the use of complementary programs or foundationally similar programs, such as target relational programs, attachment, Circle of Security, Bringing Up Great Kids, or responding to trauma interventions, enhances the broader improvement in challenging childhood behaviours and the development of productive parenting skills. The foundational programs are integrated in a manner that is consistent with the validity of the foundation program and does not compromise its therapeutic improvements in developing parenting skills. This is only possible with a highly-experienced manager with appropriate skill levels. Figure 3.2 (below) illustrates the foundational premise of the Circle of Security program.

**Figure 3.2 The Circle of Security: attending to children's need**

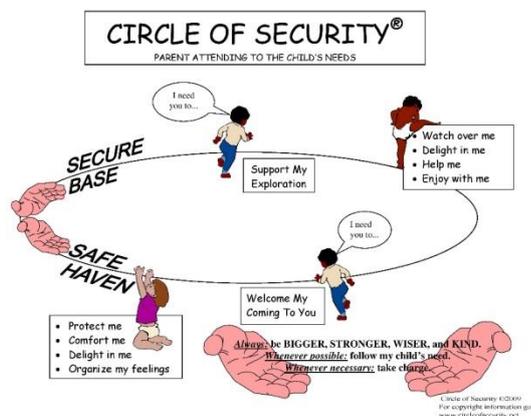


Figure 3.2 (above) is used as a basis for the Being with Baby program and explains the interactions between child and parent/caregiver. The use of diagrams, theoretical information, and easy to understand language ensures that the programs are accessible for a variety of parents and caregivers regardless of their literacy, socioeconomic, and cultural backgrounds.

## **Home visiting**

The Being with Baby program includes a home visiting component for those infants and parents assessed at being of higher risk. This is in line with national and internationally recognised best practice principles (NSW FSC 2014; EUROCHILD 2012). High risk includes families dealing with economic instability, complex socioeconomic issues, poor mental health, substance abuse and domestic violence (NSW FSC 2014; EUROCHILD 2012). Home visiting refers to the delivery of a structured parenting program that is delivered in whole or in part to individual families in the home or alternative site (NSW FSC 2014; EUROCHILD 2012). Home visiting has been shown to improve maternal-child wellbeing and actively engage isolated families with timely and appropriate services (NSW FSC 2014; EUROCHILD 2012).

Along with the 'buddy' the parents are assigned a worker who may visit one or more times per week depending on the needs of the family. The clients set the goals with regard to how they will engage with the home visiting. Home visits build on the parenting concepts taught onsite in the program. These may include individual safety plans or making connections with professionals such as psychologists. As well as practical support that may be needed, families are connected to community mental health services where appropriate. In this way the program aligns with research evidence regarding actively engaging isolated families with timely and appropriate services. The successful use of the home visiting interventions are well documented in the literature on longitudinal studies (Mildon & Polimeni 2012). Additionally, while parenting support programs are often used as secondary or tertiary interventions in high-risk families, these have been recognised as effective as universal primary prevention programs (Mildon & Polimeni 2012). The use of home visiting and collaboration with the Community Hub is targeted to the specific needs of this disadvantaged and high risk group of children and their families consist with Department of Social Security protocols (Department of Social Security 2017). Another complimentary and foundational practice delivered to all participants (parent and children) is the use of trauma-informed principles of child care.

## **Introduction and background: Trauma-informed principles of child care**

The Being with Baby and the FamilyZone Community Hub use trauma-informed principles of child care to guide the program sessions and parent/facilitator interactions. This framework and foundational principles ensure the delivery of the program responds

appropriately to any families that may have experienced trauma. Traumatic experiences are common in Australian society being the result of multiple adverse events, such as racism, family violence, war, poverty, homelessness and isolation, and are experienced across the life span (CFCA 2017; SAMHSA 2016). The outcomes of traumatic experience are often serious and deleterious and need to be taken into account in human service delivery organisations to prevent compounding traumatisation. Failure to address trauma will exacerbate the trauma while using trauma-based principles on those who have not experienced trauma has no adverse effects. Salisbury Communities for Children facilitators and human services delivery staff use trauma-informed principles in workforce development, and collaboration between consumers, professionals and service providers to meet the needs of the community across service systems.

### **Trauma-informed care**

An essential component of trauma-informed care is that the interventions and services provided do not inflict any additional trauma on the person, or reactivate their past traumatic experiences (Hodas 2004, p6). Importantly, this is ensured by the consideration of trauma needs across all the systems and services involved, not just, for example, refugee, adult or mental health settings. Being with Baby and FamilyZone Community Hub programs have recognised and implemented trauma informed approaches to programs and services delivery, thus preventing the re-traumatisation of individuals, especially children, using the services. The Being with Baby program delivers programs in a manner that uses trauma-informed principles of service delivery. This practice addresses possible trauma that may be present thus reducing aspects of possible re-traumatisation of children. It is not always possible to know a child's or parent's trauma history prior to attending the Being with Baby program, therefore, using trauma informed principles is best practice service delivery.

Trauma-informed care meets the individualised needs of each person. It aims to understand the trauma and its impact on the person's life, eliminating restrictive practices such as seclusion and restraint, and creating compassionate, non-coercive settings. Everyone, including staff and consumers who have not experienced trauma, benefits from trauma-informed approaches to service delivery.

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Falloot 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and

presentations may be adaptations to trauma rather than as pathologies (Herman 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings and systems contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al. 2013).

### **Principles of trauma-informed care**

A likely risk factor for those at risk of PND is early childhood trauma. Furthermore, parents with PND can predispose children to develop a trauma response to stress. Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al. 2005; Hopper et al. 2010; Jennings 2004; Kezelman & Stavropoulos 2012; SAMHSA 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated. For an example of an Australian model of trauma-informed care, (Tucci & Mitchell 2015) outlines the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: [9 Plain English Principles of Trauma Informed Care \(link is external\)](http://www.childhood.org.au/blog/home/2015/april/trauma-informed-care)  
<[www.childhood.org.au/blog/home/2015/april/trauma-informed-care](http://www.childhood.org.au/blog/home/2015/april/trauma-informed-care)>.

An understanding of these principles informs BWB facilitators with the kind of information that enables successful engagement and maintenance of a productive therapeutic relationship with participants in the program.

### **Therapeutic models of care**

#### **Being with Baby and FamilyZone Community Hub aims (objectives)**

Salisbury, Ingle Farm and surrounding suburbs have been recognised as an area where a larger percentage of children can experience high rates of developmental vulnerability (AEDC 2015). The Being with Baby program is delivery by speciality manager, staff and volunteers with child development specialist expertise and knowledge. The multi-component Being with Baby program delivers an intervention program which consists of several parts:

1. Dealing with Maternal Depression program:
  - a. Home visiting to support mothers who are having difficulty in leaving the home
  - b. Working directly and therapeutically with parents and children in a group setting that address the issues of anxiety and depression in parents
  - c. Working individually to increase the parent's understanding and knowledge on child development
  - d. Working individually to directly address parental concerns and 'behavioural issues' such as fussy eaters, toilet training, sleep routines
2. Parental skills development: 'Circle of Security', 'Attachment Theory' 'Playtime', and 'Communication Development', programs are all interwoven throughout the Being with Baby program sessions
3. Parental development sessions: a series of developmental educational sessions provide knowledge and understanding of young children's developmental needs, and provide strategies for professionals to use with parents to assist young children to meet their developmental milestones

Play is crucial to the development of children's gross and fine motor skills along with development of language, cognitive and social skills. Parents often notice only the development of the gross and fine motor skills (see Themes in the Findings section), however along with the motor skills the children meet the other developmental milestones. Through play, children practise and perfect control and coordination of large body movements, as well as small movements of hands and fingers. Child care in the Support Playgroup by staff provides modelling to parents to augment parental support of young children's motor development by planning play activities that provide children with regular opportunities to move their bodies. The Being with Baby program provides evidence-based early interventions that address the developmental needs of young children. These include the use of play-based interventions that aid infant/child/parent communication, and the development of relationships and bonding to enhance the infant/child's wellbeing and reduce risk factors. Additionally, communicating effectively and appropriately to children aged 0-5 years is imperative in the development of language, reading and neurological development. The parents are guided in the use of early learning, development, and language skills.

Each of the components incorporate activities based on validated methods of engagement, group therapy and home visiting individual interventions, and relationship-

building that have developed over time in consultations with the families receiving the Being with Baby program. These strategies promote maternal and paternal infant attachment and support the reduction of family dysfunction. Importantly, the program is free at point of use and includes inter-sectoral and inter-professional delivery. It actively seeks to liaison between health, education, and social support services delivered by the Being with Baby staff, with inputs from mental health and child development via referrals to experts on the inter-professional collaborative methods of delivery and referrals that are important to the outcomes of the intervention. This ensures the program provides a cost-effective service model. It brings together long-standing, effective, pre-established pathways of care, networks, and sponsored community supports in an evidence-based practice model of care to address the specific needs of families dealing with disadvantage, poverty and social isolation.

## **Parental attributes that increase levels of vulnerability in children**

There are many factors that can impact on parenting abilities and capacity. Two characteristics that impact on parenting that are prevalent in Salisbury, Ingle Farm and surrounding areas are outlined below. These factors are by no means exclusive but rather indicative of the issues the Being with Baby program needs to directly address.

### **Migrant and refugee families and parenting**

Migrant and refugee families can have complex needs (Lewig, Arney et al. 2009). Refugee families have often been subjected to traumatic experiences before arriving in Australia (Lewig, Arney et al. 2009). Parents have endured human rights abuses, trauma and loss often associated with genocide, rape, war and torture (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). These life circumstances can leave parents emotionally and psychologically impacted by trauma which can impede functioning at times of parental stress, such as differing acculturation rates between parents and children (Renzaho & Vignjevic 2011). As acculturation occurs faster in children than parents, different expectations of family, gender roles, domestic violence, and parenting styles result (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011).

Additionally, parenting practices and styles may be vastly different than those viewed as acceptable in Australia (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). For some cultural groups the use of punitive or corporal punishment styles is commonplace in

parenting (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). This authoritarian style is often at odds with Australian parenting styles and child protection expectations (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). For example, some refugee and migrant groups use older children to care for younger children or leave children unattended while the parents are at work. This practice can, in some circumstances, constitute abuse and neglect in the Australian child protection context (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). There is an over-representation of refugee and migrant families in the child protection system (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). Improving parental capacity and competencies is paramount given the increasing numbers of migrant and refugee families in the child protection system (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). Promoting culturally competent parenting practices aims to decrease child protection notifications, poorer child health outcomes, and numbers of refugee and migrant children in out-of-home care (Lewig, Arney et al. 2009; Renzaho & Vignjevic 2011). Therefore, the Being with Baby program directly addresses the needs of migrant and refugee families through culturally appropriate and respectful interventions that are mindful of the parents and child's potential exposure to trauma. Another prevalent issue parents present with to the Being with Baby program is prenatal and postnatal depression.

The emphasis on physical correction and raised voices in some cultures highlights the need to include information from neuroscience regarding age-appropriate discipline and the impact of harsh parenting on child development. There are some communication challenges involved with this as it is a new concept to many from diverse cultural backgrounds. Facilitators need to respond to the question: 'What can we do if we can't spank and raise our voices?' A 'Parenting Together' course is offered as an alternative approach as it trains parents and caregivers to work together with each other. This approach does not need punitive strategies as it breaks down the power struggle that often occurs in families. As well as conversations between parent and child, parent and parent, parents and child, parent and teacher, more of an extended family conference may be more useful in some cultures.

Some cultural groups, such as Afghanis, have been prevented from becoming literate even in their own language by oppressive regimes. For these people, understanding concepts other than smacking and yelling will require extra time and patience from group facilitators to explain the concepts, and they will need to keep their language as uncomplicated as possible. Use of the more complex self-efficacy pre and post tests will be

extremely challenging with such groups and the simplified version would be more appropriate. Alternatively, we do well to continue to make further adaptations as we become more familiar in working with specific differences in parenting of different cultural groups. It remains that while Aboriginal and CALD populations are not the core target of the Being with Baby program, by incorporating models of delivery, respectful service practices, and trauma-informed principles of intervention, the Being with Baby and FamilyZone atmosphere provides a safe environment and is already used by traditionally difficult-to-reach population groups.

### **Edinburgh Postnatal Depression Scale (EPDS)**

The Edinburgh Postnatal Depression Scale (EPDS) has been validated for use in pregnancy and postpartum to reliably measure depressive symptoms (Bergink et al. 2011; Bowen, Bowen, Balbuena, & Muhajarine 2012; Cox, Chapman, Murray, & Jones 1996; Ji et al. 2011; Matthey & Ross-Hamid 2012). The EPDS provides concurrent and predictive validity and high test-retest reliability (Bergink et al. 2011; Ji et al. 2011). Further, the EPDS provides a tool that can specifically and sensitively measure perinatal and postnatal depression longitudinally (Bergink et al. 2011; Ji et al. 2011). Thus, the EPDS demonstrates a reliable, valid, and sensitive measure of perinatal depression over time.

### **Models of service delivery (applying the theories)**

#### **The aims of the Being with Baby and FamilyZone Community Hub**

The Being with Baby and FamilyZone programs use several models of service delivery. All families attending Being with Baby at FamilyZone Community Hub can assess the variety of other programs designed to enhance infants' and children's early learning and development through extensive community links and referral networks. The aims and goals of all the programs offered use evidenced-based theories as outlined above which develop parenting skills and care to enhance early learning strategies that improve the care of infants and children.

Being with Baby has been developed for mothers who have recently had a baby and are at risk of postnatal depression. Referrals are taken from the Child and Family Health Services screening program that identifies mothers at risk. The Being with Baby program supports and identifies the assistance that is needed for the family to be supportive and connected and builds a stronger community. The aims of the Being with Baby program meet

the CfC strategy by providing responses that is inclusive of not only parental capacity building but is also inclusive of community capacity building. This is paramount if disadvantage is going to be addressed. The Being with Baby program aims are achieved using the following activities:

- Providing parent/child interventions enhancing:
  - Emotional support of children
  - Child cognitive development
  - The importance of play
  - Developing secure attachments
  - Resilience of parents and children
  - Enhancing school readiness
- Communication Talks provides parents and carers with information on:
  - The development of communication
  - Language development
  - How to seek help with parenting and child development
- Toilet training (developed by Disability SA and widely used across the state for children experiencing delays in toileting)
- Home visiting components delivering behavioural and skill-based interventions to an individual based on the need to mitigate risk
- Support from other services such as:
  - Speech pathology
  - Occupational therapy
  - Social worker services
  - Physiotherapy services
  - Mental health services
- Connections to:
  - Playgroups
  - Kindergartens
  - Preschool
  - School
  - Referrals to:
    - Centre care
    - GPs, Physiotherapy services

- Modelling positive parenting skills and strategies

These activities improve child cognitive, language, communication, and social development along with parenting self-efficacy, and are based on validated theories and methods of engagement for children aged 0-5 years. The Being with Baby program interventions outlined above have provided significant changes and improvements in children's development and parenting and carer interactions with children (see Findings). Furthermore, the parents' skills and children's behaviour improves after participation in the Being with Baby program. Parents and carers are also more engaged in the community and more likely to participate in other parenting programs in times of need, directly reducing the levels of vulnerability experienced by the children (see Literature Review). The use of several theories and interventions, such as parental anxiety and toilet training, provides services that are comprehensive, holistic and meet the needs of the program participants (see Appendix 1). The programs are based on sound theoretical premises, for example, attachment theory, Circle of Security and parenting programs. These extensive and complimentary theoretical, and evidence-based, foundations for the programs are described in the Introduction and in the Literature Review sections above.

The use of the community hub model for the delivery of programs and services is integral to the delivery of the Being with Baby program and has been demonstrated internationally to more appropriately assist vulnerable and at risk families and children to deal with complex issues (NSW FSC 2014; Tully 2007; Department of Social Security 2017). The community hub model used by FamilyZone brings together a range of services where practitioners work collaboratively to support children, families and communities (TAS 2015; Tully 2007).

The underpinning philosophy and practice of FamilyZone and the Being with Baby program is one which fully supports integration of services and multi-component program delivery. Integration service delivery aids in empowering communities and enhancing the strengths of families and communities to solve complex issues that impact negatively on the development of infants and children (TAS 2015; Tully 2007). While the program may operate independently of an integrated family support hub, its impact and uptake is enhanced by this approach.

## **Key elements of an integrated approach**

The following key elements of the model at FamilyZone have been identified in a Promising Practice Profile developed by the Australian Institute of Family Studies.

### **Family-centred and holistic approach**

Essential to the effectiveness of the FamilyZone approach is that activities are based on the issues, concerns and preferences of parents and children. For example, the program has consistently found that if parents perceive the activities to be about telling them what they are doing wrong, they will not be well attended. Service users are empowered to participate in the hub. Both formal and informal debriefing and feedback occurs. Staff are responsive to parents' requests, which has led to the facilitation of activities initiated by parents such as school holiday programs and inter-activity evenings. Team members from different agencies work together to facilitate activities, and sharing a meal is often integral to this process. FamilyZone is a family-friendly service. The hub provides:

- internet access which is especially popular with new arrivals families;
- excellent “fenced kitchen” facilities which are great meeting place for sharing concerns, stories and ideas; and
- crèche services that enable parents to participate in group activities knowing that children are nearby in a good care.

### **Establishment of strong links with state and local government departments**

The Government of South Australia (2005) report titled The Virtual Village clearly identified the need for a whole-of-government early childhood framework for effective planning, resource allocation and delivery of early childhood services in order to improve outcomes for families. This practice contributes to better services for children and their families by breaking down the inability of professionals to communicate across their respective systems, unintentionally undermining each other's roles. A significant number of referrals to FamilyZone come from the state departments such as: Child, Youth and Women's Health Services, through the universal home visiting program; the Department of Education and Children's Services, through school counsellors at local schools; and local community services agencies.

### **Multi-agency and multidisciplinary**

Professional boundaries in relation to accessibility are necessary but can create severe frustration among service users. Professionals working in isolation from each other on limited timeframes are less likely to make service connections and utilise the pool of available volunteers. Professional isolation is also linked with burnout. At FamilyZone, service users can be simultaneously connected to a number of professionals, volunteers and peers who can neutralise this sense of frustration. Collaboration with a number of agencies enhances effective, seamless access to a greater number of services. A multidisciplinary team helps ensure families are supported more holistically. Key professional disciplines include social work, early childhood, health and adult education.

### **Subcontracting provision of key services to established local service providers**

The FamilyZone home visiting initiative was subcontracted to an agency that had previously developed a strong relationship with the CY&WHS home visiting program. Such established relationships have already created the kind of credibility needed for cross-referrals and consequently fast-track effective integrated service provision.

### **Cross-cultural competence**

FamilyZone addresses issues of cultural and language barriers by:

- matching service users with staff or volunteers of a similar culture and language;
- increasing cultural competence in staff and volunteers through the sharing of information and debriefing that occurs among team members; and
- providing staff and volunteers with opportunities to participate in various cultural competence related workshops.

### **Facilitating access to different groups that operate in the hub**

Refugee families and families who have experienced family violence have significant issues with trust and are reluctant to access new services. Such access is significantly enhanced if a peer or FamilyZone worker they are already engaged with can make a “seamless connection”. Hubs with a significant co-location aspect can provide seamless services very easily.

### **Co-location of services**

Co-location facilitates access to a much larger pool of staff and volunteers who can engage with families. This model is more conducive to supporting disadvantaged families with complex needs (Department of Social Security 2017) .

### **Unlimited access timeframe**

Removing prescriptive restraints to the timelines of service episodes means that service provision can be truly responsive to the family's needs and the context in which service is being provided. For many reasons successfully engaging and integrating a service user into the range of services available at the hub may take many months. The patient approach shown by workers (see case studies in Evidence of Outcomes section) supports the achievement and maintenance of long-term outcomes.

### **Perception of workers as friends**

Good helping relationships are more ways-of-being than strategies and techniques. Workers' relationships and engagement skills can only blossom when they are rooted in genuine care and respect for the clients they serve. Specific techniques can augment an empathic, supportive, and collaborative approach, but they cannot substitute for this (De Boer & Coady 2006, p. 41). At FamilyZone it is possible to be seen as a friend without becoming enmeshed in a dysfunctional, unprofessional relationship. Washing dishes together in the communal kitchen is one way of facilitating this kind of relationship (FamilyZone Ingle Farm Hub AIFS Promising Practice Profile).

Overall, the program has a focus on tailoring to individual needs, supporting PND in a positive manner and providing timely interventions where mainstream services have long waitlists and are not responsive to individuals in high stress. Fundamental elements include stress management, connecting emotions to rational thinking, ages and stages of development, parenting and relationships, Circle of Security principles and experiences of male and female postnatal depression (see Appendix 1). Furthermore, the longer connections Being with Baby and FamilyZone have with families enable the child development aspects in babies to be more easily monitored and measured as they develop. As babies, their development is more challenging to measure and the use of pre and post intervention measures has been difficult with some families, however, Being with Baby and FamilyZone will work on this in the future in collaboration with researchers, the community, and key stakeholders. Most improvements in developmental outcomes for children aged 0-2

years are dependent on their prime carer attachment relationship hence the focus on parental outcomes by Being with Baby and FamilyZone.

## **Research methods for the evaluation of the Being with Baby program**

Stage one of this independent evaluation of the Being with Baby program consisted of a literature review of the theories and service delivery models used to determine the evidence base for these aspects of the intervention programs involved. Stage two used quantitative data collecting and analysis, and included interviews/focus groups with providers (managers and staff), community service providers (those providing referrals to, or receiving referrals from Being with Baby), and parents. The collected qualitative data was blind peer reviewed, and analysed thematically, to provide in-depth understandings of the impact of these programs on the families and the community. These two stages together will provide a broader and deeper understanding of whether the Being with Baby program provided by the FamilyZone Community Hub has improved the health, education and social outcomes for children and families in Ingle Farm and surrounding areas.

### **Research process**

The research processes have remained consistent for all the qualitative data collection throughout this research project. The initial research processes, such as inclusion and exclusion criteria, data analysis, participant inclusion, etc. have been outlined in the Introduction. The Being with Baby program is also provided by professional staff/volunteers with a background in interpersonal relationships, child learning, child development, and parenting programs. The professional knowledge and support entrenched in the Being with Baby program (and all FamilyZone programs) ensures the interventions within the programs are theoretically sound. The theoretical base and application processes embedded within the programs provides a robust practice consistent with the theoretical underpinnings. The information provided by the key informants adds to the validity and robustness of the programs delivered.



## ***Section four:***

### ***Results***

#### **Introduction**

The Being with Baby program has developed over several years and responds to the needs of the children, families and the community. Complex families addressing multiple facets of disadvantage, such as cultural, economic, and geographic, are only successfully assisted using multiple pedagogical and theoretical interventions and educational processes (Wood 2007). Reified developmental theories and child centred approaches to ECD learning and play have provided new evidence-based practices that inform interdisciplinary program delivery and community integration (Wood 2007). The Being with Baby program has been successful for several years in developing and delivering a high quality, interdisciplinary intervention programs that improve the lives of vulnerable infants and children as espoused by the policy and CfC directives.

#### **The broader aims of the Being with Baby program delivered in a community hub model**

The Being with Baby program aims to:

- deliver a reflective and responsive program that address the maternal mental health needs and the developmental needs of children in Salisbury, Ingle Farm and surrounding suburban areas;

- deliver evidenced based interventions and preventions based on sound theoretical and practice models that improve the developmental outcomes for children and their families;
- ensure the family functioning of participant families in the community and local services is improved;
- ensure the program is based on child centre practices;
- reduce the vulnerability levels for children living in an area with higher levels of vulnerability in this disadvantaged community; and
- improve the developmental language, learning, social and psychological outcomes for the children attending the program.

The aims of the program are based on the resources and theoretic models used to support parents to provide a safe and developmentally enriching environment where children can achieve their full potential. All the activities, skills and strategies provided by the Being with Baby staff are delivered in a child-centred practice manner. This reinforces the importance of children and the consideration of children in all aspects of the programs.

## Findings

### General information

The Being with Baby program, through the FamilyZone Community Hub, has engaged with the Salisbury, Ingle Farm and surrounding suburbs for several years. Its success can be attributed to its engagement with the community and the balance of theoretical evidence-based program and meeting community needs. This is reiterated by the increasing numbers of participants attending the program and the comments in the Themes section of this report. The inter-professional and multi-professional services provided in the FamilyZone Community Hub setting and model of service delivery programs directly address the recent theoretical advances that challenge the use of singular interventions and developmental theories (NSW FSC 2014; Jutte et al. 2015; Woods 2015). Table 4.1 (below) provides an overview of the attendance levels for the Being with Baby program and the numbers of isolated families serviced by the programs.

**Table 4.1 Mothers and Children attending the Being with Baby program**

Year	FamilyZone Community Hub (n)	Being with Baby (n)	Basis for participation
2009	Mothers (n)	Mothers (45)	Total number of families = 267 Socially isolated families = 132
	Fathers (n)	Fathers (56)	
	Infants/Children (n)	Infants/Children (101)	
2010	Mothers	Mothers (60)	Preschool children and their parents/carers Socially isolated families = 120
	Fathers (n)	Fathers (60)	
	Infants/Children (n)	Infants/Children (68)	
2011	Mothers	Mothers (62)	Total number of families = 478
	Fathers (n)	Fathers (46)	
	Infants/Children (n)	Infants/Children (88)	
2012	Mothers	Mothers (76)	Preschool children and their parents/carers Socially isolated families = 426
	Fathers (n)	Fathers (69)	
	Infants/Children (n)	Infants/Children (245)	
2013	Mothers	Mothers (41)	Preschool children and their parents/carers Socially isolated families = 221
	Fathers (n)	Fathers (53)	
	Infants/Children (n)	Infants/Children (94)	
2014	Mothers	Mothers (47)	Preschool children and their parents/carers Socially isolated families = 119
	Fathers (n)	Fathers (56)	
	Infants/Children (n)	Infants/Children (103)	
2015	Mothers	Mothers (62)	Preschool children and their parents/carers Socially isolated families = 275
	Fathers (n)	Fathers (73)	
	Infants/Children (n)	Infants/Children (335)	

Year	FamilyZone Community Hub (n)	Being with Baby (n)	Basis for participation
2016	Mothers	Mothers (74)	Preschool children and their parents/carers Socially isolated families =74
	Fathers (n)	Fathers (70)	
	Infants/Children (n)	Infants/Children (92)	

Table 4.1 (above) illustrates the total numbers of families and children being serviced by the FamilyZone Community Hub and the Being with Baby program. Of note is the AEDC results indicating that especially from the years 2012 to 2015 there has been an increase in the numbers of vulnerable children and the domains of vulnerabilities in children in this area. Therefore, more investment in programs such as Being with Baby is needed to address the community deficits. The Being with Baby program provides practical strategies based on children’s developmental needs that are child-centred and strengths-based to build parental capacities and abilities. These attributes are captured in the thematic analysis section.

Table 4.2 (below) illustrates the types of participants involved in each stage and step of data collection. Table 4.2 also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Being with Baby program. Additionally, Table 4.2 provides an explanation for the type of data collected and the level of involvement of the participants. The Being with Baby program has developed a reputation (see Themes) for assisting parents in developing and maintaining a positive and productive relationship with their children through activity. The methods used in the data collection inform the analysis used in the evaluation.

**Table 4.2: The type of participants and method of data collection used**

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
Providers (managers and staff) (S)	3	Responsible for delivering the CfC Being with Baby program.	Focus group interview. Staff also provided observational information (on behavioural changes in families and children), or phone interview.
Parents (P)	14	Participated in the	Focus group, and Face-to-

<b>Participant Type</b>	<b>Numbers</b>	<b>Basis for Recruitment</b>	<b>Component of Research Involved In</b> (e.g. survey, interview, focus group, observations)
		Being with Baby program	face/phone interviews.
Pre-program EPDS quantitative data set	27		Pre-Program data collection over several years.
<b>Total</b>	<b>44</b>		

There was a total of 44 participants providing various types of responses used in this mixed method report. The Being with Baby program staff and parents were interviewed or participated in a focus group as per Table 4.2 (above). Table 4.2 illustrates the role of each participant and the component of responses provided by each participant, such as in an interview. The 27 participants completing the EPDS questionnaire were tracked and matched, that is, participant 1 for the pre-program questionnaire was the same person as participant 1 in the post-program questionnaire. The 14 parents contacted for a focus group or interview were 13 mothers and 1 father. The component for participation was organised by the researcher in accordance with the participant's wishes and convenience, for example all parents were offered a focus group or interview. Interviews were conducted either face-to-face or via the phone as per the participant's request. All interviews or focus groups were conducted in a private and safe place. The theoretical links discussed during the interviews included attachment theory, ECD practices, Circle of Security, and trauma-informed principles of service delivery which are explained in previous sections of this report. The information collected outlines the intensive support provided by the Being with Baby program assisting families and their children to deal with social and cultural issues of becoming a parent along with caring for a baby appropriately.

The use of complimentary and foundationally similar programs enhances the practical application of the interventions provided to parents to assist the parent in changing their child's behaviour. The literature review and data collected supports the findings that these programs are not only imperative to the populations they serve, but also meet the broader and direct aims of the CfC Federal government strategy, the Being with Baby program, and the use of the community hub service delivery model to deal with community disadvantage and at-risk children. The use of several sources of data, informants, and information provides a robust analysis and evaluation of the Being with Baby program.

It has been established above that the use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry & Willis 2013). The key informants in the Being with Baby program were The Salvation Army, FamilyZone managers and direct delivery staff, and parents, who provided the theoretical knowledge and background for the program development and implementation.

Bearing in mind that Being with Baby is a training course with weekly sessions delivered over an eight week period, with each session having a duration of approximately 2 hours, the course equips mothers/mothers-to-be with tools, tips and knowledge on how to better care for themselves and their child.

Once a referral is received, the course facilitator contacts the potential participant. Most participants are home visited prior to the course. A welcome letter is also sent to each attendee. The course facilitator customises the course to the specific needs of the attendees but addresses the following core topics:

- Stress and anxiety management
- Self-care
- Mindfulness
- A baby's relationship with their mother/attachment issues
- Child development (including the importance of play for a child)

The course also includes social outings, such as trips to the library, to increase the confidence of participants to be involved in the community. A crèche is also provided for mothers attending the course with a strong emphasis on developmental activities for the children. Being with Baby attendees/partners of attendees are also strongly encouraged to access other services during and after the delivery of the course including:

- 'Dad's Matter' Group (parenting support group for fathers)
- Dad's playgroup
- Being with Baby specific playgroup (to allow transition into a mainstream playgroup)

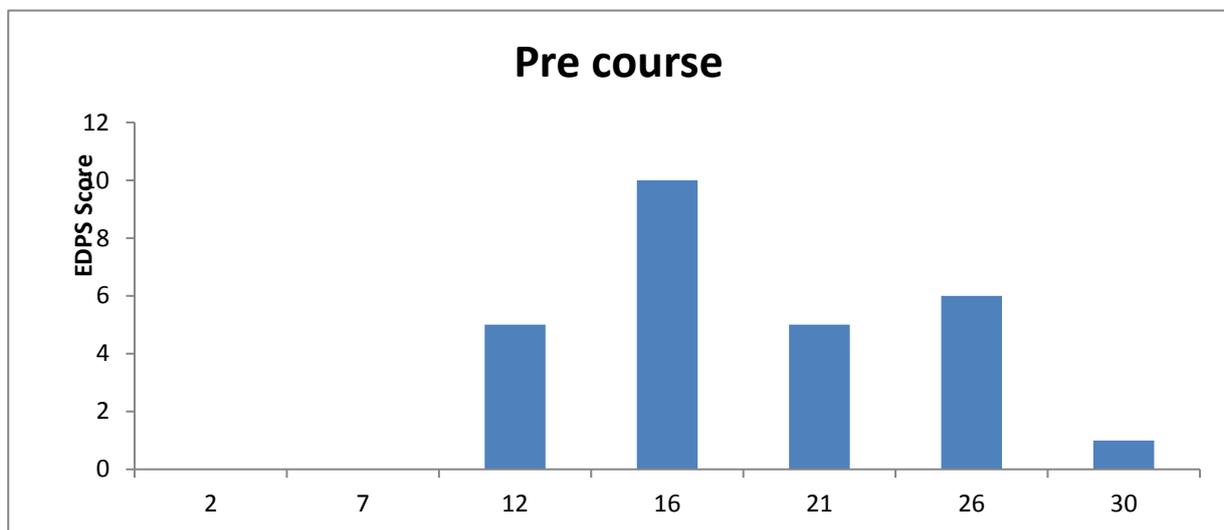
The following results confirm its effectiveness in addressing the aims of the program. The pre-program participation data analysis found that from 4 groups conducted during the following time periods:

- Group 1: 4/05/2013 to 21/06/2013
- Group 2: 22/07/2014 to 9/09/2014
- Group 3: 5/02/2014 to 26/03/2014
- Group 4: 7/10/2015 to 25/11/2015

A data set from a total of 27 participants was included in the evaluation with 89% of course participants home visited and 93% attending 90% of all sessions. This highlights the ability of the program to engage with these vulnerable and difficult to reach population groups. The results in presented below in Graph 4.1 are derived from all the program participants during the data collection period. All participants attended a minimum of 6 out of the 8 sessions. Additionally, a paired t-test was conducted to evaluate the differences between the pre and post EPDS scores. The pre and post responses were matched. These results are displayed in Table 4.3 (below).

The results in Table 4.3 from the pre and post EPDS demonstrated that there was a strong correlation,  $R^2=0.81$ , between the pre and post EPDS scores demonstrating a strong linear relationship. These results confirm that as attendance rates increased (dosage), so too does the improvement in mental health and decrease in levels of depression. It was also noted that there was a significant difference in the means,  $p < 0.05$ , with the EPDS indicating a drop of by 3 points, on average, for participants after completion of the course. Histograms were plotted to determine whether data was of a normal distribution to ensure the validity of performing a t-test. This was confirmed in Graph 4.1 (below).

**Graph 4.1 Pre-program EPDS Being with Baby scores.**



Graph 4.1 (above) clearly illustrates the average score for most participants on the EPDS was 16 with 10 participants scoring this average. Furthermore, the mean illustrated in Table 4.3 is representative of the average EPDS score for the participants in the sample. Graph 4.1 also highlights the normal distribution of the data which is useful in establishing

the parameters required before performing any further analysis. Therefore, the data present in Table 4.3 is valid and robust and this is reflected in the results.

Table 4.3 (below) provides a summary of the results obtained from the data analysis.

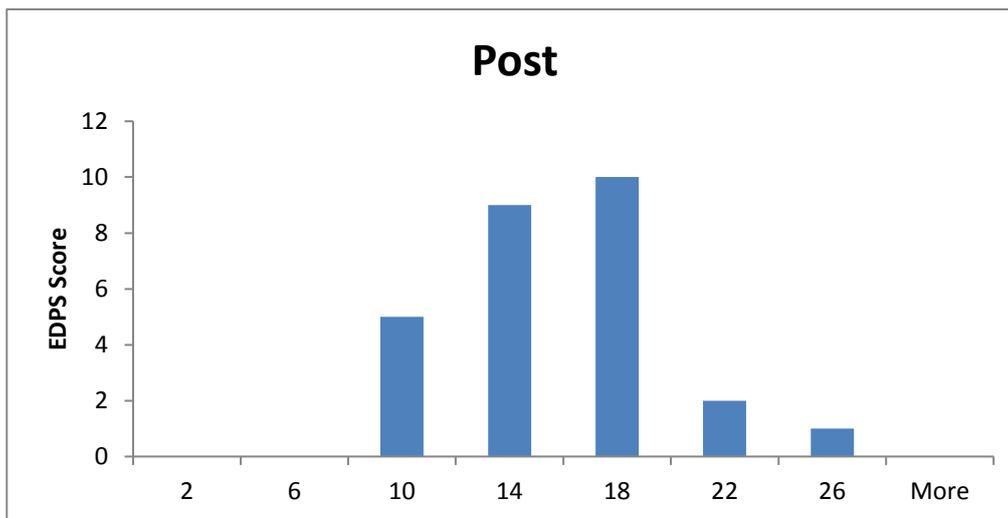
**Table 4.3 – t-Test: Paired Two Sample for Means**

Results	pre-EPDS score	post-EPDS score	Significance
Mean	16.33333333	13.44444444	
Variance	23.61538462	17.94871795	
Observations	27	27	
Pearson Correlation	0.814514675		
Df	26		
t Stat (t value)			5.29. p<0.05
P(T<=t) one-tail			7.65. p<0.000
t Critical one-tail			1.70 p<0.000
P(T<=t) two-tail			1.53 p<0.05
t Critical two-tail			2.05 p<0.05

In Table 4.3 (above), the results indicate that there was a significant difference between the EPDS score before and after participation in the Being with Baby program. This indicates a change in the level of depression experienced by the mothers following participation in the Being with Baby program. There is an important decrease in the mean from  $\bar{x}=16$  to  $\bar{x}=13$ . While this is still above non-clinical levels of postnatal depression using EPDS it is a marked improvement. This conclusion is supported by the DSS Data Exchange SCORE Graph 4.2 (below).

The post score illustrates an improvement in levels of depression as captured by the EPDS screening tool. Therefore, participation in the Being with Baby program and attending FamilyZone have somewhat improved maternal levels of depression.

**Graph 4.2: Post Being with Baby average score and distribution**

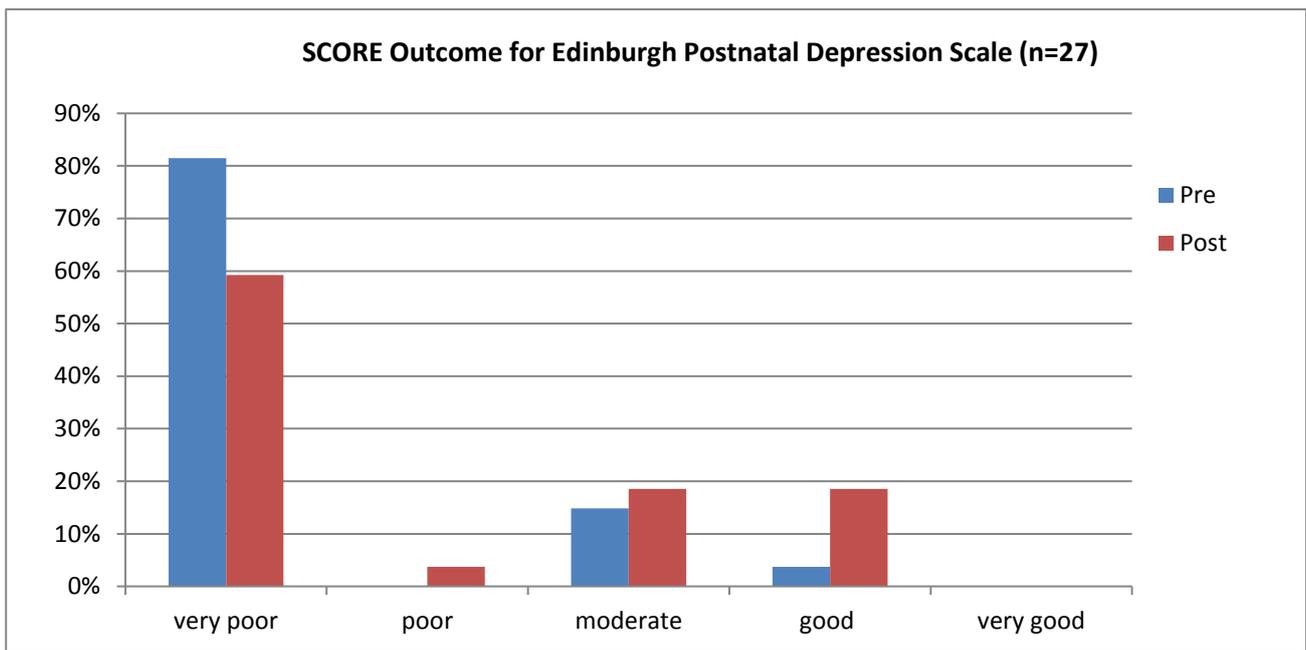


The EPDS scores were also translated using the DSS Data Exchange SCORE methodology. This demonstrated that there was a significant improvement (reduction) in the EPDS scores with a 22% reduction in the number of participants with lowest SCORE rating and a 19% increase in the number of participants with a moderate/good SCORE rating. As suggested in the DSS Data Exchange SCORE methodology, these results show progress in achieving the following outcomes:

1. SCORE Component 1: Changed client circumstances, Domain: Mental Health, Wellbeing and Self-Care which is expected to be a result of the following outcomes:
  - a. Improved mental health of mother
  - b. Increased understanding of self (emotions, actions, thoughts, strengths and values)
  - c. Improved mother/child health and wellbeing through increased attachment/child development knowledge
2. SCORE Component 2: Progress in achieving individual goals, Domain: Changed Behaviours which is expected to be a result of:
  - a. Information and education on child development/needs
  - b. Improved parental self-efficacy

The DSS Data Exchange Score represent a method of validating the change between the pre and post participation in Being with Baby. The Being with Baby program may improve levels of depression in mothers attending the program. This is presented in the Graph 4.3 (below).

**Graph 4.3: DSS Data Exchange SCORE.**



Graph 4.3 (above) demonstrates that participation in the Being with Bay program provides a significant improvement on the mothers' mental health, evidenced by the decrease from over 80% having very poor mental health to under 60%. Given the links between poor maternal mental health and child developmental outcomes this is an improvement for the children as well. The use of quantitative research has shown an improvement in maternal mental health by participating in the Being with Baby program and the qualitative results presented below support this conclusion.

### **Qualitative Results**

Imperative to the qualitative aspects and methodology of this research project was the use of multiple coders (Patton 2000; Tong et al. 2007). Each transcript was coded independent and manually and then comparisons were made for consistency of the emerging themes (Tong et al. 2007). Further, while the method of data collection varied as the community partners, external service provider staff, managers and staff participated in face-to-face or phone interviews, and the parents participated in focus groups, the fundamental premise of questions regarding the Being with Baby program remained the same. Additionally, follow-up information for clarification provided further data and information to understand and elucidate participant meaning and attributions of some of the data and information provided. The parents participated in small focus groups or face-to-

face/phone interviews. The main themes arising from the interviews and focus groups are summarised below.

## Themes

It is imperative to remember that there was a dearth of services in the Ingle Farm and surrounding areas. It is also crucial to note that this area has been one of the highest levels of child developmental vulnerability in Australia. There were four main themes found within the data. Data saturation was achieved in all areas presented below. The sampling of families ceased once the saturation of themes occurred (Mason 2010). Mason (2010) maintains that there is a point of diminishing returns where further interviews add little to the defensibility of the research process and findings.

Interestingly, there did not appear to be any difference in comments between the Being with Baby and FamilyZone Community Hub parents and staff. The inclusion of the FamilyZone Community Hub was outlined as imperative to the mothers attending Being with Baby as it provided support when the program was not available. For instance, if Being with Baby occurs on a Thursday then FamilyZone was used on the other days of the week as a support hub for mothers. All participants found the Being with Baby program to be a unique and high quality program. The use of multiple sources used from a variety of perspectives increases the robustness and validity of the responses presented here. The use of narratives ensures the richness and the depth of the responses. The themes presented below are in order of importance within the data with Theme 1 being more prevalent than Theme 2, etc.

### **Theme 1: Improved child development knowledge and improved caring for children**

All participants responded positively to this theme. The views presented in this theme have been derived from all participants including, the staff, managers, community partners, and parents/caregivers. The improvement in knowledge on normal children development and meeting developmental milestones is imperative in decreasing children's developmental vulnerabilities. The responses quoted below are indicative of the responses from the participants:

*I thought I knew about kids and how to bring them up, I'm a grandma, but it wasn't until I volunteered to help support the mums with postnatal depression that I realised how little I knew and I was a receptionist at xxxx before (S3).*

*I now have friends here and they are good friends and provide positive support...it also helps that I know more stuff now about how to look after my baby and what to expect, you know what happens next. The Being with Baby programs has given me so much I now know what to do to help my kid you know get their brain to grow and what to do to keep them happy and interacting (P6).*

*I have learnt so much about how kids grow up and what they need to grow up. I didn't know it before. I never learnt it in school or anything and I have no family here to teach me all this stuff (3).*

*I was talking to my mum, she's interstate, and didn't know this stuff about how baby's brain grows and what it needs. (P4)*

The comments above link the theoretical premise of the programs, and the use of the internationally researched programs to the outcomes for the participants. There are well-recognised and documented links between the lack of parental knowledge of child development and developmental vulnerabilities.

## **Theme 2: Decreased perinatal and postnatal depression and kept baby safe**

The views presented in this theme have been derived from all participants. That is the staff, managers, community partners, and parent's/caregiver's views are acknowledged here. In many instances, there were positive comments about the comprehensive nature of the individual support, parenting support and supportive links provided by the Being with Baby program through the parenting support, advice, and changes, using supportive modelling of parental behaviour techniques, child behaviour change techniques, managing stress strategies for children and adults, and referrals to other community providers. Further, there were positive comments claiming that the Being with Baby program had driven changes in the parents' lives that would not have been achievable without the program or the FamilyZone Community Hub. Examples included 'I wouldn't be here if it wasn't for Being with Baby and FamilyZone' and 'Being with Baby gave me the confidence to learn new things and now I have a job'. These changes would not have occurred prior to the parents attending the programs. The quotations below reflect the managers and staff (S), community partners (CP), and parent's/caregivers (P) responses to participating in the Being with Baby program:

*Being with Baby has saved my life, literally. I was diagnosed with Severe Postnatal Depression, my Psychiatrist wanted me to be admitted to Helen Mayo House. I was going to end it for me and my baby. My Psychiatrist rang Helen Mayo House [SA maternal psychiatric*

unit] and asked that I get admitted immediately, but they didn't have a bed. Luckily I came here to FamilyZone, and Kathlene got me into Being with Baby straight away...Helen Mayo House did not have a vacancy for 12 months. 1 year later they rang back and said they had a spot for me. If I had waited for them neither me or my baby would be here. It frightens me to think what would have happened (P1).

I was really depressed and couldn't leave the house. I was in a bad way. If I admit it, I wasn't looking after baby either...I couldn't cope. I got a home visit through Being with Baby and I came to FamilyZone. When Being with Baby wasn't on I came to FamilyZone. I was every day Monday to Friday 9 to 5 at FamilyZone. It kept me sane, I was losing it. The staff at Being with Baby and FamilyZone understood and helped me. I would hate to think what would have happened if Being with Baby and FamilyZone wasn't here (P2).

The Being with Baby program and theoretical basis is used throughout FamilyZone there is a consistency here...its supportive and a welcoming family environment. The parents aren't judged. It assists the parents to cope with parenting and decreases levels of vulnerability in the children (S2).

I was in a very bad way...I had been told to go to Helen Mayo House, my depression was really bad. My psychiatrist put in a referral for an immediate place in Helen Mayo. I needed to be admitted straight away. In the mean time I went to Being with Baby and FamilyZone. I went every day [to FamilyZone]. I needed that level of help, you know daily help. The [FamilyZone] staff were always supportive and guided me to connect to baby. I was on the waiting list for Helen Mayo House, my psychiatrist said it was very urgent, but it took 12 months before a space there [Helen Mayo House] opened up. If I didn't have Being with Baby, and FamilyZone or Home visiting, I wouldn't have survived. I know I was so ill. It's not ok to be so ill and have to wait 12 months. So FamilyZone and the programs was very important, I would hate to think what would have happened to me and baby without their support (mum crying) (P3).

I was diagnosed with depression and anxiety. Other services didn't meet my needs and didn't welcome my children. Other services didn't even recognise my needs or help support my parenting. You feel like a number or all the same...just someone else with anxiety and depression. But FamilyZone you never feel that, they are so professional, so approachable and that's really important when you are depressed. They know their stuff about infants, children and me, and they're so supportive of me and my children and my needs as a parent. They really care (P4).

The skills provided by the Being with Baby and in FamilyZone are foundational for the best start to parenthood and directly address Postnatal Depression. The complimentary

and interwoven theoretical basis of the program informs the delivery of skills for parents. Along with the delivery model that ensures a holistic and wrap around individualised service delivery model. The staff assess the needs of each child and parent, and direct the activities to meet the levels of parental anxiety and depression, along with the language, social, learning and developmental needs of the infants and children. This process also includes a focus towards an overall end-point of preparing the children for entry into kindergarten and school.

### **Theme 3: Links to education and then future employment**

The views presented in this theme derive from all participants. All the parents and staff interviewed discussed the confidence gained through the Being with Baby program and attending FamilyZone.

*I have got my confidence back. With the parenting programs, Being with Baby especially. The whole atmosphere there [FamilyZone] is one of support and no judgment. This confidence helped me to want to learn. I didn't feel like that in high school so it was really different for me. I wanted to learn other things so I went on to TAFE and then uni, and now I have full time work. Without FamilyZone and Being with Baby I wouldn't be in work...I couldn't have done it without them. The emotional support and sometime practical support just helped me so much. They helped link me into the education that would help me go forward (P10).*

*They helped me return to the workforce. I have postnatal depression so bad and Being with Baby made a difference. The depression really knocked my confidence and they [Being with Baby staff] got me back to work. I couldn't have done it without them (P6).*

Another prominent response theme was that of isolation. From the literature above, it is recognised that isolation is a risk factor for children which can lead to higher incidence of behavioural problems, abuse and neglect, along with failure to meet developmental milestones. Most of the parents discussed their isolation from other families and services and the Being with Baby program had provided a means for them to connect to others. Gaining support and understanding with issues that accompany parenting. The parents recognised that isolation had negatively impacted on their parenting capacity. The skills attained through the Being with Baby program and supportive staff had helped to link the isolated families with other families, other children and their community. This enhanced the support the parents and children received. The therapeutic interventions were constructed to alleviate the impacts of issues described below. The use of the activities are specially

designed to improve the child/parent interaction and relationship while connecting isolated parents, and enhance parental attachment to their children.

#### **Theme 4: Isolation**

The views presented in this theme have been derived from the professionals delivering the program and the parents participating in the program. Isolation is a recognised risk factor for children increasing the vulnerability of the children and the family. Additionally, the method of therapeutic intervention allows the parents/caregivers to receive support from one another in a purposeful and constructive manner. These aspects are illustrated in the quotations below:

*I was so isolated. I have no family here [South Australia] and my husband family is all rural SA. So there is no one to turn to when baby is unwell and stuff. But I came to Being with Baby and I have met some great mums and workers, and I know I can get good and sound advice from them (P4).*

*My mum wasn't much good, I was taken into care when I was young, so I had no one to show me how to parent, you know, what to do. The Being and Baby staff don't judge you they just help you. The whole Circle of Security stuff it makes great sense (P7).*

*Even when you are having a really bad day and feeling really isolated with FamilyZone you have somewhere to go. The programs like Being with Baby are get you get so connected to other mums, worker and community stuff. It has helped so much. I just can't over emphasise how great it is (P6).*

*Relatives may try but they just don't get it. I have 3 children and they all have different needs one has sensory problems. Relatives just don't get it but at FamilyZone they do get it. It is such a relief when you go somewhere and they get it. You don't have to worry about how people are going to respond. They [FamilyZone and Being with Baby] have given me some great coping skills and things to use to help all 3 children with their behaviour. The Being with Baby was my first contact with FamilyZone and both things have been brilliant. It saved my sanity. I would be lost if it wasn't here. The Being with Baby helped me connect and care for all 3 of my children. FamilyZone helped connect me with other services, like health, and education and other community services that have been very important in supporting our family (P9).*

*I have 4 kids and all 4 I have brought here. We don't have any family here [South Australia]. So I was very isolated and my partner was too. He has come to the dads stuff here and the Being with Baby dads programs and he has a much better connection with the kids now. I*

*had the home visiting program too and that was great I couldn't leave the house sometimes but I really needed that connection. FamilyZone and Being with Baby meets all mine, and my children's needs, it's so individualised which is what you need sometimes and it's there when you need it. Not, you know, like this 6 weeks we do this and this 7 weeks we do that. Those programs haven't worked for us they are just not there when you need them and just not long enough. Sometimes we cover Circle of Security, and sometimes its attachment, it is what we need and what will work for us [group session]. I've been to other programs and once you have done the time its shut so you can't go back next week and get help no matter how bad things are. FamilyZone and Being with Baby stop things from getting worse as they are there when you need them. It's a much better way of working with families I think (P5).*

These comments capture that for families dealing with isolation there can be stress, depression, and anxiety. According to the literature, isolation is a major risk factor for infants and children. The Being with Baby program and the FamilyZone Community Hub provides the opportunity to connect with other families, support services, and educational opportunities (for parents and children) that would not have been available to the parents had they not attended the services. The Being with Baby program and the FamilyZone Community Hub provide interpersonal relationship-building programs in a physical, psychological and social space that promotes parent/child relationships. The small group environment and one-to-one service delivery at times of parental stress enables the parents to deal with the impact of isolation and ensure the children are connected to professionals able to handle child and parental distress effectively. The staff model opportunities to be calm with their young children and promote an environment that encourages child development and behavioural control. This is coupled with the instruction, knowledge and skills that enhance positive interpersonal support, relationships and respect.

### **Theme 5: Increased racial tolerance and understanding**

Although this theme was not a direct focus or aim of the Being with Baby program and the FamilyZone Community Hub environment, it was discussed as an important outcome by the parents and staff interviewed. The views presented in this theme have been derived from the all the participants, including staff and the parents participating in the program. The outcome of racial tolerance is an important outcome for the community as it is a recognised risk factor for children, increasing the vulnerability of the children and the family.

*The FamilyZone and Being with Baby are great along with the whole atmosphere there. My children have been exposed to different cultures, you know people who look different. My kids don't get that anywhere else and it prepares them for school as in this area we have a lot of migrants and refugees. My kids don't get that anywhere else. The kids get to do Aboriginal painting and learn about Aboriginal culture. I have joined in with the Afghan women's group and I'm an aussie. I have learnt so much about how difficult life has been for them. It has helped me to understand more (P8).*

*I was home-visited, I had a buddied with one of the volunteers/staff here, I am happy about this, and it was great as I [go to] know this person and he [she] were Australian, and the whole thing was great help to fit in here...I found everything hard here, things are so different from where I'm from...the health system I didn't know about Medicare and other things. On days I don't feel like go out of the house they [worker] come here and it helps (12).*

*There are lots of different programs the families can become involved in...often they come to Being with Baby and then join other programs or are linked in with other supports. One of the most amazing things is to see the local mums supporting the Afghan mums and joining in the activities...all the babies and children play happily together and it helps create a community harmony and increases levels of tolerance (S1).*

This finding is of note as it was unexpected and highlights the extended and unexpected consequences that occur from programs using a community hub model of service delivery. The Ingle Farm area has become multicultural over several years and concerns have been raised by community leaders regarding community harmony. Additionally, the programs use a range of referral pathways to other professionals to provide inter-disciplinary and holistic family interventions. These types of initiatives are important as it connects the programs with the isolated families and prepares the family and child for integrations into the health, education and social systems.

## **Summary**

The themes discussed above occurred frequently throughout the transcripts analysed. The transcripts were independently reviewed and themes compared by the researchers against the themes arising in the literature. This ensured an inductive and deductive research procedures and methods were applied to the transcript analyses. The themes illustrate that the community partners, external other service staff, and parents were unanimous in their support of the program, the uniqueness of the program and its ability to

meet the needs of the children and improve their child behaviours and interpersonal relationships. Many parents spoke of the fundamental and unique support and knowledge provided by the Being with Baby and FamilyZone staff which they believed to be critical to the success of the interventions the Being with Baby program provided, 'making a profound and important impact on the children and families' involved with the service.

The Being with Baby program provides high-quality interventions and the necessary referrals, supports, professional practices, modelling and behavioural interventions that reduce parent mental health issues and the risk for children in failing at kindergarten and school, along with improving support of the families and empowering families to make changes to address issues and problem behaviours. The importance of these interventions cannot be overstated for the children and families involved. These findings are repeated throughout the results section of this report.





## ***Section five:***

### ***Discussions and conclusions***

As stated in the Introduction, it is well established by Early Child Development (ECD) that for infants, children, and adults to succeed educationally, socially, and psychologically, and participate as productive members of a family, community and society, then participation in well-conceived and evidence-based high quality ECD programs is paramount. The research indicates stark differences between those who participate in well-conceived ECD programs as successful learners in kindergarten, primary, secondary and tertiary education (Mustard 2006; DoCS 2009; Dockery, Grath et al. 2010; Mustard 2010; Reynolds, Temple et al. 2011). On the whole, young children who participate in high quality ECD programs are more competent socially and emotionally, and show higher verbal and intellectual development (Mustard 2006; DoCS 2009; Dockery, Grath et al. 2010; Mustard 2010; Reynolds, Temple et al. 2011). The Being with Baby program provides child development knowledge, such as the importance of play, language, structure and activities for children's learning. Developmental knowledge assists the parents in providing a home environment that aids child learning and safe development. Neurobiological and brain development information is also given to the parents. This can aid in the understanding of children's behaviour and needs.

The use of the activities is specially designed to:

- improve the child/parent interpersonal relationship
- increase the child's social and empathic development
- increase positive reading and language development
- increase the adult's knowledge of child development
- improve and increase the provision of age appropriate play, pretend play and activities
- address some aspects of obesity through increased physical activities
- improve a sense of self-worth of the parents
- enhance attachment
- provide purposeful and well-constructed activities that meet the children's developmental milestones such as fine and gross motor skills
- model exemplary parenting and attachment behaviours
- provided one on one support for parents having difficulties with parenting skills

These aims/goals of the Being with Baby program have been achieved according to the literature evidence-base, qualitative and quantitative data analysis, findings, and research outcomes provided in the previous sections. The participants outlined the positive changes that had occurred as a direct result of attending the Being with Baby program and the use of the FamilyZone Community Hub.

The intensive supported provided in Being with Baby, including home visiting and the added support provided by the FamilyZone supportive learning environments and activities, improved the parenting skills of those who attend and the overall quality of parenting provided to children of those families. Additionally, the managers and staff modelled appropriate child engagement behaviours and strategies for the mother to use at home. Furthermore, the Aspire staff provided one-on-one sessions for parents who appeared to be distressed or struggling thereby circumventing future parenting problems and providing a strengths-based approach to parental skill development.

There was a great deal of discussion on the need for the program to continue and expand given the uniqueness of the program and its outstanding involvement of disadvantaged families. This outcome is also maintained by the literature. Furthermore, the research has outlined that only evidence-based therapeutic prevention and intervention program improves the levels of family functioning that are equivalent to this program outcome.

The literature supports the findings here. Attachment programs are instrumental in promoting maternal bonding, sensitivity to infants' needs and responsiveness to the children's emotional needs (Suchman et al. 2010). The findings are consistent with the international results that state that all services provided in a non-stigmatised environment are empowering in their focus, results, and are strengths-based orientated, and that 'soft entry' provided better longer term outcomes for families and community (EUROCHILD 2012; Suchman et al. 2010). Furthermore, the results support the use of multi-component programs and highlight that these programs provide better outcomes than singularly focused ones (NSW FSC 2014; EUROCHILD 2012).

The use of multiple components and elements in Being with Baby that are provided in a place-based community hub service delivery model enables the clients to engage within their own distinct comfort zone. The parents decide their own level of need and how they will become engaged in the FamilyZone Community Hub and Being with Baby. This creates a unique level of trust not available in single delivery programs in an unsupported site that are more amenable for use with advantaged populations. The families then build on the relationships with each other and the staff to use the hub in an ongoing manner. This process and delivery model also enables the staff to monitor the child's development and suggest areas of support that the parents may need. The use of the 'warm' referral and 'soft entry' then promotes a trusting environment where staff suggestions are acted upon and entry into developmental programs are actively pursued by the parents/caregivers.

The use of Attachment Theory, Circle of Security, and knowledge of child development across all programs at Family Zone ensures that the changes in parents and children are consistent and standardised due to the use of validated and reliable intervention techniques and practices. The use of staff trained to deliver consistent intervention is central to the success of the program.

Furthermore, given the vulnerability of the target populations attending, the stability of the staff has also enhanced the use of this program. Vulnerable populations can present as difficult to engage; however, the staff have successfully gained the support of the community and the target participants.

## **Limitations**

This evaluation research is limited as the results are specific to the Being with Baby program. Also, fathers were barely interviewed or present in any of the focus groups. Only

one father was interviewed. The mothers interviewed did express a need for more engagement with fathers. The mothers did acknowledge the availability of programs for fathers but there remained an unwillingness for fathers to attend. The program would benefit from a data collection process that included a dosage result that would enhance correlational analysis.

## **Conclusion**

The Being with Baby program uses several evidence-based complementary foundational theories to deliver a unique program that addresses the needs of this disadvantaged community with higher than average levels of childhood vulnerability. Theoretically, evidence-based interventions are successful and this is supported by the numbers of main themes found within the data that discuss the importance of the program and the difference it has made to: how the parents relate to their children; the improvements in the child's behaviour; and school readiness. It is also evident from the interviews and focus group data provided that this would not have occurred without this program, and the children would remain exposed to unacceptably high levels of vulnerability, which would impact on their schooling and their ability to learn. The success of the theoretically-substantiated and evidence-based programs has been enhanced by the delivery of these programs by highly qualified staff who are well connected with the target population and the local community.

The methods used to collect the data have informed and enhanced the use of different types of analysis. This process has further validated the results and provided evidence that has triangulated, substantiated and corroborated the data from many sources. The similarities in the themes, were consistent across all types of data collection. This is testament to the use of theoretically-based and evidence-based interventions and methods of working with at-risk families and children. Additionally, the use of multiple informants and key stakeholders has provided a circular process that ensures triangulation and robustness of all data collection and the research process.

The use of the community hub model of service delivery enhanced the Being with Baby program and the effectiveness of the program also benefited from being multi-component. If either of these aspects of the program or service delivery were missing there may be an impact on the success of the program and its effectiveness.

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# **Program Manual**

## **for**

# **Being with Baby**

**This manual is a guide to the operations of Being with Baby with parents / carers and their children. The program provides opportunity for parents to learn new social and emotional skills in working with their children. Discussions with parents/carers about parenting will follow some of the information from the Foundational Principles listed theories and programs.**



<b>Week 1</b>	Welcome & Introduction Housekeeping Paperwork: Pre-assessment Group Norms & Aims <b>Group Discussion on Adapting to motherhood</b>
<b>Week 2</b>	<b>The Stress Management</b> Relaxation Strategies
<b>Week 3</b>	<b>Connecting emotions, actions and thoughts</b>
<b>Week 4</b>	<b>Connecting emotions, actions and thoughts</b>
<b>Week 5</b>	<b>Practical Activity</b> Experiencing the benefits of activity
<b>Week 6</b>	<b>Assertiveness &amp; Negotiation</b>
<b>Week 7</b>	<b>Strengths &amp; Values</b>
<b>Week 8</b>	Playing with your child <b>Play Power</b> (Angela Stephenson)

***Please note:*** During the course of the group, there may be an opportunity to have a guest speaker provide information and education on a particular topic. Your facilitators will notify you with as much advance notice as possible. Course topics and activities are subject to change.



**What is stress?**

Stress is a *demand* or *pressure* that's placed on you that can make you feel tense, unhappy, or uncomfortable. This demand or pressure is often called the *stressor*. Having exams, being told off by your boss, meeting a deadline, or moving house are examples of situations that many people find stressful.

When the demand exceeds our capacity to cope is when we experience stress.

Stress *can* affect us all in different ways. The table below lists some of the effects that people *may* experience. It is not a complete list, nor is it a list of what to expect in the future. It is simply a guide to show how stress *can* affect us physically, emotionally, behaviourally and can also have social effects.

<b>Physical Signs</b>	Head aches Tiredness Sickness Sleeping problems Backache Loss of pallor Baldness Chest pains	Increased perspiration Constipation/ diarrhoea Sore/ baggy eyes Posture changes Indigestion Palpitations High blood pressure Muscle cramps
<b>Emotional Signs</b>	Frustration Anger Self doubt Low self esteem Irritability Short attention span Blaming others Forgetting Over reacting	Feeling unloved Intolerance to noise Reduction in will power Uncontrolled emotions (rage, crying, etc.) Anxiety Depression Boredom
<b>Behavioural Effects</b>	Eating too much Increased alcohol intake Increased smoking Nail biting Reduced sex drive Absenteeism	Proneness to accidents Inability to relax Inability to finish tasks Impulsive behaviour Inability to make decisions
<b>Social Effects</b>	Poor relationships with others Inability to fulfil social and family roles	Social isolation



#### **What is relaxation?**

Relaxation is a way of producing a quiet body and a calm mind. The physical and mental unwinding is termed the relaxation response and it counteracts the stress response.

People who normally live with a high degree of tension and/or stress are more likely to experience problems when an extra stress occurs.

These people may be able to lower their general level of tension by practicing regular relaxation techniques as a prevention to overstress. By regularly practicing relaxation techniques and strategies additional stress may be better tolerated.



#### **How can I become more relaxed?**

- You can *physically* relax by letting go of tension in your muscles (e.g. stretching & other exercise)
- You can *mentally* relax with various techniques to alleviate thoughts which can cause tension (e.g. meditation techniques, cognitive behavioural therapy (CBT) )

#### **What will assist me to relax?**

1. *A place free* from sudden sounds and interruptions
2. *A suitable time.* Relaxation is slightly less effective after a meal, and it is important to allow a cooling down period after strenuous exercise. Otherwise any other time of day is acceptable. Try slotting it in at a regular time to allow it to become a habit. It is best to build up your relaxation time, so that you may have an opportunity to practise every day.
3. *A position* in which you are able to let go of muscle tension and in which you won't fall asleep – unless that is your aim.
4. *A mental focus* to occupy your mind, encouraging positive thoughts and visualisations.
5. *The right mental attitude.* You cannot make yourself relax, but you can allow it to happen. Accept the fact that your mind will stray, and there may be disturbances, or discomforts initially. Gently return your focus, reaffirming the benefits of the process.
6. *Willingness to practice.* Regular practice will help you relax more easily, deeply and pleasantly. You may find in time that can bring about a relaxed state in situations that were difficult for you at the start of this process.



***How can relaxation benefit me?***

It may help you to:

- Think better and enjoy improved concentration
- Feel calmer. Happier and more energetic
- Improve co-ordination
- Relieve pain and physical discomfort
- Lessen the risk of stress-related illnesses
- Enjoy a more restful sleep
- Use your imagination more creatively
- Improve your relationships, because people respond more warmly to a relaxed and friendly person.

**Relaxation has no side effects.**



It feels good, costs nothing and is a skill for life!

## simple strategies



**A handout for women**  
**Circle one thing from each area you will do for yourself within the next week.**

### Physical

- Reconnect with exercise and your physical fitness (there is evidence that this kind of activity measures up to the effects of antidepressants)
- Keep a healthy diet and keep the fluids up
- Keep the daily goals small!
- Accept practical help from partner, family, friends, neighbour, church etc.

### Psychological

- Keep note of what you did well (for example, fed baby, got dressed, cooked a nice meal, made contact with someone, went out for a walk)
- Keep a reflective journal and use this with your worker and GP to talk about issues
- Remember to take it one hour, one day, one week at a time
- Utilise parent help lines in your state
- Spend time noticing your body's reactions and think about what your baby is thinking and feeling

### Personal

Now is not the time to meet others needs, its time to focus on yours, the baby's and your partners. Others needs will just have to wait.

- Organise childcare for childfree time
- Return to work part-time
- Meet up regularly with another parent(s) to swap time, talking, and listening
- On the days it feels really bad, do something that used to give you a lift (and do it even if it doesn't feel like it works) eg your favourite music, wearing bright clothes, gardening, bushwalking, a craft activity, call someone and ask them just to listen and be there while you have a good cry

### Peace

Motherhood changes every aspect of who we are as women, our body, our mind, our relationships. Finding things that help you to feel good, whole, 'together' inside will help, however you may have to do them many times before you start to feel better more of the time.

- Do one nice thing for yourself
- Do yoga, relaxation
- Meditation
- Quiet time out in the sunshine
- Listen to your favourite music
- Play your favourite musical instrument.

### Useful websites

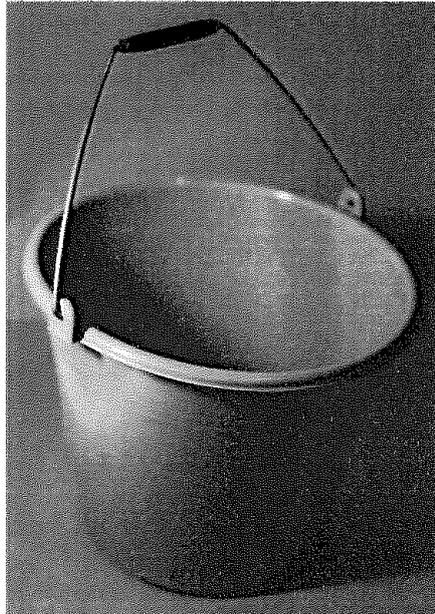
<http://www.zerotothree.org>  
<http://www.beyondblue.org.au/postnataldepression>  
<http://www.moodgym.anu.edu.au>  
<http://www.panda.org.au>

*Permission is granted to copy*

feeling attached - parent & infant mental health resources  
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## The Stress Bucket



We all have an inner 'stress bucket'. This is where we put all those things in our life that cause us stress!

Our bucket is made up of major stressors like money pressures and relationship problems, health issues and parenting. There can also be smaller stressors like being cut-off in traffic, running late for an appointment or not being able to settle a child. Additional factors that can contribute to our stress bucket can be hormonal levels, illness and lack of sleep.

Sometimes, without even realising, our stress bucket can get close to overflowing. If the all of our stressors have accumulated, smaller and smaller things can make us feel stressed and ready to 'overflow'. 'Overflowing' can take the form of anger, tears, anxiety, irritability or overeating

The good news is that we can lower the level of our stress buckets! There are a range of stress reduction strategies that we can incorporate into our everyday lives such as relaxation, positive lifestyle practices, engaging in enjoyable activities. Over the page are just a few examples you may like to consider.

## WAYS TO INCREASE SELF COMPASSION

**Self-Kindness** - "What would a caring friend say to you in this situation" "What is a kind and constructive way to think about how I can rectify this mistake or do better next time?" Try putting your hand over your heart or gently stroking your arm when feeling a lot of pain as a gesture of kindness and compassion.

**Self-judgment** - "Who ever said human beings are supposed to be perfect?" "Would a caring mother say this to her child if she wanted the child to grow and develop?" "How will I learn if it's not okay to make mistakes?"

**Common Humanity** - Think about all the other people who have made similar mistakes, gone through similar situations, and so on. "This is the human condition - all humans are vulnerable, flawed, make mistakes, have things happen that are difficult and painful" "How does this situation give me more insight into and compassion for the human experience?"

**Isolation** - "I am not the only one going through such difficult times, all people experience things like this at some point in their lives." "Although I take full responsibilities for my mistakes and failings, I also recognize and understand that my actions and behaviors are connected to other people's actions and behaviors - nothing happens in a vacuum."

**Mindfulness** - Take several deep slow breaths and try to be with your pain exactly as it is. Let yourself feel the pain without suppressing, resisting, or avoiding it. Take a moment to stop and say to yourself, this is really hard right now. Let yourself be moved and touched by your own pain. Try to see the situation clearly with calm, clarity and a balanced perspective. "I fully accept this moment and these emotions as they are."

**Over-identification** - Try not to get lost in the drama or storyline of your situation, feel the feelings as they are, without running away with them. Can you feel the emotions in your body (a constriction in your throat, knot in your stomach, etc.) without getting lost in the storyline behind the feelings? "These difficult emotions so on do not define me, such feelings will inevitably change and pass away." "Don't take your emotions so personally."

Dr. Kristin Neff - Human Development Area Educational Psychology Department, University of Texas at Austin  
<http://www.self-compassion.org/>

P:\Therapeutic Modules\Self Compassion\CARLSON & SELF COMPASSION.docx

## Be Grateful when you're feeling good and Graceful when you're feeling bad



The happiest person on earth isn't always happy. In fact, the happiest people all have their fair share of low moods, problems, disappointments and heartache. Often the difference between a person who is happy and someone who is unhappy isn't how often they get low, or even how low they drop, but instead, it's what they do with their low moods. How do they relate to their changing feelings?

Most people have it backward. When they are feeling down, they roll up their sleeves and get to work. They take their low moods very seriously and try to figure out and analyse what's wrong. They try to force themselves out of their low state, which tends to compound the problem rather than solve it.

When you observe peaceful, relaxed people, you find that when they are feeling good, they are very grateful. They understand that both positive and negative feelings come and go, and there will come a time when they won't be feeling so good. To happy people, this is okay, it's the way of things. They accept the inevitability of passing feelings. So, when they are feeling depressed, angry, or stressed out, they relate to these feelings with the same openness and wisdom. Rather than fight their feelings and panic simply because they are feeling bad, they accept their feelings knowing that this too shall pass. Rather than stumbling and fighting against their negative feelings, they are graceful in their acceptance of them. This allows them to come gently and gracefully out of negative feeling states into more positive states of mind .....

The next time you are feeling bad, rather than fight it, try to relax. See if, instead of panicking, you can be graceful and calm. Know that if you don't fight your negative feelings, if you are graceful, they will pass away just as surely as the sun sets in the evening.

From Richard Carlson (1997) *Don't Sweat the Small Stuff... and it's all Small Stuff*, NSW, Random House/Bantam.



### What we do-Behaviour & Action

*Behaviour is essentially anything that a person says or does. Our behaviour can be influenced by people and the environment we are in.*

Who we are in life, and how we relate to others is based around our *behaviour* or *actions*, not the way we think or feel.

We still have the ability to undertake certain actions, regardless of how we think or feel.

When it comes to *behaviour* or doing, we have direct control because *behaviour* can be influenced directly by our will.

We are responsible for our *behaviour* irrespective of how we think or feel.

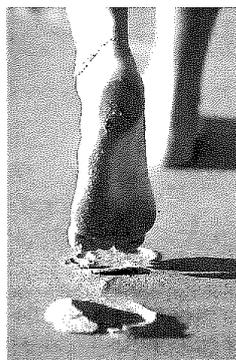
Actions can positively influence the way we think and feel

Actions or behaviour can assist us to keep our focus on the present

As we are able to manage our *behaviour* and actions we are able to improve or modify them so that they can work more effectively in supporting us in our day to day life.

People are valued for what they do, rather than how they think or feel.

It is the *action* or *behaviour* part of our lives that holds the key for us to move towards living a rich, full and meaningful life.



Adapted from Constructive Living Australasia Pty Ltd



**Learning to Accept Emotions** - adapted from Russ Harris (2007) [www.actmindfully.com.au](http://www.actmindfully.com.au)

It can be helpful when you feel an unpleasant emotion take hold, to first take a few slow deep breaths. Once you have done this, tune into your body to notice any uncomfortable sensations.

Now look for the sensation that makes you feel most uncomfortable, the strongest, or the one that may worry you. Everyone notices these differently. You may feel sick in your stomach, tense in your shoulders or your heart rate may have elevated a little.

Now move your attention to that sensation. Try to approach your attention to this sensation from a different perspective, with an open mind and curiosity.

Now begin to pay more attention and tune into this sensation. Where does this sensation begin and where does it end? In your mind, trace a line around the area. Where is the sensation the strongest, where is it the least strong? Is there any difference from the middle to the edges? Is it soft or hard, light or heavy? Is there any other feeling within the sensation? A pulse, a vibration? Is it still or moving around?

Try taking a few more deep breaths, going into the sensation, rather than struggling against it. Breathe right into it, visualising that each breath is flowing around and into that sensation.

In learning to accept this emotion, allow room for it. Relax the area around it, making a decision to allow it to be there. This doesn't mean that you have to like or enjoy this sensation, just simply allow it to be.

Observing the sensation does not mean to think about or analyse it. If your mind begins to question it and ask questions, simply acknowledge it, and bring yourself back to observing, almost like from a third party perspective with a child like curiosity.

Like with many things that are new or different, you may initially find this process difficult or even strange. Your automatic response may be to fight against the emotion, to analyse it or push it away. If you are experiencing these difficulties, that's ok too. Just acknowledge this in it's own right, and allow yourself to shift your focus back to observing.

The idea is to not try to change or remove the sensation—just to simply go with it and allow it as it is. If it does change by itself, that's ok. But equally if it doesn't change, that is ok too.

You may like to start by observing the sensation for a few seconds and then try a few minutes. Again, like anything new start slow and build yourself up slowly. Be kind to yourself, these will be new experiences that will take practice. The goal is to bring yourself to a point where you no longer struggle with the sensation. With time, practice and patience hopefully you will learn a new skill in managing and accepting your emotions.

If you feel you want to, scan your body again for any other sensations and repeat the above process. You may continue with this technique for as long or as short as you feel you need to in practicing to *accept* rather than struggle with these feelings.

When practicing this exercise, your feelings may or may not change—that is ok! The goal is just to simply learn to accept the feelings rather than change them.

#### **Russ Harris's (2007) 4 Quick Steps to Emotional Acceptance**

1. **Observe** Bring awareness to the feelings in your body.
2. **Breathe** Take a few deep breaths. Breathe into and around them.
3. **Expand** Make room for these feelings. Create some space for them.
4. **Allow** Allow them to be there. Make peace with them.

Some people find it helpful to silently say to themselves:

*'I don't like this feeling, but I have room for it.'* or *'It's unpleasant, but I can accept it'*



**Learning to Accept Emotions** - adapted from Russ Harris (2007) [www.actmindfully.com.au](http://www.actmindfully.com.au) & Russ Harris (2009) [www.actmadesimple.com](http://www.actmadesimple.com)

**Russ Harris' (2007) Take Ten Breaths**

1. Throughout the day, pause for a moment and take ten low, deep breaths. Focus on breathing out as slowly as possible, until the lungs are completely empty, and breathing in using your diaphragm.
2. Notice the sensations of your lungs emptying and your ribcage falling as you breathe out. Notice the rising and falling of your abdomen.
3. Notice what thoughts are passing through your mind. Notice what feelings are passing through your body.
4. Observe those thoughts and feelings without judging them as good or bad and without trying to change them, avoid them or hold onto them. Simply observe them.
5. Notice what it's like to observe those thoughts and feelings with an attitude of acceptance.

**Russ Harris' (2009) Drop Anchor**

1. Plant your feet on the floor
2. Push them down-notice the floor beneath you, supporting you
3. Notice the muscle tension in your legs as you push your feet down
4. Notice your entire body-and the feeling of gravity flowing down through your head, spine and legs into your feet
5. Now look around and notice what you can see and hear around you. Notice where you are and what you're doing.

**Russ Harris' (2007) Notice Five Things**

This is a simple exercise to center yourself and connect with your environment. Practice it throughout the day, especially any time you find yourself getting caught up in your thoughts and feelings.

1. Pause for a moment
2. Look around and notice five things you can see.
3. Listen carefully and notice five things you can hear.
4. Notice five things you can feel in contact with your body. (E.g. your watch against your wrist, your trousers against your legs, the air upon your face, your feet upon the floor, your back against the chair etc.)

## Repairing Relationships with a Time-In

(This is a guideline. It is, of course, harder than this page makes it sound.)

### *I'm Upset and My Child is Upset*

When necessary, I start with a "Time-Out"\* (for me, for my child, or for both of us) until:

- I know that I am bigger, stronger, wiser, and kind, and
- I remind myself that no matter how I feel, my child needs me.

\* A "Time-Out" can be helpful as a first step, but not as a punishment.

### *I'm Calm (enough) and My Child is Upset*

We can build a safe "repair routine" together (remember: the first 1,000 times are the hardest!).

- I take charge so my child is not too out of control.
- We can change location. Go to a neutral place that is our "Time-in" spot, where we sit together and let feelings begin to change.
- I maintain a calm tone of voice (firm, reassuring, and kind).
- We can do something different (for several minutes): read, or look out the window, or attend to a chore together.
- I help my child bring words to her/his feelings. ("It looks like this is hard for you." "Are you mad/sad/afraid?")
- I talk about my feelings about what just happened. ("When you did that, I felt...")
- I stay with my child until s/he is calm *enough*. (It may take a while for a child to calm down from overwhelming and unorganized feelings. Rule of thumb: Stay in charge and stay sympathetic.)

### *I'm Calm (enough) and My Child is Calm (enough)*

I use the following to support our repair and to make repair easier in the future.

- I help my child use words for the needs and feelings that s/he is struggling with by listening and talking together. (Remember KISS—Keep It Short And Sweet)
- I help my child take responsibility for her/his part and I can take responsibility for my part. (Rule of thumb: No blaming allowed.)
- We talk about new ways of dealing with the problem in the future. (Even for very young children, talking out loud about new options will establish a pattern and a feeling that can be repeated through the years.)

**B**ottom line: It's the relationship (and only the relationship) that will build my child's capacity to organize her/his feelings. My child's problem may look like something that is being done on purpose. But at its root, it's an issue of needing to reconnect and learning to handle difficult



**Emotions - adapted from *Optimistic Kids***

They can be hard to define. Most experts agree emotions:

- Originate from the midbrain
- At the core of an emotion is a complex series of physical changes throughout the body
- These physical changes prepare us to take action

*For example:*

Anxiety may involve physical changes such as an increased heart rate, increased sweating, rapid breathing and we may experience sensations such as tightness in the chest, churning stomachs and trembling legs. We may have the urge to run away or quit what we are doing and we may have action tendencies to fidget, talk rapidly or pace.

**Nine basic human emotions include:**

- Fear
- Anger
- Shock
- Disgust
- Sadness
- Guilt
- Love
- Joy
- Curiosity

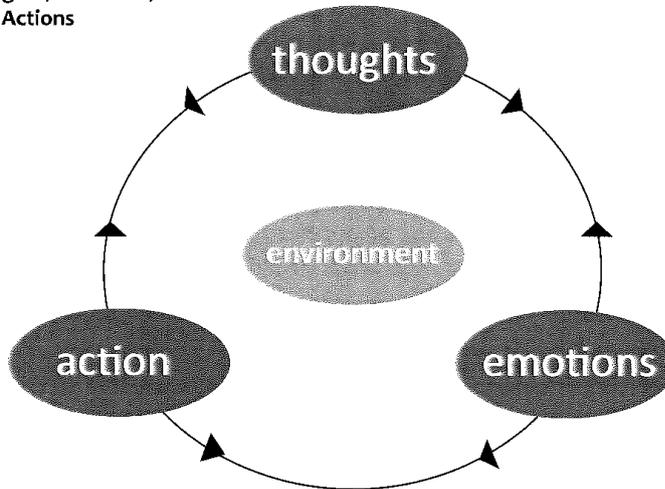
**Adding to our discomfort.....questions / comments like:**

- Why am I feeling like this?
- What have I done to deserve this?
- What's wrong with me?
- I can't handle it
- I shouldn't feel like this.

*Emotions are like the weather—they are always present and constantly changing. They continually ebb and flow, from mild to intense, pleasant to unpleasant, predictable to utterly unexpected. (Russ Harris, 2007)*



**Linking Thoughts, Emotions,  
Behaviours / Actions**



**Scenarios**

For the scenarios below, name your emotions and think what would be helpful and unhelpful to do. Then think of some scenarios from your own life where you have experienced strong emotions.

*You are at a supermarket checkout. Your baby won't stop crying. In the next aisle is a lady with a happy smiling baby and a quiet toddler.*

Emotion .....

Helpful action .....

Unhelpful action .....

*A friend has offered to look after your child for you to have some time out. At the last minute she rings to say she is ill and can't come.*

Emotion .....

Helpful action .....

Unhelpful action .....

*Think of a scenario that relates to you.*

Emotion .....

Helpful action .....

Unhelpful action .....



**What is assertiveness?**

Assertiveness is a direct communication style that is delivered in a calm manner, clearly outlining how you are feeling and asking for what you want or need, without any put-downs or emotional outbursts. Assertiveness ensures a "win-win" situation for both parties, promoting open communication, enhancing self esteem and respecting the other person's feelings. Assertiveness is a *learned* communication skill that will take time and practice (*How to stop worrying, 1996*).

In the table below you will find an examples of aggressive and assertive communication styles (*Adapted from Your Depression Map, 2003*)

	Passive	Aggressive	Assertive
<b>Behaviour</b>	Keep quiet. Don't say what you feel, need or want. Put yourself down frequently. Apologise when you express yourself. Deny that you disagree with others or feel differently.	Express your feelings and wants as though any other view is unreasonable or stupid. Dismiss, ignore, or insult the needs, wants and opinions of others.	Express your needs, wants and feelings directly and honestly. Don't assume you are correct or that everyone will feel the same way. Allow others to hold other views without dismissing or insulting them.
<b>Posture</b>	Make yourself small. Look down, hunch your shoulders, avoid eye contact.	Make yourself large and threatening. Eye contact is fixed and penetrating.	Body is relaxed, movements are casual. Eye contact is frequent but not glaring.
<b>Attitude</b>	Other's needs are more important and more justified than yours. They have rights, you don't. Their contributions are valuable. Yours are worthless.	Your needs are more important and more justified than theirs. You have rights, they don't. Your contributions are valuable. Theirs are silly, wrong or worthless.	Your needs and theirs are equally important. You have equal rights to express yourselves. You both have something valuable to contribute.
<b>Feelings</b>	Fear if being rejected. Helpless, frustrated and angry. Resentful toward others who 'use' you. Your self respect may suffer.	Angry or powerful at the time and victorious when you win. Afterwards: remorse, guilt, or self-hatred for hurting others.	You feel positive about yourself and the way you treat others. Self-esteem rises.
<b>Goal</b>	Avoid conflict. Please others at any expense to yourself. Give others control over you.	Win at any expense to any expense to others. Get control over them.	Both you and others keep your self-respect. Express yourself without having to 'win' all the time. No one controls anyone else.



**Let's try this exercise:**

Think back over your dealings with others over the past week. Try the following exercise for two of the interactions you found difficult. Briefly describe the situation, then your reaction. Consult the descriptions of passive, aggressive and assertive behaviour to see which best describes your response. For each passive or aggressive response, write down an assertive response that might have been better.

**Situation:** \_\_\_\_\_

What did you do? \_\_\_\_\_

Alternative assertive response? \_\_\_\_\_

**Situation:** \_\_\_\_\_

What did you do? \_\_\_\_\_

Alternative assertive response? \_\_\_\_\_

Are there any situations coming up this week that will require your assertiveness skills? In the space below describe the situation, the people involved, the outcome you would like and the assertive strategy that you would like to use.

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*Adapted from Your Depression Map (2003)*



**STRENGTHS** (Adapted from Parent Wellbeing: *Signature Strengths*)

**Creativity** (imagination, originality, ingenuity,)

Thinking of ways to do things differently, 'outside the square', being resourceful.

**Curiosity** (inquisitiveness)

An eagerness and interest to explore new experiences.

**Open-mindedness** (flexibility)

Being open and to new ideas and perspectives. The ability to assess situations from an unbiased view, looking at the evidence from all sides, to come to a fair conclusion.

**Love of Learning** (life-long learning)

To be willing and open to learn new skills and gain further knowledge at every stage throughout your life.

**Perspective** (wisdom)

Being there for others to share your knowledge and insight. The way in which you view the world that make sense to yourself and others.

**Courage**

Facing and accepting challenges or difficult situations, even if they make you feel uncomfortable.

**Persistence** (determination, perseverance)

Completing tasks, seeing things through until the end. 'Hanging in there' even when things get tough.

**Integrity** (being 'authentic', honesty)

Being genuine, acting on your own principles and values. Taking responsibility for your own feelings and actions.

**Vitality** (energy, strength, enthusiasm)

Looking at and approaching life with energy and enthusiasm.

**Love**

Nurturing and valuing close relationships, especially when the caring and sharing is reciprocated.

**Kindness** (compassion, generosity, thoughtfulness, humanity)

The practice of showing consideration to others, either by understanding them and their situation or offering to assist them in some way.

**Emotional Intelligence** (social intelligence)

Being aware of other people's feelings and your impact on other people with your feelings and actions.

**Social responsibility** (loyalty, teamwork)

The ability to work as part of a team or group, considering other people's needs and feelings. Being loyal to that team or group.

**Fairness** (equality)

To treat all people as equal, with principles of fairness and justice, without allowing your own opinion or judgment cloud the treatment of others.



**Leadership**

The ability to positively influence and guide others, whilst maintaining a good working relationship.

**Forgiveness**

Being able to forgive others who may have in some way upset us. Accepting that we are not all perfect and all have faults. Giving people the opportunity to have another chance.

**Humility** (being humble, respectfulness)

Allowing your accomplishments to speak for themselves. Being open to new ideas and suggestions. Through your actions and behaviour, treating everyone with respect and understanding, in the way that you would want to be treated.

**Practicing Care** (good judgment, discretion)

Being careful in your decision making and choices. Thinking through your actions, behaviour and words so that you may be able to avoid regretting anything later on.

**Self Control** (self management)

The practice of being able to manage one's habits and desires e.g. excessive eating, drinking, shopping. Being able to regulate how you feel and what you do. Positive things that you do to manage your health and mood e.g. exercise, eating well, relaxation techniques.

**Appreciation of beauty**

Being able to fully appreciate and benefit from beauty in all forms, for example nature, art and music. The practice of 'mindfulness' may enable you to learn to appreciate these things *in the moment* and in their entirety.

**Gratitude**

Noticing good things that happen to you and being appreciative of what you have. The practice of expressing your appreciation. For some people this may be through their own spirituality/religion or culture, thinking of 5 things they are grateful for, writing in a journal of things to be appreciative of, or simply expressing their gratitude another person in some way.

**Hope** (optimism)

Remaining positive that a situation will improve in the face of diversity. For example thinking positive thoughts like: "This will pass" or "Things can only get better". Taking steps to work towards a positive adjustment or goal.

**Humour** (playfulness)

Being lighthearted, ability to see the funny side to life and it's situations. Bringing smiles to other people. Enjoyment of humour and sharing in a good laugh.

**Spirituality** (values, religion/culture)

Spirituality, religion and culture are all a very deeply personal set of values and beliefs. Some people have particular practices or groups that they may be involved with that enables them to connect to these values and beliefs. Some may simply believe in a higher purpose, or feel reconnected by being in nature. There are no rights or wrongs, it is a personal set of beliefs that differ with each person.



**Values** adapted from [www.thehappinesstrap.com](http://www.thehappinesstrap.com)

**What are values?**

Values come from inside of you, your qualities, what you uniquely stand for and believe in. They assist us through life in making decisions and maintaining our relationships. Values can also be what we would like to strive for to enhance our lives in some way. If someone close to you were to make a speech about you as a person, what would you like them to say?

**What are goals?**

Goals assist us to keep us on track to get what we want, for example, returning to study to complete a degree. Goals can easily be identified once they are achieved (e.g. degree achieved) but if we are wanting to completely change careers for a specific purpose to enrich a part of our lives, this is driven by a *value*. If our value was to change careers to enable us to spend more time with family (enriching our relationships) or if it were because it is an area that you feel passionate about (e.g. being a nurse/ youth worker/ marine biologist) this goal is driven by your values and is an ongoing process, it will not stop once you have landed the career you want, it will continue to motivate and satisfy that desire that you have inside of you.

Here are some common areas in life that may assist some people to consider what is important in their lives. Everyone is unique with their own set of values. There are no right or wrong values and what may be important to one person, may not be as high as a priority right now in *their* lives. Please note that they are not listed in any specific order.

**Relationships** (Family relationships, parenting, social and intimate relationships)

How do you see them? How would you like them to be? What do you value about your relationships? What qualities can you bring to improve them?

**Career & education**

How do you see yourself in your work or study? What do you value in your work or study? How could you enhance your current work or study situation? (e.g. build on relationships or learn new skills). If you could choose any other career, what would it be? What do you value that would draw you to that career? Is there any other way that you may be able to fulfill these desires? (e.g. become involved in some community activity or volunteer in an area you feel passionate about).

**Recreation**

What do you like to do to relax, unwind and have fun? What activities do you/did you previously enjoy doing? Do you think you might be able to find a way to incorporate some of these activities back into your life, or find some new activities that you could enjoy that may suit your current lifestyle?

**Spirituality, culture & personal growth**

What do you deeply value? What helps you to connect with these values/culture? Are there any ways that you could enhance this connection or reconnect with these values or culture? Is there a group or culture that shares in the same values that you could participate in? Or do you have a simple practice that makes you feel at peace and reconnected e.g. walking in nature or meditating? What would you like to do to enhance your personal growth, learn more about yourself and techniques that may assist you in your life?

**Community**

How do you see your local community? Does your community share in your values? Do you find pleasure in participating and sharing your qualities in your community? Which environments or community groups do you enjoy participating in? Are there any other communities where you feel you can participate and contribute? What are your values about the environment? In which ways could you contribute to better your environment? E.g. recycling, plant a veggie patch, participate in a community garden, buy local produce, teach your child/ren your values about the environment.

**Health**

How do you see your current health? How do you value your health? What things do you do to look after yourself? E.g. diet, exercise, relaxation. What things could you do to improve your health?



## positive statements



### **A handout for women**

- 1 I am doing the best I can.
- 2 This is going to take a long time, whether or not I try to speed it up.  
I must take one day at a time.
- 3 I cannot expect too much from myself right now.
- 4 It is okay to make mistakes.
- 5 There will be good days and bad days.
- 6 It is okay for me to have negative feelings.  
If I fight having these feelings, it might take longer to feel better.
- 7 Even though I feel so bad, just getting through the day is proof of my strength.  
I can be proud of how much I have accomplished when I get through the day feeling this bad.
- 8 I know that some of the pain I am feeling right now is part of the recovery process.
- 9 Today, when I am feeling bad, I know that I will not feel bad all of the time.  
This is just a bad day. I will get through this day the best I can. I will try to rest.  
I will pamper myself a bit. I will treat myself well because I deserve it.  
And I will wait this out.
- 10 Some of what I am feeling is just like what other mothers feel. Not all of my  
bad feelings are symptoms of Post Natal Depression. All mothers of new babies  
feel tired, irritable or stressed at times.
- 11 It is okay that not everyone understands what I am going through.  
I still have an illness that is treatable, even if other people don't know  
anything about Post Natal Depression.
- 12 I will feel like myself again.

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## simple strategies



**A handout for women**  
**Circle one thing from each area you will**  
**do for yourself within the next week.**

### Physical

- Reconnect with exercise and your physical fitness (there is evidence that this kind of activity measures up to the effects of antidepressants)
- Keep a healthy diet and keep the fluids up
- Keep the daily goals small
- Accept practical help from partner, family, friends, neighbour, church etc.

### Psychological

- Keep note of what you did well (for example, fed baby, got dressed, cooked a nice meal, made contact with someone, went out for a walk)
- Keep a reflective journal and use this with your worker and GP to talk about issues
- Remember to take it one hour, one day, one week at a time
- Utilise parent help lines in your state
- Spend time noticing your body's reactions and think about what your baby is thinking and feeling

### Personal

Now is not the time to meet others needs, its time to focus on yours, the baby's and your partners. Others needs will just have to wait.

- Organise childcare for childfree time
- Return to work part-time
- Meet up regularly with another parent(s) to swap time, talking, and listening
- On the days it feels really bad, do something that used to give you a lift (and do it even if it doesn't feel like it works) eg your favourite music, wearing bright clothes, gardening, bushwalking, a craft activity, call someone and ask them just to listen and be there while you have a good cry

### Peace

Motherhood changes every aspect of who we are as women, our body, our mind, our relationships. Finding things that help you to feel good, whole, 'together' inside will help, however you may have to do them many times before you start to feel better more of the time.

- Do one nice thing for yourself
- Do yoga, relaxation
- Meditation
- Quiet time out in the sunshine
- Listen to your favourite music
- Play your favourite musical instrument.

### Useful websites

<http://www.zerotothree.org>  
<http://www.beyondblue.org.au/> postnataldepression  
<http://www.moodgym.anu.edu.au>  
<http://www.panda.org.au>

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# Circle of Security

(Birth to Twelve Months)

Creating the

**SECURE BASE**  
**SAFE HAVEN**

When I'm Feeling OK...

Be With Me...

- Delight in me as I fall in love with your face
- Watch over me as I turn to new sights, sounds, and touches
- Try to see the world through my eyes and talk to me about it
- Connect with me by matching my voice, face, and movement
- Wait for me when I look away to keep from getting too revved up

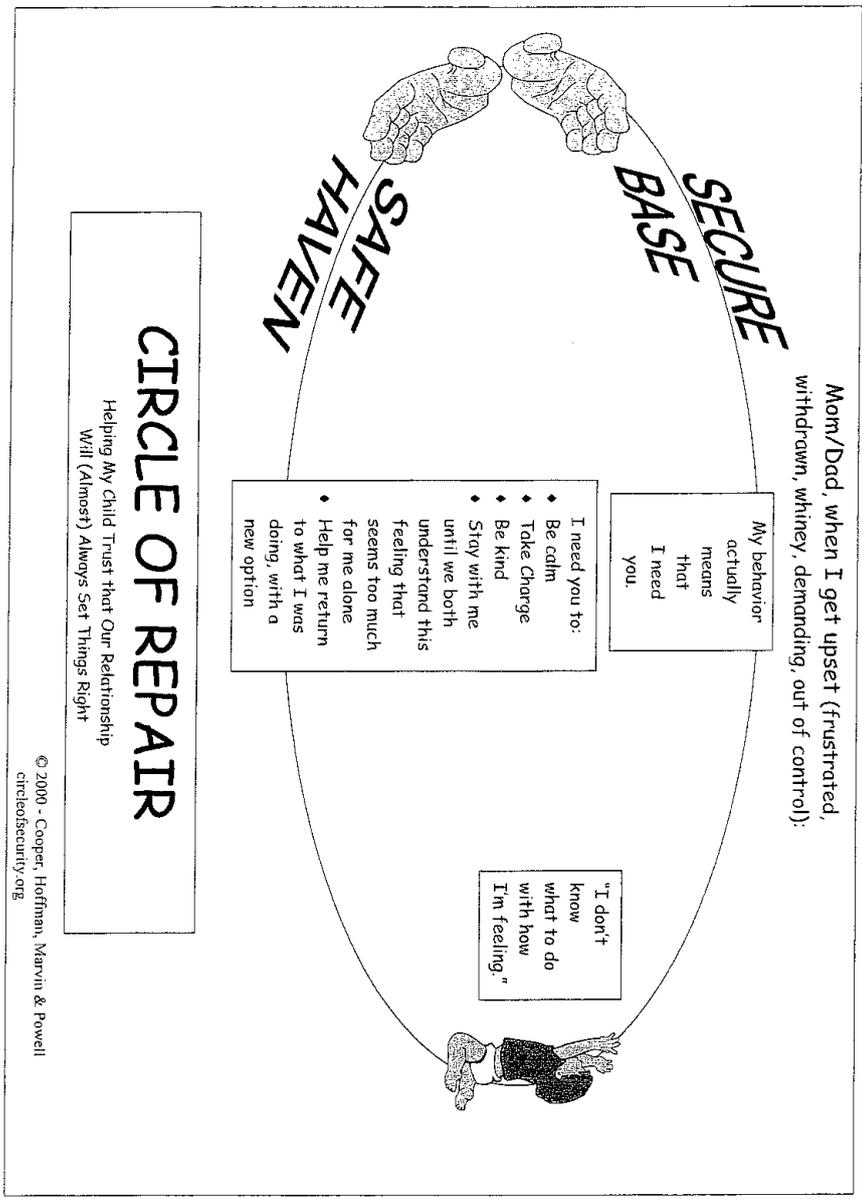
When I'm Feeling Upset...

Be With Me...

- Protect me
- Help me feel you "get it" by matching my emotions with your voice, face and touch
- Stay with me even when my distress upsets you\*
- Wait for me when I look away, so I can learn to use both you and myself to calm down
- Organize my feelings by sharing, naming, and accepting them without fear

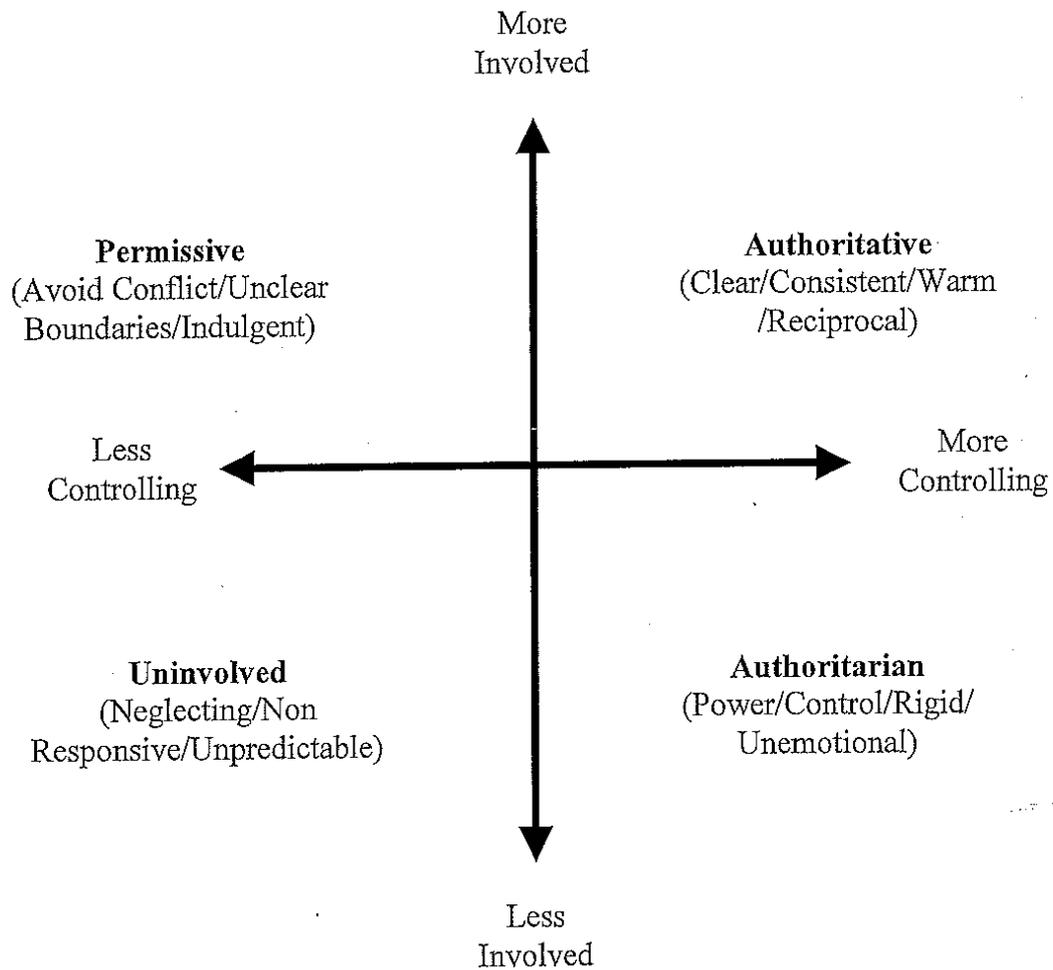
\*If you are too upset, please reach out to someone for support!

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# Parenting Approaches (Models)



**Permissive**  
**Authoritative**  
**Authoritarian**  
**Uninvolved**

## Permissive Parenting: Broad Overview

Permissive parents believe that showing their child love and feeling loved in return, is a significant goal in parenting. Permissive parents tend to avoid conflict at any cost. Discipline and limits are often missing from the permissive household.

Permissive parents do love their children and are highly bonded to their children. They believe the key to their child's heart is to relate to their child as a peer instead of as a parent. Rules, if they exist at all, are inconsistent at best. If a permissive parent needs a child to act on a rule or expectation, often the parent will use any means necessary including bribery, gifts, food and other motivators to gain their child's compliance.

One of the problems with permissive parenting is that children do need healthy limits and expectations not only to learn appropriate behaviour for functioning as a member of society but also to feel valued and cared for. Often, over time, children of permissive parents suffer a loss in self esteem, may be more immature than their peers and do not readily take on responsibility.

Children feel like an important part of a functional unit - the family unit - when they are held to a higher standard and are required to be part of that functional family unit whether it is through chores or routine bedtimes or other structured family activities. Permissive parents, in their desire to be everything to their children, often miss the boat entirely and have very little to offer that a peer at school can't also fulfil.

When a permissive parent does try to discipline, children quickly learn how to manipulate these parents to get what they want. Permissive parents, wanting to please at any cost, cave to this manipulation time and time again. In the end, permissive parents often end up feeling resentful and taken for granted. But these parents simply have not learned to provide and keep to boundaries in a consistent and firm but fair way.

Permissive parents raise children who grow into adults that have no strong inner sense of discipline, no sense of connectedness or family and essentially have to re-parent themselves, which puts them at a disadvantage in all areas of life as adults. It is not unusual for adult children of permissive parents to feel resentful or angry toward their parents as they realize the many lessons they were not taught as children because their parents were so desperate to not make waves at any cost.

We know through experience that permissive parenting does not work. Permissive parents are better off trying for a more balanced approach. Having love and affection is a healthy part of parenting but it becomes unhealthy if there isn't also a balance of guidance and discipline.

## Authoritative Parenting: Broad Overview

Authoritative parents believe in developing a close and nurturing relationship with their children while also upholding and maintaining a reasonably high level of expectations and rules or guidelines. While the most difficult to accomplish, an authoritative parenting style is the healthiest and most well-balanced style in which to raise children.

Authoritative parents develop clear and fair behavioural guidelines for their children. These guidelines are age appropriate and flexible, taking into consideration special circumstances, personality styles and changes that might occur. In other words, they are clear and consistent, but not rigid.

The Authoritative parent is a good listener and respects that their relationship with their child is a two-way relationship. Parents may even encourage their children to make a good argument for consideration before making a final decision on a heated topic. Arbitrary rules have no place in the authoritative household. But in an authoritative household, the parents will always make the final call.

The authoritative parent leads by example, realizing that they are role-models to their children. But the authoritative parent also acknowledges that no one is perfect, least of all themselves or their children and is willing to openly apologise when a situation requires it.

The authoritative parent and their children have a warm, friendly, mutually respectful relationship. Even when there are disagreements, they occur in a respectful way. The child in an authoritative household knows they are loved even when they have upset their parents.

The authoritative parent encourages a child's growing sense of autonomy by slowly increasing the freedoms allowed to the child based on the child's maturity, responsibility and trustworthiness. An authoritative parent's goal is to prepare children to live fully autonomous lives upon adulthood.

As a result of the love and mutual respect shown in an authoritative household, the number of conflicts may be reduced. When they are required, punishment will consist mainly of natural and logical consequences.

## Authoritarian Parenting: Broad Overview

Authoritarian parents believe in holding their children to a very high level of achievement and status. The desire for discipline is often so paramount in this relationship that the relationship, itself, is devoid or low on love, affection and nurturing. This is not to say that an authoritarian parent does not love their child but the child often does not perceive the love as being unconditional. Many children of authoritarian parents equate success with love.

One of the problems with authoritarian parenting is that children, when in need of guidance and problem-solving assistance, naturally turn to someone they feel loved and accepted by. This is often not the authoritarian parent. So while these parents often hold such high standards out of a desire to create high-achieving and successful adults out of their children, they often miss out on real opportunities for guidance when the child needs it most.

Authoritarian parents often confuse punishment for discipline. Discipline occurs from within, punishment occurs externally. Children raised with authoritarian-style parents are often very good at obeying authority but seldom have a strong sense of inner discipline as this is not something that is encouraged in childhood by authoritarian parents.

Likewise, the punishment style of authoritarian parents is often harsh and may not "match the crime". It isn't uncommon for parents to use spanking as a primary means of punishment in an authoritarian family. One problem is that spanking used primarily for discipline leaves no other effective tools in one's parenting tool belt. For parents who are desperate for control over their children, when spanking doesn't work (and often, it will not), the relationship turns abusive, either physically or emotionally or both.

We know through time that authoritarian parenting does not work. Authoritarian parents are better off trying for a more balanced approach. Having expectations and limits is a healthy part of parenting but it becomes unhealthy if there isn't also a balance of love and affection.

June 2016

## **Being with Baby Session**

- Program facilitated by an Occupational Therapist and a Speech Pathologist.

### **Aims**

- Learn the skill of emotion coaching to improve relationships.
- Introduce a greater understanding of child development.
- Improve communication and positive influences on relationships.
- Learn appropriate responses to child's needs.
- Provide a safe environment for learning and positive nurturing.
- Increase knowledge on how to have better family relationships.
- Encouragement of appropriate support and bonding with the child.
- Reflection on parents own child hood experiences and needs and how to support their own child's needs with self-reflection.
- Role modelling appropriate behaviour from the Being with Baby instructor (worker) to parent/carer and child.
- Group peer support and social buffering.
- Build confidence in managing difficult circumstances and managing risk in the environment.
- Appreciation of the mindful relationship to self, others and environment.
- No cost activity relieving the financial burden of participating in a supported specialised activity.
- Support decision making skills between parent /carer and child.
- Encourage a physically healthy lifestyle.
- Explore choice and consequence while Being with Baby protected waters.
- Learn skills around risk management.
- Increase motor skills and coordination.

### **Foundational Principles**

- Evidence Based Programs information incorporated in session discussions
- Child centred practise
- Attachment Theory
- Child Development
- Circle of Security
- Bringing up Great Kids
- Tuning In To Kids
- Positive Parenting Program

# **Founding Principles**

## **Child-Centered Practice**

The core components of a child-centered approach can be identified as being:

- It keeps the child central at all times
- Features specific to childhood must form the foundation for approaches
- The effectiveness of interventions must be in the terms of the outcomes for the child
- The same room must be used each time to promote a sense of belonging
- Persons working with the child must be comfortable to play and be skilled and knowledgeable about establishing rapport and communication with the child at their level, both physically and verbally
- Interventions are tailored to the child's individual developmental needs
- And the goal of therapy must be the continued growth and development needed for the child to develop adaptive functioning skills.

(Mudaly and Goddard 2006)

### **Attachment theory and the importance of relationships**

The most important aspect of attachment theory is that an infant needs to develop a relationship with at least one primary caregiver for the child's successful social and emotional development, and in particular for learning how to effectively regulate their feelings and emotions. Fathers or any other individuals, are equally likely to become principal attachment figures if they provide most of the child care and related social interaction. In the presence of a sensitive and responsive caregiver, the infant will use the caregiver as a "safe base" from which to explore.

John Bowlby (1958) "the Nature of the Child's Tie to his Mother".

Harry Harlow (1958) "the Nature of Love".

### **Trauma-Informed Principles**

Parents and carers may benefit from understanding that traumatised children are likely to find it difficult to utilise reasoning and logic to modify their behavior or reactions. These children are also unlikely to learn from consequences, particularly when they are in heightened arousal states. It is possible to support parents and carers to avoid the frustration associated with the failure of traditional parenting approaches by increasing their knowledge of trauma. If they understand that trauma acts to scramble cortical functioning and reduce children's capacity to be guided by rule based frames of behavior, they will be less likely to rely on such parenting methods. In addition, children's recovery from trauma will be enhanced through interactions with parents and carers which promote physical activity that stimulates lower order parts of the brain responsible for movement, play and balance. (ACF 2013. [www.childhood.org.au](http://www.childhood.org.au)) June 30, 2016).

Australian Childhood Foundation (2013) information highlights Key Trauma Intervention principles to be:

- Safety- to offer a 'felt' sense of safety to the child
- Relational
- Flexible, predictable, consistent and repetitive
- Child focused
- Trauma informed
- Recognise sequential development
- Purposeful
- Child able to meaningfully participate
- Focused towards attentional focus
- To work toward mediating physiological arousal levels

## Attachment Theory and Circle of Security

### What is Attachment?

- Attachment is the enduring emotional connection or the pattern of the relationship, between a child and parent/care giver.
- Attachment is not present at birth but develops intensely during the first 3 years of life.
- Loss or threat of loss of the attachment figure causes anxiety and distress.



# Attachment.....



- Secure early attachment is the secure base from which the child explores and learns about their world.
- Secure early attachment is an important foundation for healthy social and emotional development.
- Early attachment experiences may strongly impact the child's future relationships.

## Attachment Impacts on a Child's Development of:

- ◆ Trust
- ◆ Ability to form relationships
- ◆ Exploring skills
- ◆ Self-regulation
- ◆ Identity formation
- ◆ Moral framework
- ◆ Core belief system
- ◆ Defense against stress and trauma
- ◆ Physical health and growth

## Appendix 2: Program Logic: Being with Baby

